

# HIV/AIDS in Nigeria

## Toward Sustainable U.S. Engagement

Report of the CSIS HIV/AIDS  
Delegation to Nigeria  
March 11–18, 2005

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The CSIS Task Force on HIV/AIDS is cochaired by Senators Bill Frist (R-TN) and Russell Feingold (D-WI) and is funded by the Bill and Melinda Gates Foundation. Now in its second two-year phase, the task force seeks to build bipartisan consensus on critical U.S. policy initiatives and promote U.S. leadership in strengthening prevention, care, and treatment of HIV/AIDS in affected countries. CSIS is grateful to Senators Frist and Feingold for their leadership and to the Gates Foundation for its continued support and vision.

# HIV/AIDS in Nigeria

## Toward Sustainable U.S. Engagement

### Executive Summary

Nigeria's struggle with HIV/AIDS will be long and uncertain. Given the scale of the response required and the country's political, economic, and cultural diversity, having an impact on the epidemic and measuring success or failure of HIV/AIDS interventions will be difficult and slow. The Nigerian government, together with international donors, has embarked on an ambitious strategy to combat HIV/AIDS, with a strong emphasis on providing access to treatment for those infected with HIV. However, the national response will confront significant challenges in managing expectations and resources, in maintaining adequate focus on HIV prevention, and in ensuring a sustainable long-term response.

The stakes for Nigeria and for Africa are high. Nigeria is a hub of African trade, transportation, and travel, and Nigerians themselves are highly mobile within Africa and beyond, making the transborder spread of HIV/AIDS a serious risk. Because of the country's size (more than 135 million people—one-fifth of Africa's population), even fractional increases in Nigeria's HIV prevalence rate will mean many hundreds of thousands of new infections and dramatic increases in demands for care and treatment. This in a context that is politically and economically fragile, where popular disenchantment with government remains high, and where institutional and health capacities have been hollowed out by decades of malgovernance and military rule. Nigeria grapples with numerous sources of potential instability and faces a monumental struggle in rooting out endemic corruption.

At the same time, Nigeria has a number of strengths, which, if mobilized and supported, may advantage the country in responding to HIV/AIDS. A vibrant media, a recovering non-governmental sector, powerful religious networks, and an energetic youth culture all have the potential to contribute positively to curbing the pandemic.

The stakes for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and for U.S. engagement more broadly are high as well. Nigeria is the largest of the PEPFAR focus countries, with among the most ambitious prevention, treatment, and care targets and the highest levels of U.S. funding. Too, Nigeria is among the most important of the United States' strategic partners in Africa, and U.S. relations with Nigeria are multifaceted, with key U.S. interests in oil, democracy, regional stability, and African peacekeeping operations and governance initiatives at stake.

The CSIS Task Force on HIV/AIDS organized a mission to Nigeria from March 13 through March 18, 2005, to deepen its general understanding of the status and

distinct drivers of the epidemic in Nigeria, the trends in Nigeria's national response, and U.S. engagement through the President's Emergency Plan for AIDS Relief.

In particular, the delegation examined two areas: first, the status of prevention efforts in a context of increasing attention on provision of antiretroviral treatment; and second efforts to combat HIV/AIDS within the Nigerian military.

Among the delegation's key observations:

- The Nigerian HIV/AIDS pandemic is still in an early phase, and a variety of factors put Nigeria at risk of reaching much higher prevalence rates before HIV/AIDS interventions bear fruit. Available surveillance and behavioral data are weak, and success or failure of HIV interventions on a national scale will be difficult to measure.
- Nigeria's federal leadership has been outspoken about the threat of HIV/AIDS and active in developing a national strategy to combat it. In Nigeria's federal system, however, implementation will depend heavily on the commitment of the country's 36 state governors, who to date have demonstrated varied awareness and commitment on this issue.
- Political sensitivities surrounding U.S. engagement through PEPFAR remain high. Although initial frustration with the lack of consultation and coordination has been assuaged, there will be continued need for careful communication with the Nigerian government, and strong reassurance that U.S. engagement will be sustained.
- Both the Nigerian national response and the U.S. PEPFAR strategy have set ambitious targets for providing antiretroviral therapy to infected individuals. There is serious concern that resources and supportive interventions—testing, counseling, referral systems, procurement mechanisms, and monitoring—are inadequate to reach and maintain these targets over the long term. There is a high risk of unmet expectations, disruptions in supply, distortions in an already weak health infrastructure, and inequities in access to treatment.
- Prevention efforts are at risk of being eclipsed by official, popular, and international focus on ARV treatment. Additionally, HIV/AIDS has been obscured by broader debates on worsening poverty. Nigeria's exceptional cultural diversity and the relative invisibility of HIV/AIDS to date will make crafting and mobilizing support for prevention strategies a daunting challenge. Although the delegation saw a number of promising prevention interventions, it was more difficult to discern an overarching prevention strategy or lines of accountability and evaluation in this area.
- There is some evidence that U.S. domestic debates and conditionalities surrounding outreach to high-risk groups, along with pitting exhortation to abstinence against condom distribution, are impinging on public health imperatives on the ground and constraining U.S. flexibility in responding to Nigeria's unique requirements. Prevention outreach to high-risk groups, especially commercial sex workers (CSW) and their clients, warrants greater attention and emphasis in an overall prevention strategy.

- There are encouraging signs of leadership on HIV/AIDS within the Nigerian military, offering an opportunity not only to improve the military's HIV/AIDS status, but also to develop positive vectors for change in the broader Nigerian society. The PEPFAR-supported partnership between the U.S. Department of Defense (DOD) and the Nigerian Ministry of Defense has the potential to make significant contributions to surveillance and treatment capacities of the armed services.
- At the same time, HIV/AIDS prevention within the Nigerian military, as in other sectors, is at risk of being neglected in favor of more politically attractive and immediately tangible interventions in treatment, testing, and upgraded laboratory facilities. U.S. support to HIV prevention in the military has been intermittent and relatively small-scale. There is an opportunity for much deeper engagement here, with potentially high returns in prevention impacts.

### **Recommendations**

The CSIS delegation fully appreciates the daunting challenge of crafting a U.S. approach to a country the size and complexity of Nigeria. PEPFAR is still in its early stages, and definitive pronouncements on what will and will not work in Nigeria will be a long time coming. The recommendations provided here should not require major changes in strategy, but rather shifts in emphasis and pragmatic steps that may support a sustained, long-term U.S.-Nigerian engagement.

- The U.S. Office of the Global AIDS Coordinator (OGAC) should map out the realistic resource and support requirements—testing, counseling, monitoring, and referrals—of a sustainable treatment program in Nigeria, as it endeavors to place 350,000 people on antiretroviral therapy by 2008. OGAC should take time for a revised assessment of projected costs. As ARV therapy prolongs lives, the number of individuals dependent on health care infrastructure—those newly infected and those on long-term ARV therapy—will rise dramatically. It is essential to plan for adequate resources now to ensure that achieving treatment targets does not undermine or distort health infrastructure and priorities, impinge on less easily measurable targets (notably prevention), raise unrealistic expectations, or prove unsustainable over the long term.
- An immediate step should be to address the uncertainty surrounding pricing and a procurement mechanism for ARVs that simultaneously provides reliable safeguards against both corruption and disruption of supply. The United States won agreement from the Nigerian government to provide brand-name drugs through PEPFAR for its first year. However, uncertainties around whether the United States will move to generics or win continued agreement to use brand-name drugs will make a realistic assessment of resource requirements impossible. Questions of in-country delivery mechanisms for ARVs, transparency and accountability guarantees, and who will qualify to sell high-volume, low-cost ARVs to PEPFAR will need to be resolved quickly.
- Prevention must remain an urgent priority. PEPFAR has brought a considerable infusion of new prevention funds to Nigeria, and the expanding availability of

treatment in itself will clearly be a boon to prevention efforts. But increasing availability of ARVs can go only so far in bolstering prevention efforts, which must go far beyond the health care infrastructure and the relatively limited sites (relative to Nigeria's size and population) where ARV treatment will be visible and accessible. A long-term prevention strategy will require systematic outreach and communication with a broad range of nongovernmental actors—media, youth, people living with HIV/AIDS, religious leaders, community gatekeepers, and Nigerian social scientists—to craft, implement, and measure the effectiveness of awareness and prevention strategies that target the country's many distinct, micro-cultures and communities. Prevention will need to be carefully and consistently integrated into treatment programming and other health interventions.

