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An assessment of the response to the HIV/AIDS pandemic in Taraba State, Nigeria

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Taraba state has one of the highest HIV/AIDS prevalence rate in north eastern Nigeria. It has many high risk settings and increasing behavioural attitudes that enhance the spread of the virus. This study evaluates the response of the State Government to the HIV/AIDS pandemic and how the conceptualization of the problem impacts on the government's response in the State. The finding shows that the high risk settings and the behavioural factors causing the disease still prevail, if not worsening by the day in the State. These include the presence of alcohol drinking 'joints' in rural markets all over the State, high level of poverty among both urban and rural dwellers across the state, increasing number of widows, orphans and divorcees, especially in the rural areas and the fear of stigmatization. Of the 16 LGAs in the State, only 8 general hospitals and 4 referral hospitals have HIV/AIDS testing kits and six sites (in 4 LGAs) that provide ART drugs in the State. Other factors compounding the problem include the challenges of denial, stigma, discrimination, low literacy levels, poverty and the very low government support for HIV/AIDS at the state and Local Government Areas (LGAs) levels. The study recommends adequate funding by way of special budgetary allocation to the fight against HIV/AIDS in the State.

Key words: Assessment, HIV/AIDS, pandemic, response.

INTRODUCTION

HIV/AIDS is considered not only as the greatest global public health disaster but also as the biggest "development challenge" of the twenty first century. It affects the most economically productive sector of the population and threatens development achievements in many countries of the world. According to UNAIDS (2004), 36.1 million people worldwide are estimated to be living with HIV/AIDS: 1.4 million children under age 15 and 34.7 million adults, 16.4 million of whom are women. It is estimated that 70% (25.3 million) of all HIV/AIDS cases worldwide are in sub-Saharan Africa: 3.8 million new infections occurred in this part of the world in 2000. Of three million deaths due to HIV/AIDS during 2000, 2.4 million occurred in sub-Saharan Africa (UNAIDS, 2006). It is estimated that 3.6% of the population of Nigeria are living with HIV and AIDS (UNGASS, 2010). Approximately 220,000 people died of AIDS in 2009 in Nigeria (UNAIDS, 2010).

The first case of HIV/AIDS in Nigeria was reported in 1986 (Kanki and Adeyi, 2006). In 1991, the Federal Ministry of Health (FMOH) conducted the first sentinel sero-prevalence survey in Nigeria. In this survey, and in subsequent surveys conducted in 1993, 1999, and 2001, pregnant women attending antenatal clinics (ANCs), patients with sexually transmitted infections (STIs), patients with TB, and female commercial sex workers (FCSWs) provided the population for the HIV sero-prevalence estimates. These surveys show a rise in HIV infection in Nigeria: from 1.8% in 1991 to 4.6% in 2008 (Table 1). These figures indicate that about 3.5 million Nigerians between the ages of 15 to 49 are infected with HIV/AIDS. It is therefore a significant threat to Nigeria's development. Nigeria has the highest number of people placed on ART in Africa. This imposes a huge financial burden on the country. The country has already surpassed the 5% explosive phase. By 2002, the epidemic had killed 1.7 million people and orphaned 1.5 million children and presently, 3.5 million Nigerians are living with the virus (Peterson and Obileye, 2002). UNAIDS in its 2008 global report stated that there were an estimated 2,600,000 persons infected with HIV/AIDS in Nigeria and approximately 170,000 people died of AIDS in 2007 alone (NDHS, 2008). By the experience of countries that have surpassed the Nigerian HIV prevalence

Table 1. HIV/AIDS Prevalence Rate in Taraba state.

Year	National rate (%)	Taraba state rate (%)
1991	1.8	7
1993	3.8	7
1995	4.5	6.0
1999	5.4	5.5
2001	5.8	6.2
2003	5.0	6.0
2005	4.4	6.1
2007/8	4.6	5.2

Source: Taraba State SACA.

rate (5.8%), HIV/AIDS in all likelihood will pose a significant burden on the already stressed and depleted resources and dilapidated infrastructure available to fight the disease.

