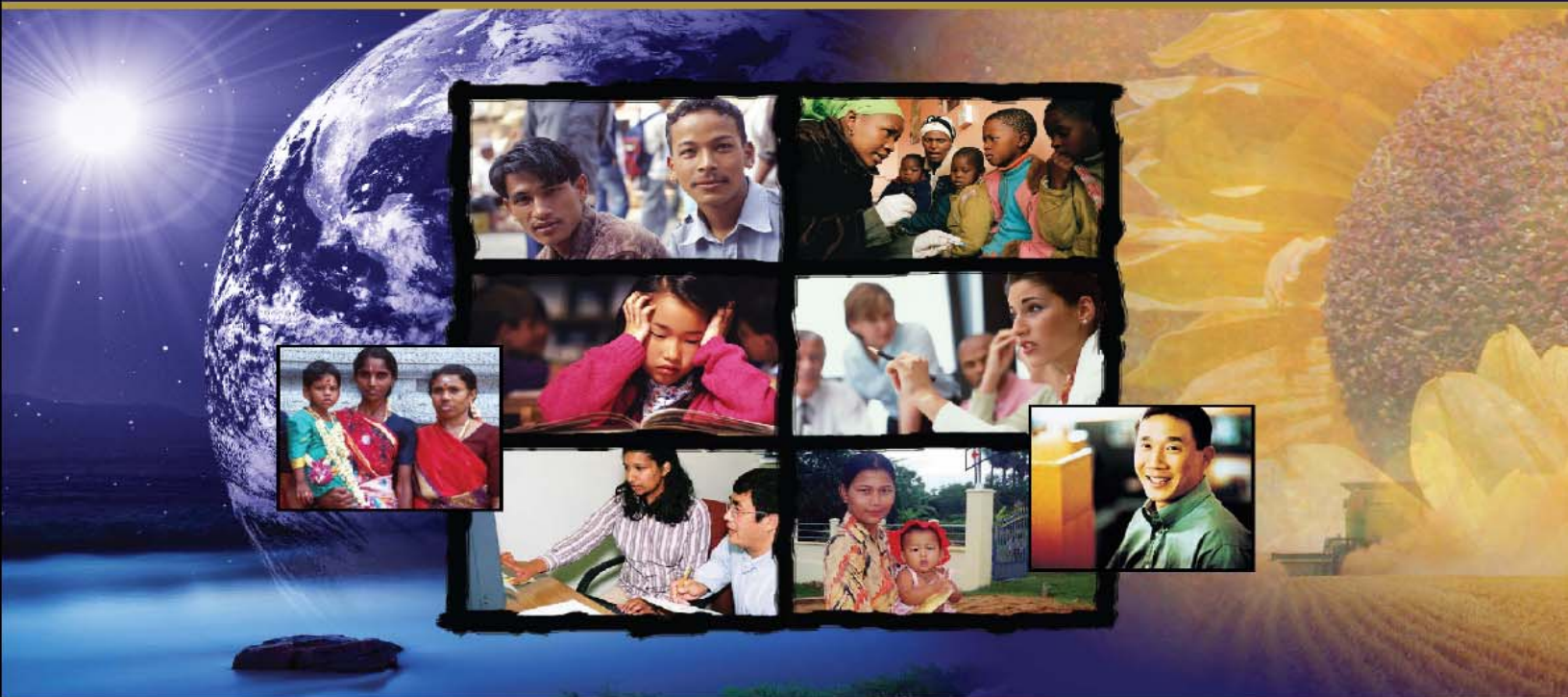


Preparing for Microbicides Access

NIGERIA COUNTRY PROFILE



Submitted to: The International Partnership for Microbicides (IPM)

Submitted by: Constella Futures, Ltd.



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The content of this publication is the sole responsibility of Constella Futures and can in no way be taken to reflect the views of the European Union.

PREFACE

With funding from the European Community, the International Partnership for Microbicides (IPM) commissioned a series of country profiles that compile information on demography, HIV and health systems in countries hosting or planning to host microbicide trials. These profiles are intended to provide basic overviews that can inform the development of more detailed policy research agendas and support future planning for the introduction of microbicides. They do not set out detailed microbicide introduction strategies or address product specific challenges.