- U.S. Global AIDS Coordinator Randall L. Tobias has done well in balancing and responding to the moral/philosophical concerns of U.S. domestic constituencies that pit exhortation to abstinence and fidelity against distribution of condoms and outreach to high-risk groups. OGAC should insulate the country missions from these domestic political pressures and queries more vigorously, insisting on evidence-based and results-based strategies best suited to the realities on the ground.
- The U.S. response should place stronger emphasis on outreach to high-risk groups. As a second-wave state, where the prevalence differential between the general population and high-risk groups is high, there is an urgent need to expand outreach to high-risk groups, including commercial sex workers and their clients, both to protect their health and to curb a more generalized epidemic. This is a public health imperative emphasized in Nigeria's National Strategic Framework that the United States should more fully support.
- The Office of the Global AIDS Coordinator and the U.S. embassy in Abuja will need to assure Nigerian counterparts that U.S. engagement will be sustained. This will require outreach and systematic dialogue with the U.S. Congress to convey the serious costs that unpredictability or dramatic shifts in U.S. funding levels will entail. This should also include strong encouragement to the government of Nigeria to increase its own investments in health in keeping with the 2001 Abuja declaration in which President Olusegun Obasanjo and other African heads of state pledged to set a target of allocating at least 15 percent of annual national budgets to health sector improvements.
- The U.S. State Department should consider creating a new position within the U.S. embassy for a senior Foreign Service officer specifically to coordinate PEPFAR efforts and manage diplomatic outreach and engagement on PEPFAR and other health-related issues. Burnout and fatigue among U.S. mission staff, in Nigeria as in other PEPFAR focus countries, are becoming evident. Given the size of the PEPFAR budget in Nigeria, the need for persistent and energetic diplomatic engagement and consultation with federal and state governments, the high potential for misuse of funds, and the enduring damage this would do to

U.S. and congressional support for engagement, additional support for in-country management capacity and oversight of the program is essential.

- U.S. Department of Defense engagement with the Nigerian Ministry of Defense holds strong promise both in curbing HIV/AIDS within the Nigerian military and in furthering U.S.-Nigerian cooperation around broader strategic goals. The United States should look to build a long-term engagement in this regard. PEPFAR should supplement the DOD program with additional prevention programming, working with nongovernmental organizations and the Armed Forces Program on HIV/AIDS Control. Outreach to other uniformed services, especially the police force, should be given greater emphasis, and there is an apparent openness there for greater collaboration.

## Delegation Background

The CSIS Task Force on HIV/AIDS organized a mission to Nigeria from March 13 through March 18, 2005. The Nigeria mission followed similar delegation visits to China, India, Ethiopia, and Russia to examine the special challenges of combating the threat of generalized HIV/AIDS epidemics in large, populous “second-wave” states. The Nigerian delegation was chaired by General Carlton Fulford, director of the Africa Center for Strategic Studies and former vice commander of the U.S. European Command, and J. Stephen Morrison, director of the CSIS Africa Program and executive director of the CSIS HIV/AIDS Task Force. The delegation comprised representatives from the public health and policy arenas, the military, academia, foundations, and operational NGOs.

The U.S. embassy and U.S. Agency for International Development (USAID) mission in Abuja provided valuable guidance and participated in a number of the delegation’s meetings. The delegation also benefited enormously, especially during its regional site visits, from the assistance and advice provided by the in-country offices and staff of the David and Lucile Packard Foundation, Family Health International, and the Society for Family Health.

In a series of consultations, public forums, and site visits, the delegation met with representatives of Nigeria’s senior health and military leadership; police officials; military and civilian health officials at the federal and state levels; nongovernmental activists; country representatives from the World Bank, UNAIDS, and members of the UN Theme Group; health professionals; media representatives; community educators; religious leaders; high-risk groups; and people living with HIV/AIDS (PLHA). In addition to consultations in Abuja, delegates traveled in two separate subgroups to Lagos and Kano states.

In its size and diversity, Nigeria struggles with a host of HIV-related issues. The delegation did not attempt to cover them all nor, in this report, to offer a comprehensive assessment of the current response. Rather, the delegation sought to deepen its general understanding of the status and distinct drivers of the epidemic in Nige-

ria, the trend lines in Nigeria's national response, and U.S. engagement through the President's Emergency Plan for AIDS Relief.

In particular, the delegation focused on two key issues, both of which will be critical to Nigeria and have broad relevance to other HIV-affected states. First, it examined the status of prevention efforts in an era of increasing attention to provision of antiretroviral treatment. Getting prevention "right" in Nigeria will be difficult, controversial, and hard to measure but will be absolutely essential to Nigeria's long-term success in the fight against HIV/AIDS.

Second, the delegation looked at efforts within the Nigerian military to combat HIV/AIDS. In this area, there are promising signs of high-level Nigerian commitment and an incipient engagement with U.S. Defense Department counterparts that warrant continued attention and support. Efforts to fight HIV/AIDS in the military are off to an encouraging start and could help spearhead a more robust national response. Given the mobility of Nigerian armed forces, both within Nigeria and in African conflicts and beyond, a failure to stem the epidemic within the military will have broad strategic and regional impacts.

## The Nigerian Context: High Stakes and Multiple Challenges

Nigeria's success or failure in the fight against HIV/AIDS will have significant repercussions in West Africa and beyond. The country looms large in its regional influence, its military capacity, economic sway, and foreign policy ambitions. It has been a continental leader in bringing attention to HIV/AIDS and is a key interlocutor in the larger dialogue between the developed and the developing world on debt, global trade agreements, regional peacebuilding, and trafficking in illegal goods. At the same time, it is an inherently unstable place, with multiple fissures along regional, religious, ethnic, and class-based lines. U.S.-Nigerian relations are generally warm, but they are also complex. HIV/AIDS, while an important element, is but one of many Nigeria- and Africa-related agendas at play within the relationship.

### A Regional Power, Internally Fragile

With some 135 million citizens,<sup>1</sup> Nigeria is Africa's largest nation. Nigerians are highly mobile throughout the region: beyond the deployment of peacekeeping troops in a number of African conflicts, 2 million Nigerians reside in Côte d'Ivoire, 1 million in Ghana, 2 million in Cameroon, and 3 million in South Africa. Over 1 million Nigerians live in the UK, and over half a million in the United States. The country serves as a key transit node for traffic in drugs, persons, and stolen oil. Nigeria's population is young—45 percent of the population is under 15 years of age—and growing numbers of disaffected, unemployed youth are increasingly vul-

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1. A national census is planned for November 2005. The current population is estimated at 120 to 150 million.

nerable to manipulation by political or criminal elements, creating a cycle of violence and destabilization.

Nigeria is the largest fledgling democracy in sub-Saharan Africa, and a failure of democracy in Nigeria could unleash considerable instability in the West African subregion. Despite the return in 1999 of elected civilian government after years of brutal military rule, Nigeria remains politically fragile. Years of military rule left civil society in abeyance. It is now reviving slowly but remains weak, divided, and highly disaffected from the government. The country is riven by religious, ethnic, linguistic, and political tensions; corruption on a massive scale remains endemic; institutions are weak and basic services and social infrastructures corroded. Per capita income today is lower than it was at independence in 1960. Adult literacy, which once stood at 85 percent, is 46 percent today. More than 90 percent of the population earns less than \$2 per day, and 5 percent of the population holds 80 percent of the country's wealth. Social indicators and inequities are likely to worsen as Nigeria's population grows by 3 percent per year, unless GDP growth accelerates dramatically.