The prevalence rate for Taraba state in the same period ranged from 7.0 to 5.2% (Fidelis, 2007 and Taraba state HIV/AIDS Strategic Plan, 2007). Going by the 5.2% HIV/AIDS prevalence rate in Taraba state as at 2008, it could be estimated that about 127,167 people were living with the virus in the state. As at 2007, only 2,541 infected persons in the state were known to be placed on the antiretroviral therapy (ART) programme in the state. A rapid assessment survey of HIV/AIDS prevalence carried out by the Family Health International (FHI) (2000) shows that the state has LGAs with high risk settings. Some of these LGAs include Zing LGA (Sabon Layi area), Gassol LGA (Mutum Biyu, Tella, Dan-anicha area), Jalingo (Sabon Layi, Gidin-Dorowa and the city center), Wukari and Sardauna (Gembu area).

This is as a result of high sexual networking among the adolescents and young adults, extra-marital sex and concurrent sex partnerships, street hawking, polygyny; early marriage, divorce and frequent re-marriages/wife inheritance. Amongst the population, most women are vulnerable through sex because of poverty. Recent review has shown that 'relatively few interventions to reduce AIDS stigma have been conducted, or at least rigorously evaluated and documented, in the State and the country in general. Despite this, government response to the pandemic over the years has been very poor, characterized by lack of political will, poor coordination of programmes, lack of data or baseline information on the actors, programmes, location, budget and impact of various interventions in various parts of the state.

This study evaluates the response of the state government to the HIV/AIDS pandemic and how the conceptualization of the problem impacts on the state's response.

Aim and objectives

The aim of this paper is to evaluate the progress made by Taraba state Government in its response to the HIV/AIDS pandemic. The specific objectives include;

i. To examine the causes of the spread of HIV/AIDS in the state.
ii. To examine the progression of the prevalence rate of HIV/AIDS in the State.
iii. To evaluate some of the programmes aimed at curtailing the spread of HIV/AIDS in the state.
iv. To identify impediments to the success of these programmes and recommend possible solutions.

Theoretical conceptualization

There are many conceptions of the problem of HIV/AIDS. Some scholars aligned themselves to the western notion which sees the disease as having African origin (whether through African Monkeys or sexual practices). Others view AIDS as a disease affecting mostly members of the gay community, prostitutes, and intravenous drug users (mostly western lifestyle) and as such a product of Western Science. Even within Africa, there are different perceptions of the problem of HIV/AIDS. Some religious groups believe that AIDS is a curse from God as a punishment for man's numerous sins. Many people believe that HIV/AIDS is a disease common among prostitutes, unfaithful partners and people with many sex partners. The strong moral tone against such sexual conduct underscores the African attitude to ostracize the disease and the victim along. While the western culture is liberal towards sex, the African culture is conservative. It perceives sex as sacred, an activity that must be engaged in by specific categories of persons socially and spiritually defined. Sexual behaviours which violate these socially defined norms are seen as anti-social, aberration of community norms and offensive to the gods.

This study aligns itself also to the concept of globalization because it perceives HIV/AIDS as a product of globalization which has reduced the whole world to a global village, so that whatever happens in one part of the earth easily spreads to the other parts, including diseases.

Globalization, according to Ogunbiyi (2002 as cited in Kiely, 1998), connotes instances where the "world's societies, culture, politics and economy have, in some sense, come closer together". According to Scholte (2001), globalization can be appreciated when viewed as an intensification of cross-border interactions and interdependence among nations, as the spread of various objects and experiences to people at all corners of the earth, as a shift in geography where borders lose some of their overriding influences, or as cultural imperialism and systematic imposition of the culture and tradition of dominant nations. As Barnett and Whiteside (2000) pointed out, health and wellbeing are international concerns and global goods, and inherent in the epidemic are lessons to be learned regarding collective