Constella Futures was commissioned to prepare profiles for India, Nigeria, Rwanda and Tanzania. Studies were also conducted separately in South Africa and Zambia. The country profiles are available at www.ipm-microbicides.org.

The recommendations made in the reports are those of the authors and do not necessarily reflect IPM's views, positions or plans.

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REPORTS IN THIS SERIES

Prepared by Constella Futures:

- India Country Profile
- Nigeria Country Profile
- Rwanda Country Profile
- Tanzania Country Profile
- Preparing for Microbicides Access: A Synthesis Report

Prepared by Jo Heslop (data are comparable to Constella Futures reports):

- South Africa Country Profile
- Zambia Country Profile

Prepared by Health and Development Africa:

- A Country Preparedness Assessment of Microbicide Access and Use in South Africa

Prepared by JHPIEGO/ Zambia:

- Microbicide Country Preparedness Assessment – Zambia: Prospective Introduction of a Microbicide to Prevent or Reduce HIV Transmission

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ACRONYMS

ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behaviour change communication
BI	Bamako Initiative
CBO	Community-based organisation
CCE	Constituencies coordinating entities
CHAN	Christian Health Association of Nigeria
CCM	Global Fund Country Coordinating Mechanism
CIA	Central Intelligence Agency
CSW	Commercial sex worker
CLMS	Commodity logistics management system
DFID	Department for International Development
DMA	Drug management agency
EDL	Essential Drug List
FBO	Faith-based organisation
FHI	Family Health International
FSW	Female sex worker(s)
GDP	Gross domestic product
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GHAIN	Global HIV/AIDS Initiative Nigeria
GMP	Good Manufacturing Practice
HBC	Home-based care
HIV/AIDS	Human immunodeficiency virus/ Acquired immunodeficiency syndrome
IEC	Information education, communication
ILO	Intensive labour organisation
IPM	International Partnership for Microbicides
JSI	John Snow International
LACAS	Local action committee on AIDS
LASACA	Lagos State HIV/AIDS Control Agency
LGA	Local government area
MAP	Multisectoral AIDS programme
M& E	Monitoring and evaluation
MOH	Ministry of Health
MOU	Memorandum of understanding
MSM	Men who have sex with men
MWRA	Married women of reproductive age
NACA	National Action Committee on AIDS
NAFDAC	National Agency for Food, Drug, Administration and Control
NASCP	National AIDS and Sexually Transmitted Disease Control Programme
NDHS	National Demographic and Health Survey
NEEDS	National Economic Empowerment Development Strategy
NGO	Non-governmental organisation
NPHCDA	National Primary Healthcare Development Agency
NPTs	New prevention technologies
NHVMAG	Nigeria HIV Vaccine and Microbicides Advocacy Group
OVC	Orphans and vulnerable children
PEPFAR	The President's Emergency Plan for AIDS Relief
PHC	Primary health care
PPFN	Planned Parenthood Federation of Nigeria
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
PRB	Population Reference Bureau
PSI	Population Services International

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RH	Reproductive health
RHCS	Reproductive health commodity security
SACA	State Action Committee on AIDS
SACP	State AIDS Control Programme
SFH	Society for Family Health
SRH	Sexual and reproductive health
STI	Sexually transmitted infection(s)
SWAp	Sector-wide approach(es)
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing of HIV
WHO	World Health Organization
WIPO	World Intellectual Property Organization

EXECUTIVE SUMMARY

This report for Nigeria is one of a series of country profiles commissioned by the International Partnership for Microbicides (IPM) to build a background on which to begin to examine microbicide access at the country level. The objectives of the project are to look at country settings and begin to identify implications for microbicides in developing countries. The team built the profiles as desk-based research using standard data sources, and in-country consultants assisted the researchers by interviewing stakeholders and filling important gaps unavailable in the grey literature. Although data for Lagos in the south and Kano in the Muslim north were scarce, efforts have been made here for a more detailed profile of the two states.