A new economic "dream team," led by Finance Minister Ngozi Okonjo-Iweala, is endeavoring to implement macroeconomic reforms but has little popular support and confronts powerful and politically entrenched vested interests as it tries to root out corruption. Too, rising oil prices have produced an oil-revenue boom similar to that of the 1970s, creating high expectations among the general public, which has yet to see any concrete benefits.

Nigeria's federal system devolves considerable authority to the 36 state governments, and the central government must engage in careful negotiation to assuage the political, regional, and economic demands and grievances of powerful state governors. Religious tension is pervasive. Nigeria is home to 67 million Muslims, one of the largest Muslim populations in the world. Twelve of the northern states have adopted Shari'a law. Fundamentalist Christian churches are becoming an increasing force in the south and southwest, and a number of cities have seen violent sectarian clashes. In the oil-producing Niger Delta, well-armed militias, controlled by political and ethnic leaders, siphon massive amounts of oil—estimates range between 50 and 200 thousand barrels per day—fueling a Colombia-like cartelization and conflict.

The 2003 elections were highly problematic, with high levels of insecurity and violence in the run-up to election day and massive rigging and fraud documented in a number of areas. The stakes in the 2007 elections will be extremely high, and electoral politics are already becoming a central preoccupation of many Nigerians. Implementation of PEPFAR will therefore be occurring in an environment of increasing political tension and volatility.

### **Nigeria's Health Infrastructure**

Nigeria's public health system has deteriorated dramatically over the last two decades. Structural adjustment programs of the 1980s de-emphasized health and human services, and the advent of military rule drove out most donor assistance and many health professionals; one expert estimates that 13,000 to 16,000 skilled health workers left the country during the 1990s. One indication of this decay is the

woeful state of reproductive health: Nigeria has one of the highest maternal mortality rates in the world (“off the charts,” according to one observer), with 800 women dying per 100,000 live births each year.

Much of the responsibility for health infrastructure is devolved to the state level. The federal government is responsible for policy formulation, strategic guidance, coordination, supervision, monitoring, and evaluation, and has responsibility for disease surveillance, essential drugs supply, and vaccine management. The federal government oversees tertiary health institutions (university teaching hospitals and federal medical centers); the states largely operate secondary health facilities (general hospitals and comprehensive health centers); and local governments provide primary health care, generally an individual’s first contact with the health system. As in other sectors, the Federal Ministry of Health cannot compel state ministries of health to implement health policies and programs, and there is often a wide gap between federal policy formulation and implementation by states and local governments.

### **U.S.-Nigerian Relations: A Mixed Picture**

U.S. engagement in Nigeria has gone through multiple changes over time, and while relations are generally good, they are susceptible to tensions and political sensitivities. During the tenure of military dictator Sani Abacha from 1993 to 1998, U.S. and other donor development assistance was dramatically cut, leaving Nigerians to fend for themselves under a singularly brutal and kleptocratic regime. Memories of this abrupt disengagement continue to feed popular skepticism about U.S. staying power even today—and they color perception of the sustainability of PEPFAR and other assistance programs.

President George W. Bush and President Olusegun Obasanjo enjoy warm relations, and Obasanjo has been a key African partner in leading diplomatic and peace-building efforts in Sierra Leone, Liberia, Sudan, and elsewhere. U.S. training of Nigerian troops for deployment to Sierra Leone in 2000–2001 vastly improved the professionalism and conduct of the peacekeepers by most accounts. But sanctions imposed by the U.S. Congress—first, in response to a massacre perpetrated by Nigerian soldiers deployed internally to the city of Benue, and subsequently to pressure President Obasanjo to turn over former Liberian president Charles Taylor to the Special Court in Sierra Leone<sup>2</sup>—greatly constrain such training and leave a generation of Nigerian forces without substantive contact with the U.S. military.

Nigeria accounts for almost 10 percent of U.S. oil imports, and U.S. oil companies have massive investments in the Gulf of Guinea, at once strategically important and highly vulnerable to disruption. Nigerians, however, will likely view any U.S. moves to protect those assets with enormous trepidation.

U.S. diplomatic capacities in Nigeria have for a long time been overtaxed and unsettled. Despite the country’s strategic importance within Africa, during 2003–2004 the U.S. embassy in Abuja went for over a year without an ambassador, and a number of key vacancies persist, some at a fairly senior level. The United States has

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2. These latter sanctions are the subject of some bemusement among many Nigerians, given that President Obasanjo granted Charles Taylor asylum at the U.S. administration’s request.

no permanent presence in the north of the country where distrust of the West and antagonism to U.S. policies in the Middle East are increasing. Ambassador John Campbell, now in Abuja for almost a year, is in the process of rebuilding the embassy's capacities and morale, but the State Department has yet to make the substantial investment in the U.S. presence and capacity that the country's size and complexity of issues warrant.

## HIV/AIDS Status and Response

Foremost, it is important to recognize that surveillance data in Nigeria are extremely weak. According to U.S. Ambassador John Campbell, "What is striking about Nigeria's HIV situation is how much we simply do not know"—an observation echoed repeatedly by other experts with whom the delegation met. According to UNAIDS, Nigeria's adult HIV prevalence is approximately 5.4 percent (the high estimate is 8 percent; the low estimate, 3.6 percent); 3.8 million people are living with the virus; 310,000 people died of AIDS in 2003. Many observers think these figures underestimate Nigeria's pandemic, and even more agree that the potential for much higher rates in the future is very real. Today, youth in the 15–24 year-old age group account for at least 60 percent of total HIV infections. Incidence among this age group last year was 12 percent.

Estimated prevalence varies greatly from state to state, as do awareness and attitudes about HIV/AIDS. Adult HIV prevalence ranges from 1.2 percent in Osun, 6 percent in Kaduna, 6.3 percent in Plateau, 9.3 in Benue, to 12 percent in Cross Rivers. All of Nigeria's 36 states have an HIV prevalence of more than 1 percent, and over a third have prevalences of more than 5 percent. Prevalence is generally higher in urban than in rural areas. According to the Federal Ministry of Health, sentinel surveys of high-risk groups have consistently shown the highest rates to be among commercial sex workers, with the prevalence rate in one city rising from 17.5 percent in 1991 to 35.6 percent in 1995 when they were last surveyed.

President Obasanjo has expressed a deep commitment to fighting HIV, not only in Nigeria but continent-wide. In 1998, before Obasanjo came to office, the Nigerian federal government allocated a maximum of \$3,000 annually to HIV/AIDS. On entering office, President Obasanjo created the Presidential Advisory Committee on HIV/AIDS (PAC), which he heads, and the National Action Committee on AIDS (NACA), now directed by Professor Babatunde Osotimehin, which sits within the Office of the Presidency. NACA is responsible for coordinating a multi-sectoral response, and in 2001 formulated the HIV/AIDS Emergency Action Plan (HEAP), now updated and replaced by a five-year National Strategic Framework (NSF). There are efforts under way to establish NACA as an independent agency to ensure its independence and institutional sustainability beyond the current presidential term.

Within the Federal Ministry of Health, the National AIDS and STD Control Program (NASCP), housed in the Department of Public Health, is responsible for formulating health-related policies, providing technical support to state and local government AIDS programs, and procuring ARV drugs. The health ministry has

responsibility for voluntary counseling and testing (VCT), preventing mother-to-child transmission (PMTCT), safe blood, and ARV strategies.

State and local level responses vary. A number of the State Action Committees on AIDS (SACAs—the state-level counterpart to NACA) are dysfunctional, and most Local Action Committees on AIDS (LACA) have yet to be established. Federal, state, and local governments are supposed to work together on HIV/AIDS, but there is often little effort made, and there is, says one expert, a thorough lack of accountability at all levels. NACA director Babatunde Osotimehin is credited with energizing a number of state governors to take HIV/AIDS more seriously and to invest greater attention and resources in their health and SACA teams. “Governors are not always as engaged as we would like,” said Osotimehin, “but without their buy-in, we won’t get far.” Some observers feel that the president could do more to engage state governors systematically on HIV/AIDS and offer incentives to states to take the issue up more proactively.