responsibility for universal human health. The AIDS pandemic has become one of the defining fears of our globalized world. So many scholars have demonstrated the indispensability of theories of globalization to conceptualization of the HIV/AIDS epidemic. Globalisation is midwife to the spread of the disease, as modern travel facilitates rapid dissemination of HIV infection across national borders. Hence through concerted global action, triumphant conqueror over its devastating impact and expansion can be achieved. Although poorer countries are having increasing access to money, effective and affordable interventions, and technical support, the epidemic continues unabated in many of these resource-constrained regions of the world. A major reason for this continued spread is the numerous constraints within health systems in developing countries, which impact upon government policy, strategic and health policy management. Thus globalization equally determines the state and national governments response to the HIV/AIDS pandemic. This is because State and National governments that adopted neo-liberal policies have a weaker capacity to respond effectively to HIV/AIDS because of the negative impact of global policies on the 'drivers' of the social determinants of health, some of which include privatization and underfunding of public services (including health), labour market reforms, peace and political stability. There is a growing realization that HIV/AIDS is worsened by several trends in globalization and that it cannot be addressed by an externally designed global response (Globalization and HIV/AIDS, 2008). Local and National capacities are needed to resist and respond to the many severe impacts of globalization on HIV and other health issues in the state and country at large.

Description of study area

Taraba state is located between latitude 6°25'N to 9°30'N and longitude 9°30'E to 11°45'E with tropical continental type of climate. Taraba state, with a land area of about 60,291km^2, the second largest in Nigeria, has a total population of over 2.3 million people according to the 2006 population census and annual growth rate of 3.1% per annum. Taraba state is located on the mountain ranges in the Eastern borderland of Nigeria separating Nigeria and Cameroon Republics. It is bordered on the west by Nassarawa and Plateau States, to the north by Bauchi and Gombe states and by Adamawa State to the northeast. It also shares its south western boundary with Benue State. Taraba State is bounded on the south and south east by the Republic of Cameroon (an international boundary). The State lies largely within the middle of Nigeria and consists of undulating landscape dotted with mountainous features. The state has a location disadvantage with respect to HIV/AIDS (Obioha, 2008). Obioha observed that the state shares boundary with Benue and Plateau states in the north central zones which have the highest rates of HIV/AIDS in the country and Bamenda region in the Republic of Cameroon which also has high HIV/AIDS in that country (Interview, 2009a). The state has the longest international boundary with neighbouring Republic of Cameroon (about 437km long) (Oruonye, 2010). This contributes greatly to the high prevalence rate of HIV/AIDS (7%) in Sardauna LGA. Here, there are two private hospitals sponsored by NGOs (Gembu Centre for HIV and AIDS and Advocacy in Nigeria - GECHAAN and the Mambilla Baptist Mission Hospital in Gembu town) that handles HIV/AIDS cases. The state also has a long trunk road with satellite towns dotting on the highways.

METHODOLOGY

Secondary data were used in this study. They include information on relevant data that were required for effective planning of measures to combat HIV/AIDS in the state. The secondary data include information from the report of Consultants, Committees, Magazines, Newspapers, Journals, Dissertations (published and unpublished), official gazettes and information from files and memos of ministries and departments, hospitals and clinics. Interview schedule were used to elicit vital information from government officials and officials of some hospitals, clinics and other groups based on their experiences in the state and some of their challenges. Such interview schedule were structured in such a way that it was used to generate information on some of the behavioural factors causing/enhancing the spread of HIV/AIDS, the geographical spread of HIV/AIDS, some of the previous programmes aimed at curtailing the spread of HIV/AIDS, the level of success or otherwise of such programmes and some of the problems or impediments to the success of such programmes in the state.

RESULTS AND DISCUSSION

HIV/AIDS prevalence in Taraba State

One of the greatest problems of development in Taraba state is the increasing rate of the HIV/AIDS pandemic. A sentinel surveillance system conducted among pregnant women aged 15 – 49 attending antenatal care has been used to track HIV prevalence in the country since 1991. Information from UNAIDS (2004) update report shows that Jalingo metropolis had HIV prevalence rate of 1.28, 4.0 and 6.69% in 1995, 1999 and 2001 respectively, while Zing LGA had a prevalence rate of 9.87, 7.0 and 5.67% in 1995, 1999 and 2001 respectively among pregnant women. Wukari LGA had a prevalence rate of 8.92% in 1995, while Bali LGA had a prevalence rate of 2.14% in 1995 among pregnant women. Zing LGA also recorded HIV prevalence rate of 11.49% among STI patients and 17.11% among tuberculosis patients, while Jalingo recorded 60.87% among sex workers and 6.12% among STI patients in 1995. About 5,500 pregnant women in Taraba State tested HIV positive according to

the 2005 sentinel survey. Based on the same 2005 sentinel survey, there were about 63,300 HIV infected people in the state (Daily Trust, 12 May 2009). The absence of reliable database in the state is one of the greatest constraints to HIV/AIDS programs. The prevalence rate of HIV/AIDS in the state is about 5.2% as shown in Table 1.