Demographic situation. Nigeria, the most populous country in Africa with 134 million people, has a complex federal system with much power residing at state level. The country combines many different religious groups with a history of ethnic tensions. Use of family planning is low and fertility is high; ideal family size is eight and actual fertility is approximately six children per woman. The population is set to more than double by 2050.

HIV situation. Nigeria is a high-burden, low-income country facing a mature, generalised AIDS epidemic. The epidemic is becoming increasingly feminised, as women now account for 62 per cent of infections.¹ Nigeria has a million children orphaned from HIV—one of the worst situations in the world.

Health system. Nigeria's health system is weak, poorly coordinated and fragmented, with very little capacity to deliver health services at state and local levels. The government spends only 2.9 percent of its overall budget on health. A majority of the population look to the private sector for their health needs.

Regulatory capacity. The Nigerian National Agency for Food and Drug Administration and Control (NAFDAC) regulates and controls the importation, manufacture, advertising, distribution, sale and use of drugs or devices in Nigeria. NAFDAC's leadership is implementing effective reforms to improve the health commodity situation in Nigeria, which had seen many fake or inappropriate medications flooding the market in the past. The situation is currently much improved, though there is more work to do. As so many Nigerians buy their health commodities from the private sector, it makes regulation all that more important.

Manufacturing. Nigeria has considerable manufacturing capability. Currently, there are over 50 pharmaceutical manufacturing plants with varying degrees of sophistication. Many major European and American pharmaceutical manufacturers have plants here, including

¹ UNAIDS, 2006

Nigeria Country Profile

GlaxoSmithKline, Pfizer and Evans Medical. Also, major Indian manufacturers, such as Ranbaxy and Cipla, have plants in Nigeria. Other key players include SwissPharma, Drugsfield, and Bayer-Gemini. However, the majority of the plants are indigenous organisations. The level of sophistication is reflected in the four sterile manufacturing plants capable of producing injections and infusions, one able to produce rectal and vaginal suppositories, and four ARV manufacturing plants.

Procurement. With Nigeria's large size, the need and demand for pharmaceuticals has always been enormous. Formerly self-sufficient in its drugs needs, Nigeria has become increasingly dependent on donor funding in recent years. While there are many overarching regulations and frameworks, procurement is done on a state-by-state basis. In short, the procurement system is extremely complex and the systems are not transparent.

HIV programming. Political commitment to HIV is reasonably high and the National Action Committee on AIDS emphasises a multisectoral approach. Nigeria has a HIV Emergency Action Plan and HIV/AIDS is also addressed in Nigeria's Poverty Reduction Strategy. Resources for HIV come from a variety of donors. The government, the US (PEPFAR), and DFID are the largest donors for HIV work. Knowledge of ways to prevent HIV is low, indicating the need for stronger prevention programmes. All states have at least one ARV facility but the proportion of people on ARVs who need them is still very low, although the government has begun to scale up treatment with some success. PMTCT services, however, are far from sufficient. There is a successful socially marketed condom called 'Gold Circle' and the PSI partner Society for Family Health (SFH) is one of the most efficient social marketing programmes in the world.

IMPLICATIONS FOR A FUTURE MICROBICIDE.

Two Nigerian consultants interviewed a range of key stakeholders, asking them what might have an impact or influence on a future microbicide. Below are some of the results of their informed speculation.

DELIVERY CONSIDERATIONS

Private sector. Sixty per cent of Nigerians receive their medicines from private sources. This has massive implications for the introduction of microbicides and a private sector launch might be preferable to a public sector introduction in the first instance.

Social marketing. Microbicides, if available over the counter, could be made available through social marketing programmes. Once women have learned how to use a microbicide, they could obtain their re-supply through social marketing outlets. Nigeria has one of the strongest social marketing programmes in the world.

HIV and SRH communities. There is currently little collaboration between these two communities, although there is increasing recognition of the need to integrate efforts. State and primary healthcare centres all provide family planning and could be excellent for use as microbicide entry points.

Female condom in Nigeria. Condoms were championed by civil society, including the IPPF affiliate PPFN. The barriers to their use included: a) the need for male involvement; b) the need to train providers to teach women how to use the product; c) the product was seen as noisy or oily; d) it was not widely available; and e) it was seen to be expensive and bulky.