Donor assistance at the federal level has increased significantly in recent years, with the \$90 million World Bank Multi-Country AIDS Program (MAP) beginning in 2001; PEPFAR, due to invest \$84 million in FY05; and Global Fund two-year approved funding for AIDS-related activities totaling over \$28 million. But disbursement of the MAP and Global Fund monies has been disappointingly slow: at the end of 2004, only \$20 million of the MAP’s \$90 million had been spent, and at the time of the delegation’s visit in March 2005, less than a quarter of the Global Fund money had been spent. This has been attributed to poor planning and implementation, lack of capacity, and, on the Global Fund monies, poor procurement planning and mechanisms. There is growing recognition that, given capacity gaps and slow disbursement at the federal level, direct external engagement at the state and local levels will need to increase, with a balanced presence at all levels and across regions. The World Bank program, in particular, holds promise in this regard. Among international donors, it has gone furthest in engaging with state governments and building the capacities of state health sectors and SACAs to respond.

## **Prevention Challenges**

Nigeria’s exceptional cultural, linguistic, and religious diversity will make HIV prevention messaging and behavior change a difficult challenge under the best of circumstances. There are indications that the complexities of prevention, along with an increasing focus on treatment by the Nigerian government and international donors and PEPFAR, may undermine the sense of urgency required around HIV prevention. This phenomenon is not unique to Nigeria. There is no natural constituency for prevention services, particularly in a context where HIV prevalence is relatively low and the impacts of the virus largely invisible and where stigma and denial are high. Popular and political pressures will tend toward the tangible benefits of getting people on life-prolonging treatment rather than toward pre-emptive interventions whose impacts will be difficult to measure and that will of necessity be entwined with religious, social, and cultural mores.

### **Awareness high, visibility low**

Awareness of HIV/AIDS is generally high, although according to the 2003 National HIV/AIDS and Reproductive Health Survey (NARHS), 20 percent of respondents in the North East and North-Central zones had never heard of HIV/AIDS. Knowledge about transmission and prevention is only fair, and misconceptions and myths abound. Halima, a peer educator in Tafa outside of Abuja, told delegates that a number of girls in her group believed that HIV could be transmitted by sharing a spoon and that giving birth could cleanse the body of the virus.

Importantly, perceived risk of contracting HIV is very low: of respondents who had heard of HIV/AIDS in the NARHS survey, 72 percent (75 percent of the females and 69 percent of the males) reported that they stood no chance at all of contracting HIV. In some quarters, even at a fairly senior political level, delegates encountered an apparent reluctance to acknowledge sexual transmission of disease and a tendency to fixate instead on secondary transmission routes, for example, blood safety or rural barbers who might use the same razor on several clients.

Stigma surrounding the disease is profound, and, to a large extent, the disease and its impact have remained invisible. Community leaders in a truck depot town outside Abuja told delegates that few community members had ever met a person who was openly HIV-positive or seen someone sick with AIDS because those who develop symptoms often return to their village of origin to die. The day before the delegation visit, neighbors had burned the remaining possessions of a man who was thought to have died from HIV/AIDS, fearful that they would be contaminated.

### **Emphasis on treatment**

The Nigerian government has launched one of Africa's most ambitious government-sponsored ARV programs. In 2002, it committed to putting 10,000 adults and 5,000 children on ARV treatment, and earlier this year increased that number to a total of 100,000 by the end of 2005. The program provides subsidized ARV drugs—generics manufactured by Cipla and Ranbaxy, imported from India—at 25 sites across the country. Those on therapy pay 1,000 naira (approximately \$8) per month for treatment and are also responsible for all testing and laboratory fees as well as transportation to and from the medical center. Last year, the government program experienced a major shortage of ARVs, and a number of the distribution facilities ran out of inventory, leaving many individuals in treatment without drugs for three to six months. There are no clear indications that similar difficulties in the ARV supply chain will not recur, and although the government hopes to initiate domestic production of ARVs, there is considerable skepticism that such a program will be successfully launched in the near to medium term. The major portion of Nigeria's AIDS-related proposal to the Global Fund was for the procurement of ARV drugs, although, as noted above, getting the procurement and accountability systems in place has been a slow process.

PEPFAR aims to put 350,000 people on treatment within four years. Reaching those targets will require a massive investment in testing (i.e., 10 to 20 million individuals will need to be tested), and current capacity and resources (for testing, counseling, and monitoring and evaluation) appear woefully inadequate. According to one expert, there are currently approximately 100 functioning VCT sites in

Nigeria and 100 adequately trained HIV counselors. Testing is not free, and individuals who decide to get tested will often face exorbitant or even prohibitive transportation costs to get to a facility that offers tests. At the Nigerian government's insistence, patients receiving ARVs under PEPFAR will be charged 1,000 naira per month, the fee that patients in the government-sponsored program pay. The U.S. embassy is currently working on an overall agreement with the Nigerian government on a fee-waiver system for patients who cannot afford the monthly fee. A number of U.S.-supported sites have already instituted such waivers.

Serious uncertainties remain surrounding the pricing and procurement of ARVs. The United States won an agreement from the government of Nigeria to provide brand-name drugs in the program's first year, but it is uncertain whether the United States will move to generics thereafter or win continued agreement to use brand-name drugs. How the United States will guarantee a reliable and sustained supply of ARVs is also uncertain.

Some public health experts are concerned that the PEPFAR intervention may create parallel delivery systems, with different standards of monitoring and evaluation, different pay scales for staff, and different treatment regimens. There is a fear that disparities between public and international intervention on HIV/AIDS, and between HIV/AIDS and other pressing health challenges, will distort an already fragile health system and pull personnel and resources away from other health areas that are at present at least equally urgent.

There are troubling signs that prevention efforts may be overshadowed by an increasing emphasis on treatment. The pressures, from both Nigeria and the United States, to meet treatment targets are high, and many of the attendant costs of meeting those targets—for testing, monitoring, counseling—are as yet unfunded and unplanned for. At a popular level, the perception that ARVs are a cure, rather than a life-prolonging treatment, underlines the importance of long-term counseling on adherence to treatment, on prevention for HIV-positive people, and on possible side effects of treatment. Should resource levels remain the same, there is a very real possibility that as the costs of treatment are fully recognized, prevention efforts, which can be culturally sensitive, less easily measurable, and less politically expedient, will be crowded out.

The delegates occasionally encountered an implicit assumption that if treatment is more broadly available, prevention will in some ways take care of itself—as the stigma associated with the disease declines and as more people are willing to be tested and counseled and, knowing their status, make more informed behavioral choices. There is some truth to this. The growing availability of treatment, a positive development in itself, can clearly be a boon to prevention efforts. But the advent of ARV treatment, even if PEPFAR's and Nigeria's ambitious targets are met, will not in itself resolve prevention challenges. First, even with those targets met, most eligible HIV-positive individuals will not have access to ARV treatment, especially as the number of people living with HIV/AIDS continues to rise. Too, prevention services will often coincide with treatment services in the health care setting, but will need to reach a much broader-based pool of individuals, including those who have little or no interaction with the health care system. Prevention services will need to be more community-based and more fully integrated with other

### Commercial Sex Workers

Despite the political sensitivities surrounding outreach to commercial sex workers, the delegation concluded that these interventions warrant much greater emphasis within the PEPFAR prevention strategy in Nigeria. When asked to identify successful prevention interventions, the NACA leadership stated that intervention among commercial sex workers has been one area that has had dramatic, positive, and demonstrable results. Effective interventions have included peer education—on preventing HIV transmission and seeking treatment for sexually transmitted diseases—and work with CSWs, brothel owners, and landlords to encourage and support insistence on condom use. Focused interventions in one town surveyed drove condom use and adherence to the principle of “no condom, no sex” from 16 to 69 percent, according to NACA chair Professor Oso-timehin. But, he added, far more attention and additional resources should be devoted to high-risk groups. There is also a need to work with the surrounding communities and with local police and community “gatekeepers” to improve and support outreach to commercial sex workers and to find effective ways to reach and educate their clientele.