The GECHAAN hospital (Gembu) record shows that the prevalence rate of HIV/AIDS in the area (Gembu town) is 7% annually, 15 cases weekly, 60 cases monthly and 720 cases yearly, while that of Mambilla Baptist Mission Hospital in the same Gembu town shows that between 150 to 200 persons are infected monthly (Interview, 2009a). Statistics for other LGAs are not available. Health officials in the LGAs revealed that the absence of testing facilities and data on the prevalence of HIV/AIDS in the LGAs made it difficult to draw definite conclusions about the prevalence rate or magnitude of the problem (FHI, 2000).

Causes of the spread of HIV/AIDS in Taraba State

The prevailing lifestyle in the state is a major factor contributing to the spread of HIV/AIDS. Local beer parlours in market places exist in all local markets which hold weekly across the state. The men who attend such local markets to sell their agricultural produce do not often return to their families the same day (interviews and field observations). They stay back to spend the money realised from the sales in drinking and indulging women, mostly young girls. Most of them only return to their families' days after when they might have exhausted their earnings.

Increasing rate of poverty in the state makes most of the young girls and women, particularly divorcees and orphans to become vulnerable to HIV/AIDS infection. Many young girls in the age group of 15 to 30 years are seen in every local market engaging in their sexual networking activities. Most of them leave at the end of the market day with some of the distant traders and drivers. This lifestyle contributes greatly to the increase in HIV/AIDS prevalence in the State. The young girls are easily lured with money. Most of them from poor families are still in secondary schools and do not know much about HIV/AIDS and protected sex. They are highly vulnerable to infection by HIV/AIDS because they have no resistance to unprotected sex. The high level of poverty, increasing number of widows and divorcees, especially in the rural area exacerbate this problem.

After 24 years when the first case of HIV/AIDS was reported in Nigeria, many people are still ignorant of the virus, particularly its mode of transmission, symptoms, and effective measures of prevention. This problem is more so in the rural areas where most of them are cut off from mass media and other media of enlightenment campaign by Non Governmental Organizations (NGOs) and Community Based Organizations (CBOs).

The issue of stigmatization and discrimination is further worsening the problem of the fight against HIV/AIDS in the State. HIV/AIDS is a life-threatening illness that people are afraid of contracting. The various metaphors associated with AIDS have also contributed to the perception of HIV/AIDS as a disease that affects "others," especially those who are already stigmatized because of their sexual behaviour, gender, race, or socioeconomic status. The people's perception of HIV/AIDS is that of fear. All diseases accompanied by weight loss are erroneously regarded as HIV/AIDS infection. There is also a high degree of social stigma leading to denial (FHI, 2000). Despite the campaigns over the years that people should know their HIV/AIDS status, people are reluctant to submit themselves to the free voluntary HIV/AIDS test for fear they might be stigmatized or discriminated against by the society. Hence, many people prefer to keep to themselves and die in silence with the disease. This contributes greatly to the difficulty of having correct statistics of people living with HIV/AIDS in the state and country at large.

Assessment of Taraba State Government response to HIV/AIDS problem

Taraba State Government's HIV/AIDS program is anchored in the Ministry of Health. The State HIV/AIDS Committee was established in 1992 with a State HIV/AIDS Program Coordinator appointed. Desk officers were also appointed to oversee HIV/AIDS issues in the local government areas. The State Action Committee on HIV/AIDS (SACA) and Local Action Committee on AIDS (LACA) were equally established in the state. HIV testing is done in eight general hospitals and four cottage hospitals in the state. The government provides reagents for the tests. There are many NGOs involved in HIV/AIDS work in the state, some of which include the Taraba State branch of the Society for Women and AIDS in Nigeria (SWAAN), the Fellowship of Christian Students (FCS), the National Youth Service Corps (NYSC). The Ministry of Education has no specific programme on HIV/AIDS but there has been collaboration with the FCS to raise awareness in schools. Primary and secondary school curricula include health education, but family life education is yet to be integrated.