REGULATORY CONSIDERATIONS

Categorisation of microbicides within the regulatory system is still an issue. Currently, it is unclear whether a microbicide would be considered a drug or a cosmetic. (A second generation of microbicides would most certainly be categorised as a drug.)

Quality control. If microbicides become popular and their production can't keep up with demand (or even if it can), there is the possibility that someone will try to sell fake microbicides. Despite recent improvements by NAFDAC, the problem of poor quality control is still persistent in Nigeria. Issues to consider will be packaging, number of accredited manufacturers, quantities distributed, and the clinical monitoring of their use and evaluation.

ADVOCACY

The media are strong opinion shapers in addressing HIV/AIDS issues. The influential networks include Journalists Against AIDS (JAAIDS), DEVCOMS, Internews, the National Union of Journalists (JUJ) and the National Association Women Journalists (NAWOJ). The latter focuses on stigma and discrimination. Many of these groups already work with the Nigeria HIV Vaccine and Microbicides Advocacy Group (NHVMAG) on new prevention technology (NPT) issues.

STAKEHOLDER OUTREACH

The Association of Pharmacists or the Medical Association can be major product endorsers. They also have a strong political voice. Any doubts health professionals express will need to be promptly addressed or product uptake will be slowed.

The Nigeria HIV Vaccine and Microbicides Advocacy Group (**NHVMAG**) is a **key ally**. This is the national coalition body for all advocates and activists for new prevention technologies. Nigeria is unique in having an advocacy group so oriented toward prevention technology. Initial poor understanding of NPTs was hindering the NAFDAC approval process for microbicides research. Training from the Nigeria HIV Vaccine and Microbicides Advocacy

Group (NHVMAG) has clarified many misconceptions on microbicides. Indigenous groups carry considerable credibility within Nigeria.

Traditional healthcare providers reach more people at the grassroots level and may be crucial to community level microbicide introduction as they are often strong opinion leaders. Traditional healers could be crucial to microbicide introduction at the community level. Community advocates for microbicides could begin to engage this population as product availability nears.

Religious leaders can shape consumer demand and their endorsement is valuable. Attempts should be made by community groups to engage religious leaders.

State leaders spouses are often involved in health issues and are respected as opinion leaders. These are the spouses of the state governors and are influential for product uptake.

Make NAFDAC an ally. NAFDAC's approval will be essential in getting microbicides registered for use in Nigeria. Early communication with the agency will facilitate the registration process.

Use the National Action Committee on AIDS (NACA) to help with registration and introduction of microbicides. NACA is the national coordinating body for all responses to the pandemic. It answers directly to the president. It could make a difference with subsidies, waivers, and duties and taxes and also expedite the regulatory process.

The federal Ministry of Finance can play a role in affordability through tax waivers and positive tariff determination (currently provided for ARVs). This ministry can fast-track imported products through the Customs and Excise Department of the Ministry of Internal Affairs. (Tariff exemptions for microbicides would require authorisation from the Presidency.)

1 INTRODUCTION

This report for Nigeria is one of a series of country profiles commissioned by the International Partnership for Microbicides (IPM) to build a background on which to begin to examine microbicides access at country level. IPM commissioned Constella Futures in April, 2006, to carry out the project, which is funded by the European Commission. The primary aim of the project is 'to accelerate access of women in less-developed countries to microbicides as soon as possible after clinical trials have demonstrated their effectiveness in preventing HIV infection.' Broadly, the objectives of the project are to look at country settings and begin to identify the implications for a future microbicide in developing countries.

This country profile for Nigeria is intended to be a resource for the microbicide community as access to microbicides becomes a reality over the next few years. The profile includes summary demographic and health information, as well as an overview of the procurement, regulatory and manufacturing situation. Finally, the profile includes institutional mapping and outlines the key players in HIV/AIDS and sexual and reproductive health (SRH). Implications for the introduction of a future microbicide in Nigeria conclude the report.

As Nigeria is such a large country, IPM asked the team to examine two Nigerian states in more detail. This was partly to obtain increased information on specific parts of the country and partly to find out about the quantity and quality of state-level data. Lagos state was chosen in the south and Kano state was chosen to represent the Muslim north. Data were difficult to ascertain and the quality of the data was variable.