U.S. domestic debates about outreach to commercial sex workers—for example, the requirement that organizations doing such work declare their opposition to prostitution—have little relevance on the ground. None of the women with whom the CSIS delegates met saw commercial sex work as their chosen profession, and, said one, “We pray every day that we can find other work to support ourselves.” But with few economic alternatives even for relatively educated and skilled individuals, for many it will be a life-long occupation. “Getting women out of commercial sex work is important,” said one outreach worker in Abuja, “but it is a long-term approach. As long as the demand is there, for every girl we get out [of sex work], there will be 10 more to fill her place. So my job is to make sure these girls are protected. We need to see them first as women and people who deserve care and protection. If we come telling them they are bad people, they will shut their ears or go underground.”

community-based, grassroots entities—for example, schools, religious institutions, traditional leaders, local media—if they are to reach those potentially at risk.

### Mobilizing Existing Strengths and Capacities

Despite the many challenges that Nigeria faces, particularly in the area of prevention, the delegation was struck by a number of key institutions and sectors that play a powerful role in Nigerian society and that could serve as catalysts and transmitters of knowledge, attitudes, and strategies to fight HIV/AIDS.

#### The role of religion

The delegation was struck by the profound role that religion and religiosity play in many Nigerians’ lives, and it is clear that engaging religious leadership in a positive way on HIV/AIDS could have major impacts in many communities. Religious leaders who have become active on public health issues have had significant influence, and partnerships between the religious infrastructure and programmatic NGOs or public health entities to sensitize and educate leaders could have significant impact down to the community level. But delegates also heard that a number of religious leaders are concerned that their exhortations on abstinence and fidelity have had little impact on behavior or social norms in settings in which, for example, alcohol

consumption, at least for men, is more taboo than having sexual partners outside of marriage.

The delegation subgroup that traveled to Kano met with the Emir of Kano, Alhaji Ado Bayero, who told the delegates that he welcomed U.S. assistance to fight HIV/AIDS in Nigeria. Local NGO representatives told delegates that when in 2003 the emir held an HIV-positive baby, it was considered a major step forward in combating the myths and stigma that surround HIV. But they decried the lack of a more systematic and sustained engagement by Kano's religious leadership to increase awareness and knowledge and combat stigma. Several observers pointed to the emir's outspokenness on obstetric fistulas in recent years, crediting him with reducing stigma associated with the condition and getting women to seek treatment. Religious leaders reportedly also played an important role in the child immunization campaign of 2002–2003.

Because of the sexual dimension of HIV/AIDS and the stigma that attaches to the disease itself, changing attitudes among the religious leadership, and, equally important, among the imams and clergy active at the community level, will require a sustained process of engagement, education, and dialogue. It will be important that a process of this kind be Nigerian-driven. In 2004, suspicion of Western intentions led three states in northern Nigeria to suspend the World Health Organization's polio vaccination campaign, leading to a fresh outbreak within Nigeria and reported cases in neighboring countries. The Interfaith HIV/AIDS Coalition of Nigeria, comprising leaders from all of Nigeria's major religions, offers a promising start in this direction. This group, originally assembled to discuss intersectorial violence, has expanded its agenda to include efforts to fight HIV/AIDS, an area where its members agreed that Nigeria's major religious groups could find common ground and work collaboratively to sensitize and educate the faith community, to combat stigma, to promote the empowerment of women and girls, and to advocate for the rights of people living with HIV. The coalition is in its early stages. It is a promising initiative in its diversity and objectives. Its principal challenge will be to reach the community-based clergy and congregations in their respective faiths.

### **The role of the media**

During the delegation's visit, CSIS cohosted with Development Communications Network and the assistance of the U.S. embassy's Public Affairs Section a town hall meeting titled "Getting the Word Out on HIV/AIDS Prevention: The Role of the Nigerian Media." Panelists included representatives of print, radio, and television outlets, as well as media-training NGOs and the Network of People Living with HIV/AIDS in Nigeria (NEPHWAN). All panelists agreed that the media have a powerful role to play in combating stigma and the spread of HIV/AIDS. Print and television reach a more limited but nonetheless important urban constituency; radio reaches much further into rural communities, with some 80 percent of Nigerians having access to radio. The challenge is in creating messages that have real impact and that, in the words of NEPHWAN executive director Pat Matemilola, convey "knowledge that creates wisdom, not fear, that empowers, that gives choices, and that allows informed decisions."

Nigerian media have made progress in recent years, including the creation of Journalists Against AIDS (JAAIDS) —an association of journalists dedicated to increasing AIDS awareness. Today, media reporting on HIV/AIDS is much more frequent. But the vast majority of stories are events-driven—a press briefing, a ribbon cutting, or a conference. This kind of coverage does not generally build public knowledge around preventing or managing HIV/AIDS, according to Cece Fadope, country director of Internews, a USAID-funded NGO whose “Local Voices” program works with journalists, editors, and owners to create an enabling environment for HIV/AIDS reporting. Owners and editors need to be educated on HIV/AIDS as well as encouraged to give space and incentives to HIV/AIDS stories. Entertainment, news, or radio call-in programming can be targeted to specific groups—women or youth, for example—with stories that are tailored to local communities, use local languages, and are field-based. In Kano, delegates met with the energetic staff of Ku Saurara! (or “Listen Up!”), a project funded by the Packard Foundation and others that through radio programming, rallies, and support to youth groups throughout the north offers information on reproductive health and healthy behavior to young people between 15 and 24.

Funding is a major constraint, and where journalists are poorly paid, they or their editors often turn to “checkbook” reporting, where cash payments drive news stories. One observer suggested that the Ministry of Information could be more proactive in this regard by giving incentives—for example, an annual award—to outlets with consistently effective HIV/AIDS reporting or programming. Groups like Development Communications Network, Internews, or Journalists Against AIDS, all of which work to improve the quality of media reporting on HIV/AIDS and other health issues, can partner with senior leadership and reporters to encourage accurate and sensitive messages about HIV/AIDS prevention, whether through news reporting and human interest stories, radio jingles, or entertainment programs. Panelist Alhaji Bubakar Jijiwa, chair of the Broadcasting Organization of Nigeria (BON), acknowledged that BON does not currently have an HIV/AIDS strategy, but that he was committed to partnering with others to create one. He has since proposed media workshops on HIV/AIDS for all BON members. Opportunities for public-private partnerships in this area abound.

### **The role of the social science community**

Existing prevention efforts are frequently criticized for their ad hoc design and for not being sufficiently tailored to Nigeria's diverse ethnic, religious, and regional communities. Effective prevention messages will require a significant increase in knowledge about the drivers of the epidemic in specific communities and high-risk groups. Such information is particularly necessary for interventions aimed at increasing awareness, overcoming stigma, and promoting behavior change among sexually active persons. In this regard, engaging Nigeria's academic community, particularly the social science community, to more fully understand and disaggregate local attitudes, institutions, and behaviors could help improve the design and implementation of targeted prevention strategies and messages.

Nigerian social scientists possess the analytical skills and local knowledge to advance the currently weak understanding of how HIV transmission can be

reduced among different subsets of the population. While underfunding, brain drain, and mismanagement have weakened Nigeria's academic institutions, the country remains home to a large number of capable social scientists holding appointments in its many public and private universities. Significant efforts are under way, led by overseas philanthropies such as the MacArthur Foundation, to rebuild this sector, and these efforts offer opportunities to simultaneously strengthen social science research and engagement on HIV/AIDS.