Obioha (2008) observed that only one year budgetary allocation for HIV/AIDS activities existed since the creation of the State in 1991. He further maintained that previous studies show that there were no deliberate budgetary allocations for the control of HIV/AIDS in all the LGAs except in Zing Local Government area. Even in Jalingo, the state capital, there was no budgetary allocation for HIV/AIDS programme. In other LGAs, there were plans to include the control of HIV/AIDS in their government's budget, but this never came to fruition.

Information across various local government areas indicate that they are not yet integrated into any HIV/AIDS control network, neither were they part of any HIV/AIDS control activity at the State level (Obioha, 2008). Due to poor funding, the Ministry of Health was only able to conduct few awareness and public enlightenment programs in the State.

The Ministry of Information is charged with supervision and control of all State government owned media agencies. In collaboration with international donor agencies, there is an ongoing communication programme on HIV/AIDS in the State electronic media channels. The Ministry also carries out advocacy meetings with traditional and religious leaders in the state. However, the situation on ground shows that the State government is not involved or do not allocate any money for dissemination of information through the media channels (Obioha, 2008). It only allows the State media houses to carry out sponsored programme on HIV/AIDS through their State Television and radio stations. Findings from Ministries and government agencies show that there is no specific programme on HIV/AIDS control that has been made part of their routine duty, but there are collaborative efforts.

Also, out of the 16 LGAs in the state, only 8 general hospitals and 4 referral hospitals have HIV/AIDS testing kits. Most of them sometimes run out of test reagents thereby compromising their efficiency.

Some of the challenges to the problem of HIV/AIDS in the State include; denial, stigma, discrimination, low literacy levels, poverty and the very low government support for HIV/AIDS at the LGAs level (Taraba state HIV/AIDS Strategic Plan, 2007). Other challenges include difficult terrain of the state which made HIV/AIDs activities coverage very low, limited resource/poor infrastructural capacities, over dependence on donor funding, low LGAs commitment, non implementation of HIV/AIDs curriculum in schools, lack of anti stigma/discrimination laws, limited involvement of people living with AIDs (PLWA) and unnecessary conflicts among personnel (Interview, 2010). Presently, some of the prevention and behavioural change activities of SACA include training peer educators in collaboration with various NGOs and CBOs, HIV/AIDS counselling and testing activities (HCT), prevention of mother to child transmission (PMTCT), condom programming, Blood Safety implementation, stigma reduction and Family life and HIV education.

Taraba state has a policy that exempts patients with opportunistic infections from paying fees for treatment. The state anti retroviral programme first started in Government House Clinic Jalingo in January 2004. Initially drugs were supplied by Taraba State Government to take care of only 100 patients. In 2005, the supply was increased to 200 patients and to 400 in 2006. In November 2006, the Federal Ministry of Health provided drugs for 1000 patients. There are currently six sites that are providing ART drugs in the State. These are Zing General Hospital, Mambilla Baptist Hospital Gembu, First Referal Hospital, Mutum-Biyu, General Hospital Wukari, supported by the Global Fund Round Five with technical support from Family Health International (FHI), while Government House Clinic and Federal Medical Centre Jalingo are supported by the State government. Presently 2,541 patients are on ART drugs in Taraba state. The break down shows that 145 clients are covered by the FHI supported hospitals, 346 by the FMC and 2,050 receive service at the Government House Clinic, Jalingo (Taraba State HIV/AIDS Strategic Plan, 2007). Giving the state's population of over 2.3 million in 2006 census and an annual growth rate of 3.1% per annum, with HIV/AIDS prevalence rate of 5.2 % as at 2008, it is clear that this facility is grossly inadequate. If only less than 3000 people are currently on ART, what happens to the rest of the infected people (estimated at about 127,167 as at 2007) most of whom cannot afford the drugs? What is happening to the non cooperating people living with the virus? What if they decide to come out and declare their status? Can government withstand the challenges?

In 2007 the National Action Committee on AIDS (NACA) was transformed from a committee to an agency – the National Agency for the Control of AIDS (NACA) by an act of parliament. This was as a result of the need for sustainability and improving the effectiveness and coordination of the national HIV response. There are 12 State Committees that have already been transformed into agencies between 2003 and 2008 by acts of parliament (NDHS, 2008). The bill for this transformation in the state has been passed by the Taraba state House of Assembly and is awaiting the Governor's accent (Interview, 2010).

The non committed attitude of the government to the fight against HIV/AIDS is a serious problem. Government response to the pandemic is more of a cosmetic show in the media that ends with the day's ceremony especially on such occasion as world HIV/AIDS day (1st December). There is no real commitment by way of special budgetary allocation to the fight against HIV/AIDS. The research findings show that the state is grossly lacking behind in paying its counterpart funding in its collaborative activities with some NGOs and donor agencies. Since the establishment of the State HIV/AIDS Committee in 1992, very little financial resources have been mobilized for HIV/AIDS activities in the State. These include the World Bank IDA credit facilities to which the state paid its counterpart funding in 2004 only (Oruonye, 2010).

The low government response to the problem of HIV/AIDS cannot be divorced from the concept of globalization. This is because the spread of HIV/AIDS is enhanced by numerous constraints within the health systems in the state, resulting from underfunding of the sector. The state and national governments have neo-liberal policies which make them to have a weak capacity to respond effectively to the problem of HIV/AIDS. This is

because of the negative impact of global policies on the drivers of the social determinants of health which include privatisation and underfunding.

The greatest challenge in the process of developing the Taraba State Strategic Plan on HIV/AIDS is the absence of data and baseline information on all the thematic areas. There is limited coordination and lack of readily available information on the actors, programmes, location, budget and impact of numerous interventions in various parts of the state. In spite of the appreciable HIV/AIDS interventions at various levels, there are no clear records of activities of partners that have supported the state for the period 2006 – 2009 as there was poor coordination and documentation of such activities by the State Action Committee on Aids (SACA) (Oruonye, 2010).

Conclusion

The study findings show that the HIV/AIDS pandemic has largely been treated as an outsider in Nigeria. This is even more so in Taraba State. This attitude towards the pandemic is a major explanation for the fact that not much appears to have been achieved in the fight against HIV/AIDS in the state. This reflects right from the conceptualization of the problem to the reactions to it in terms of policy formulation and execution. Thus, the lack of a coordinated multi-sectoral approach against the epidemic, the over centralization of intervention programs, the low priority given to the problem on the scale of competing development needs and the poor resource allocation to HIV/AIDS interventions are all a function of the outsider perception of the pandemic. Therefore the demand of HIV/AIDS epidemic on the already weak health system in the state has come to constitute a major insurmountable challenge.

Consequently, there is a huge gap between the need to develop and strengthen STI clinical services and care and support structures in the state and actual policy initiatives and actions. This is reflected in the failure to integrate HIV/AIDS programs into the activities of state-wide unions and associations, the lack of assistance to LGAs to develop strategic plans across the state. This also includes the inability of government to facilitate the identification of People Living with HIV/AIDS (PLWHA), Orphans and Vulnerable Children (OVC) and the establishment of networks. This manifest in the fact that it has failed to explore the possibility of OVC programming with Ministry of Women Affairs and Social Development through the office of the wife of the Executive Governor in spite of the popularity of this option across Nigeria. With the recent economic meltdown, which has made many of the donor agencies, NGOs and world leaders to back out on their promises of funding HIV/AIDS activities, the little progress made so far could be lost. It is time for the state and national governments to wake up from their slumber and acknowledge the fact that they cannot continue to shy away from their responsibility to their citizenry just by treating the pandemic as an outsider. Governments, both at the national and state levels must make proactive commitment to the war against HIV/AIDS pandemic in the country and Taraba State in particular. There is need to intensify effort at public enlightenment campaign through the use of jingles, posters and other mass media presentations. Taraba State government needs to put in more effort aimed at strengthening the monitoring and evaluation systems for HIV response activities in the state.

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