## HIV/AIDS within the Nigerian Military

Efforts within the Nigerian military to combat HIV/AIDS have strong potential for success, and the United States Department of Defense, through PEPFAR, can play a key role in helping launch a comprehensive and sustainable program. This partnership could improve the AIDS situation in the military and at the same time develop members of the military into positive vectors for change in the broader Nigerian society. Further, it could provide a valuable and positive interface between U.S. and Nigerian military personnel, rebuilding the relationship around a common and pressing goal.

The Nigerian military plays an important role not only within Nigeria but also in the West African subregion, with numerous troops deployed in ECOWAS (Economic Community of West African States) and UN peacekeeping operations. The Nigerian Armed Forces has an estimated 80,000 personnel and an associated civilian population—family members and surrounding communities—of approximately 1.2 million. What happens in the military therefore affects a significant segment of Nigerian society and has implications for other African countries.

President Obasanjo spoke out early in his tenure about the threat that HIV/AIDS could pose to the Nigerian military, exhorting military commanders to take the pandemic seriously. An apparent spike in HIV prevalence rates among troops returning from peacekeeping deployments in 2001 galvanized greater attention to the potential threat. The delegation saw strong indications of significant leadership, particularly from State Minister of Defense Roland Oritsejafor, a civilian and pediatrician by training. Under State Minister Oritsejafor, HIV/AIDS has been elevated as a priority within the armed forces. The creation of senior-level military steering and implementation groups, responsible for policy development and long-term strategy, should in principle facilitate rapid decisionmaking at the highest levels and implementation throughout the ranks.

CSIS delegates visited military hospitals in Kaduna, Abuja, and Lagos and were impressed with the commitment of medical and line officers alike to implement effective programming to combat HIV/AIDS, to acknowledge and address the problem of stigma, and to provide treatment to military personnel who are HIV-positive for as long as they need it. The clear challenge will be to ensure that that commitment is shared throughout the military hierarchy and to consolidate a strategy at the senior-most levels of each of the services. This might include more frequent and routine meetings between senior line officers and AIDS programmers

and an increased profile for HIV/AIDS efforts in the speeches, orders, and activities of the line officers.

Strengthened commitment might also include the dedication of at least a small portion of each service's budget to acquiring HIV/AIDS programming materials. At the present time, it appears that the only contribution to AIDS programming from any of the service budgets, aside from a few staff members loaned to an anti-AIDS interservice coordinating body, are funds that the Air Force is spending on an anti-retroviral program.

The three services—Army, Air Force, and Navy—vary in size and in available infrastructure. The Nigerian Army, with an estimated 60,000 troops and the largest number of foreign deployment demands, will clearly face some of the biggest hurdles. The Air Force, with 12,000 personnel, and the Navy, with 8,000, are somewhat further ahead in terms of staffing and infrastructure.

## **Nigerian Military Anti-AIDS Efforts**

### **Prevention**

The Nigerian Armed Forces Program on AIDS Control (AFPAC) was established by the services to coordinate and oversee prevention programming in all branches of the military. Over the past five years, with support from USAID and the UK's Department for International Development (DFID), the military developed a program of peer education, training, educational materials, and condom distribution. In 2003, AFPAC established an annual Armed Forces HIV/AIDS week, a week set aside to raise awareness in all military locations and surrounding communities, and in 2004 brought the chiefs of staff of all three services together, the highest-level discussion ever of HIV/AIDS within the Nigerian services.

Beginning in the second half of 2004, however, AFPAC, and by extension all Nigerian military prevention efforts, experienced an interruption in support and funding from USAID sources. Although the interruption was anticipated, coming at the end of the U.S. grant cycle, it left the AFPAC leadership somewhat bewildered and uncertain as to the status of future engagement. That was still the case at the time of the delegation visit in mid-March 2005, although USAID and DOD have since approved plans to increase support to AFPAC and other military HIV/AIDS prevention initiatives. The disruption had led to lost opportunities to train a year's worth of new recruits and officers, and the delegation strongly encourages that similar unforeseen disruptions be avoided.

### **Surveillance**

All three military hospitals that the delegates visited were staffed by well-trained, enthusiastic medical professionals clearly ready and able to take on surveillance efforts, if provided with the necessary equipment, logistics, and infrastructure support. The PEPFAR-supported DOD program (see below) should begin to address the equipment and support needs at these facilities. Similar support will obviously need to extend throughout the facilities of each service.

## Testing

Gaps in the militaries' testing policy and in its implementation suggest that there is no clear consensus on the health and HIV status of the existing military force. Official policy within Nigeria states that HIV testing is required for all recruits, for all troops being considered for foreign deployment, and for troops returning from overseas assignments. It is not clear, however, that this policy is consistently followed, nor that the military has the equipment, supplies, and resources to fully implement the policy. Recruits who test positive are not accepted into the military. They are told their HIV status; they are informed that they are not eligible to enlist. Policy also states that persons cannot be dismissed from service because of their HIV-positive status. While barred from overseas deployment, the HIV-positive individual is to be allowed to remain in the armed services as long as he or she is able to perform required duties. State Minister of Defense Oritsejafor and a number of military health officials indicated that, were resources available, they would like to move to routine annual testing as part of troop readiness efforts. Voluntary testing is also available for immediate family members. Both service members and their dependents must pay for testing, an average of around 5,000 naira, a significant burden for a junior enlisted man who may earn just 12,000 naira per month.

## Care and treatment

The government of Nigeria has a national program to provide ARVs at reduced cost (approximately 5,000 naira per month) to a limited number of individuals. All three armed services have a small number of slots under this program. In addition, the leadership of the Air Force has issued a policy stating that the Air Force will provide ARVs to all members who need them. However, the drugs themselves are in short supply, particularly at reduced prices, and it is not clear that the supplies or delivery infrastructure currently exists to ensure that these programs can be carried out consistently over time. Moreover, all armed services estimate that the need for ARVs already greatly outstrips the supply.

The military is keen to obtain help in developing Nigeria's domestic capabilities to produce quality, generic drugs. Cipla, Rambaxy, the Brazilians, and a team of Nigerian-American investors have all reportedly been exploring possibilities, and some are even hoping to bring production online in the near future. One of the facilities being targeted for potential development is a military facility in Lagos.

All three services provide members and their immediate families with treatment for opportunistic infections, to the extent permitted by infrastructure and supply limitations. Military hospitals are in principle also open to civilians in the surrounding communities, although the same infrastructure limitations are likely to limit the resources available to assist such individuals.

## U.S. Engagement

A recently launched U.S. Department of Defense program, funded through PEP-FAR, promises to significantly strengthen surveillance, testing, and treatment capacities of the Nigerian armed forces and offer opportunities for training of military health personnel. The program offers a multiyear commitment, not only of funds but of trained U.S. technical personnel who will be working directly with

their Nigerian counterparts. In 2004, at the invitation of the Nigerian military and civilian leadership, the U.S. embassy staff and medical professionals at the Walter Reed Army Institute of Research began exploring ways to expand cooperation between the U.S. and Nigerian militaries on HIV/AIDS programming. A program to develop testing and treatment capabilities at establishments of all three services was developed, receiving \$300,000 in initial seed funding through the Department of Defense HIV/AIDS Prevention Program (DHAPP) and then incorporated into the PEPFAR country strategy, receiving \$5 million of the available country allocation of \$81 million in FY05.

Through this program, DOD will contribute uniformed personnel to work directly with Nigerian counterparts in all three services. The program will be used to strengthen overall Nigerian military efforts to develop effective anti-AIDS policies and programming through coordinating bodies at various levels of the military hierarchy. In its first stage, the program will create “centers of excellence” in each of the services, and a tri-service facility to improve voluntary counseling and testing, prevention, and laboratory and other training capabilities and to administer ARVs.

If schedules hold, the program will allow these facilities to put an additional 1,200 people on ARV treatment by March 2006. Targeted hospitals are the 44 Nigerian Army Reference Hospital in Kaduna; the 45 Nigeria Air Force Hospital in Ikeja, Lagos; the Nigerian Navy Hospital in Ojo, Lagos; and the Defense Headquarters Medical Receiving Station, Mogadishu Barracks, Abuja, which serves all three military branches. After the initial stage, the plan is for similar capabilities to be developed, in consultation with the Nigerian military authorities, at other facilities across the country for each of the services. The ultimate number of locations for treatment is as yet undecided and will depend on assessments of sustainability. The military is open to the possibility of relocating HIV-positive service members to treatment centers rather than providing treatment at every location.

An important gap in the renewed U.S.-Nigerian engagement is U.S. support for prevention programming. The leadership of the new DOD program has expressed support for prevention programming to supplement their efforts and a willingness to coordinate with AFPAC. However, they acknowledge prevention is not the primary focus of their work. Beginning in 2000–2001, the U.S. government began funding small-scale prevention and training programs for the Nigerian military. Working through Family Health International, USAID funding supported the work of AFPAC with peer training, educational materials, and prevention programs in all three services. In 2001, DHAPP awarded contracts to the University of Maryland and Lincoln University respectively for surveillance and training within the Nigerian Army, Air Force, and Navy and for HIV/AIDS prevention education throughout the Nigerian military services. As noted, these programs ended in mid-2004. PEPFAR now has an opportunity to rebuild and strengthen that engagement.

The promise of upgraded laboratories and testing and treatment facilities will naturally be appealing to Nigeria’s military health leadership, and U.S. engagement in this regard will have benefits not just in the health and HIV/AIDS realm, but also in building trust and mutual understanding between U.S. and Nigerian defense hierarchies. It is important, however, that the United States continually reinforce the message that successful prevention efforts will after all be the ultimate means of

curbing HIV/AIDS within the military, and that it back this message with prevention funding to AFPAC and nongovernmental groups working in and around Nigeria's military barracks. Strengthened support to the military's prevention services will be an essential complement to the DOD's hospital- and laboratory-based work.

U.S. Ambassador to Nigeria John Campbell has played a key role in facilitating coordination between the military programming and more general AIDS efforts. Among other things, he convenes a group that brings together the senior leadership of the Nigerian Ministry of Defense, the Ministry of Health, and donors to coordinate and harmonize these two streams of work. This process has reportedly helped foster a productive environment and may provide an appropriate forum in which to reinvigorate prevention programming.

The remarkable openness of the Nigerian military leadership to U.S. engagement on HIV/AIDS provides an opportunity that should not be lost. The United States and the international community in recent years have asked a great deal of Nigeria's military establishment in peacekeeping operations throughout the continent. And as the U.S. administration seeks to build a Gulf of Guinea security strategy, the health, competence, and professionalism of Nigeria's armed forces and other uniformed services—especially police and border security—will be increasingly important to U.S. strategic interests. Collaboration in fighting HIV/AIDS within the uniformed services can help build a positive relationship based on common interests and foster greater mutual trust.

### **Engaging Nigeria's Police Force**

Nigeria's police force, which is five times the size of the country's military, should receive greater attention and support in crafting and implementing an HIV/AIDS strategy (although there are legal restrictions that may apply in the use of U.S. funds for this purpose). Police officers number approximately 310,000, and are deployed across the country, rotating into even the most remote of Nigeria's communities. The force is also internationally mobile, with police contingents assigned in six-month rotations to UN operations in Haiti, Sudan, Liberia, Kosovo, Côte d'Ivoire, Sierra Leone, Afghanistan, and Congo.

While the police force is larger and equally (if not more) at risk for HIV/AIDS, it does not enjoy the same advantages as the military in terms of health infrastructure and health personnel. Other than a police hospital in Lagos, the police have no health infrastructure to speak of and few VCT centers. Most HIV-positive individuals find out their status only when they fall ill. There is no systematic process for testing and little reliable information on prevalence rates within the force. There is currently no police budget for HIV/AIDS, and the inspector general, who does not have cabinet-level rank, may have a more difficult time persuading senior political leadership to invest adequate funds in this area.

In meeting with the CSIS delegation, the police leadership acknowledged that they have catching up to do on addressing the pandemic and obtaining support, but they also displayed real understanding of the threat and eagerness to take these steps. Both NACA and the police leadership expressed a willingness to work together to build an HIV/AIDS strategy. The delegation was struck by the potential

opportunities for prevention efforts within this seemingly neglected but clearly at-risk sector. Because of their deployment into every corner of Nigeria, police officers might eventually prove powerful agents of positive change, and a new emphasis on community policing may give added impetus to integrating HIV/AIDS into the police training curriculum. While the U.S. DOD is legally barred from working with the Nigerian police, the delegation strongly encourages the United States and other funders to further investigate the needs of the police force and to seek opportunities for enhanced engagement.

## Recommendations

The CSIS delegation fully appreciates the daunting challenge of crafting a U.S. approach to a country the size and complexity of Nigeria. PEPFAR is still in its early stages, and definitive pronouncements on what will and will not work in Nigeria will be a long time coming. At the same time, the recommendations provided here should not require major changes in strategy, but rather shifts in emphasis and pragmatic steps that may support a long-term, sustained U.S.-Nigerian engagement.

- The Office of the Global AIDS Coordinator should map out realistic resource and support requirements—testing, counseling, monitoring, and referrals—of a sustainable treatment program in Nigeria as it endeavors to place 350,000 people on antiretroviral therapy by 2008. OGAC should take time for a revised assessment of projected costs. As ARV therapy prolongs lives, the number of individuals dependent on health care infrastructure—those newly infected and those on long-term ARV therapy—will rise dramatically. It is essential to plan for adequate resources now to ensure that achieving treatment targets does not undermine or distort health infrastructure and priorities, impinge on less easily measurable targets (notably prevention), raise unrealistic expectations, or prove unsustainable over the long term.
- An immediate step should be to address the uncertainty surrounding pricing and a procurement mechanism for ARVs that simultaneously provides reliable safeguards against corruption and both disruption of supply. The United States won agreement from the Nigerian government to provide brand-name drugs through PEPFAR for its first year. However, uncertainties around whether the United States will move to generics or win continued agreement to use brand-name drugs will make a realistic assessment of resource requirements impossible. Questions of in-country delivery mechanisms for ARVs, transparency and accountability guarantees, and who will qualify to sell high-volume, low-cost ARVs to PEPFAR will need to be resolved quickly.
- Prevention must remain an urgent priority. PEPFAR has brought a considerable infusion of new prevention funds to Nigeria, and the expanding availability of treatment in itself will clearly be a boon to prevention efforts. But increasing availability of ARVs can go only so far in bolstering prevention efforts, which

must go far beyond the health care infrastructure and the relatively limited sites (relative to Nigeria's size and population) where ARV treatment will be visible and accessible. A long-term prevention strategy will require systematic outreach and communication with a broad range of nongovernmental actors—media, youth, people living with HIV/AIDS, religious leaders, community gatekeepers, and Nigerian social scientists—to craft, implement, and measure the effectiveness of awareness and prevention strategies targeting the country's many distinct microcultures and communities. Prevention will need to be carefully and consistently integrated into treatment programming and other health interventions.

- U.S. Global AIDS Coordinator Randall Tobias has done well in balancing and responding to the moral/philosophical concerns of U.S. domestic constituencies that pit exhortation to abstinence and fidelity against distribution of condoms and outreach to high-risk groups. OGAC should more vigorously insulate the country missions from these domestic political pressures and queries, insisting on evidence-based and results-based strategies best suited to the realities on the ground.
- The U.S. response should place stronger emphasis on outreach to high-risk groups. As a second-wave state, where the prevalence differential between the general population and high-risk groups is high, there is an urgent need to expand outreach to high-risk groups, including commercial sex workers and their clients, both to protect their health and to curb a more generalized epidemic. This is a public health imperative emphasized in Nigeria's National Strategic Framework that the United States should more fully support.
- The Office of the Global AIDS Coordinator and the U.S. embassy in Abuja will need to assure Nigerian counterparts that U.S. engagement will be sustained. This will require outreach and systematic dialogue with the U.S. Congress to convey the serious costs that unpredictability or dramatic shifts in U.S. funding levels will entail. This should also include strong encouragement to the government of Nigeria to increase its own investments in health, in keeping with the 2001 Abuja declaration in which President Obasanjo and other African heads of state pledged to set a target of allocating at least 15 percent of annual national budgets to health sector improvements.
- The U.S. State Department should consider creating a new position within the U.S. embassy for a senior Foreign Service officer specifically to coordinate PEPFAR efforts and manage diplomatic outreach and engagement on PEPFAR and other health-related issues. Burnout and fatigue among U.S. mission staff, in Nigeria as in other PEPFAR focus countries, are becoming evident. Given the size of the PEPFAR budget in Nigeria, the need for persistent and energetic diplomatic engagement and consultation with federal and state governments, the high potential for misuse of funds, and the enduring damage this would do to U.S. and congressional support for engagement, additional support for in-country management capacity and oversight of the program is essential.

- The United States should recognize and support the commitment of President Obasanjo and State Minister of Defense Roland Oritsejafor to fighting HIV/AIDS in the armed forces, and should encourage them to use their leadership to build an institutional commitment to AIDS control throughout the ranks of the military structure. As part of this effort, the PEPFAR-supported DOD program and other donor-funded efforts should work assiduously to develop a local sense of ownership of the programs.
- U.S. Department of Defense engagement with the Nigerian Ministry of Defense holds strong promise both in curbing HIV/AIDS within the Nigerian military and in furthering U.S.-Nigerian cooperation around broader strategic goals. The United States should look to build a long-term engagement in this regard. PEPFAR should supplement the DOD program with additional prevention programming, working with NGOs and the Armed Forces Program on HIV/AIDS Control. Outreach to other uniformed services, especially the police force, should be given greater emphasis, and there is an apparent openness there for greater collaboration.
- The PEPFAR-DOD program should continue to develop clear, end-state goals that define the capabilities and sustainable programming that each service should be able to continue on its own at the end of the five years. While this engagement warrants long-term support, in the absence of U.S. congressional guarantees the program should at least be prepared for the contingency that funding may significantly decrease after five years.
- The PEPFAR-DOD program, which is primarily focused on surveillance, testing, treatment, and training, should work with appropriate counterparts to ensure that prevention strategies are integrated throughout its own activities and its target facilities. It might also emphasize safe-blood capacity development within the military system and help strengthen hospital-based (nosocomial) transmission prevention in military health care facilities.
- The PEPFAR-DOD program should be supplemented by prevention programming to AFPAC and its partner NGOs working in and around military communities, and should encourage senior military leadership to fully integrate prevention programming into the military's AIDS planning and programming at all levels. In the past, Nigerian military prevention programming has been largely dependent on USAID funding. PEPFAR can send a signal about the importance of prevention by ensuring a steady, uninterrupted stream of funding to these efforts.
- The PEPFAR team should encourage the military health leadership to reach out to other uniformed services as they forge strategies to fight HIV/AIDS. The PEPFAR team should itself seek openings to work with other uniformed security services, especially the police, who number over 300,000 (not including family members), are highly mobile within Nigeria, and because—of their mobility and integration into communities—are equally, if not more, at risk of HIV-infection.

## Appendix A

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Dr. Peter Lamptey  
*President, Institute for HIV/AIDS, Family Health International*

Kathy Ward  
*Deputy director, International Crisis Group*

## Appendix B

### Delegation Itinerary

#### Saturday, March 12

- Site visit to 44 Nigerian Army Reference Hospital in Kaduna, Kaduna State

#### Sunday, March 13

- Country Team Brief by U.S. Embassy, USAID, and CDC at Chief of Mission Residence in Abuja.

#### Monday, March 14

- Briefing on the President’s Emergency Plan for AIDS Relief (PEPFAR) with U.S. Embassy, CDC, and USAID.
- Visit to Defense Headquarters Medical Receiving Station, Mogadishu Barracks, in Abuja and meeting with State Minister for Defense Dr. Roland Oritsejafor.
- Site visit to Saint Mary’s voluntary counseling and testing center and antenatal clinic.
- Site visit to Tafa community and brothel-based commercial sex work interventions.
- Meeting with the Interfaith Dialogue, a coalition of leaders from the broad Nigerian faith community.
- Meeting with Deputy Commissioner of Police A.E. Okeke.

#### Tuesday, March 15

- Breakfast with UN Theme Group and major bilateral donors.
- Meeting with Dr. Edugie Abebe, director of public health, Nigerian Federal Ministry of Health.
- Meeting with peer educators and members of the Network of People Living with HIV/AIDS in Nigeria (NEPWHAN).
- Town Hall Meeting, cohosted by Development Communications Network, titled, “Getting the Word Out: The Role of the Nigerian Media in HIV/AIDS Prevention”
- Dinner with operational organizations—World Bank, Society for Family Health (SFH), Family Health International (FHI), Packard Foundation, Population Services International.

#### Wednesday, March 16 – Thursday, March 17: Regional Visits

- Lagos: Visits to 45 Nigeria Air Force Hospital in Ikeja; the Nigerian Navy Hospital in Ojo; brothel-based outreach program with commercial sex workers; meeting with staff of Family Health International and Society for

Family Health; and meeting with Dr. Aderemi Desalu, chair of the Lagos State Action Committee on AIDS, and Colonel Wale Egbewunmi, coordinator of the Armed Forces Program on AIDS Control (AFPAC).

- Kano: Visits to Society for Women and AIDS in Africa/Nigeria (SWAAN) VCT center; Aminu Kano Teaching Hospital; Ku Saurara! (a project focused on radio programming to inform youth on reproductive health and HIV/AIDS prevention); Youth Society for the Prevention of Infectious Disease and Social Vices (YOSPIS) resource center. Meeting with members of the Council of Positive People (COPOP) and Voice of the Hopefuls (VOH); the Emir of Kano State, Alhaji Ado Bayero; the Commissioner for Health of Kano State Government; and the Deputy Governor of Kano State Magaji Abdullahi

### **Friday, March 18**

- Debrief with Deputy Chief of Mission Tom Furey and key embassy staff.
- Lunch meeting with Professor Babatunde Osotimehin, chairman of the National Action Committee on AIDS (NACA)

## Appendix C

### List of Abbreviations

ACSS	Africa Center for Strategic Studies
AFPAC	Armed Forces Program on AIDS Control
ARV	antiretroviral
BON	Broadcasting Organization of Nigeria
COPOP	Council of Positive People
CSW	commercial sex worker(s)
DHAPP	(U.S.) Department of Defense HIV/AIDS Prevention Program
ECOWAS	Economic Community of West African States
FHI	Family Health International
JAAIDS	Journalists Against AIDS Nigeria
LACAs	Local Action Committees on AIDS
MAP	Multi-Country HIV/AIDS Program for Africa (World Bank)
NACA	National Action Committee on AIDS
NARHS	National HIV/AIDS and Reproductive Health Survey
NASCP	National AIDS and STD Control Program (under Federal Ministry of Health)
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NGO	nongovernmental organization
NSF	National Strategic Framework (NACA plan)
OGAC	Office of the Global AIDS Coordinator (U.S. State Department)
PAC	Presidential Advisory Committee
PEFPAR	President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
SACAs	State Action Committees on AIDS (state-level counterpart to NACA)
SFH	Society for Family Health
STD	sexually transmitted disease
SWAAN	Society for Women and AIDS in Africa/Nigeria
VCT	voluntary counseling and testing

VOH Voice of the Hopefuls

YOSPIS Youth Society for the Prevention of Infectious Diseases and Social Vices