2 METHODOLOGY

The microbicides access country profiles are meant to be background documents for future microbicides research and modelling. IPM provided the outline for the country profile series and this is reflected in the table of contents for the report. The team built the profiles using standard data sources from the UN system, the Population Reference Bureau, the demographic and health surveys, and the Global Fund. These data were chosen to allow comparability across countries. Additional studies and in-country data were included, if available. In-country consultants assisted the researchers by interviewing stakeholders and filling important gaps unavailable in the grey literature.

Finally, two meetings were held by the Constella Futures team, one in London including international experts, and one in Nairobi bringing together the in-country consultants. Both sets of experts provided additional information, giving their opinions on best ways to provide microbicide access as well as identifying obstacles.

3 DEMOGRAPHIC INFORMATION

3.1 BASIC DEMOGRAPHIC AND SOCIO-ECONOMIC CONTEXT

TABLE 3.1 DEMOGRAPHIC DATA

Total population (<i>PRB, 2006</i>)	134,500,000
Population density per square mile (<i>PRB, 2006</i>)	377
Percentage of population living in urban areas (<i>PRB, 2006</i>)	44%
GDP per capita (<i>WHO, 2005</i>)	US\$407
Human Development Index (<i>WHO, 2005</i>)	0.453 (ranked 158/177)
Percentage of population on under \$2 a day (<i>PRB, 2006</i>)	92%

Nigeria Country Profile

The Federal Republic of Nigeria is a large country in western Africa, bordering Benin, Niger, Chad and Cameroon as well as the Atlantic Ocean (specifically the Gulf of Guinea). With 134.5 million people, it is the most populous and most densely populated country in Africa, with 377 people per square mile. Half the population lives in urban areas. Nigeria is a low-income country, with a GDP per capita of US\$407 and a Human Development Index of 0.453 (the 20th lowest ranking in the world). Over 90 percent of people live on less than \$2 a day.

Nigeria became independent in 1960 and later endured 16 years of military rule, which ended in 1999 with the election of the Obasanjo administration. Nigeria is now experiencing its longest period of civilian rule since independence and is working to reform an economy and infrastructure damaged by corruption and mismanagement. The capital moved from Lagos (the largest city and commercial capital) to Abuja in 1991. The country is divided into 36 states and one federal capital territory and further divided into 774 local government areas. English is the official language; other major languages spoken are Hausa, Yoruba, Igbo (Ibo) and Fulani. The population is 50 percent Muslim, 40 percent Christian and 10 percent indigenous beliefs. Oil provides 20 percent of Nigeria's GDP and 95 percent of its foreign exchange earnings. Once a major food exporter, Nigeria's high population growth means that the country must now import food. Other major industries are leather goods and textiles.²

Although there are over 250 ethnic groups in Nigeria, the three main ethnic groups are the Yoruba in the west, Igbo in the east and Hausa in the north, all with their own languages and religions. A history of ethnic and religious tension and serious violence between Christian and Muslim communities stems from incidents that occurred in Plateau and Kano states in 2004.

As discussed in the introduction, Kano state and Lagos state have large population concentrations and large urban populations, with HIV prevalence higher than the average national rate. Hence, they are examined in further depth. Unfortunately, there is very little state demographic information from reliable sources.

Kano is a state in the north of Nigeria. It has an estimated population of 5.6 million and a population density of 699 per square mile (almost twice the national population density). However, these data are based on 1991 census figures and the estimated population and density are now likely to be even higher. It is home to the city of Kano, the third-largest city in Nigeria and the economic centre of northern Nigeria. Kano is a commercially and agriculturally productive state and attracts much foreign investment. Islam is the predominant religion and Shari'a has been adopted as the state law. It contains 44 local government areas.³

² CIA, 2006.

³ FHI, 2001a.

Lagos is a state on the southwest coast of Nigeria. Lagos is the smallest state in Nigeria but is home to the largest population. The population of 10.6 million translates into a very high population density of 1,866 per square mile.⁴ Ninety-four per cent of the state's population lives in Lagos city,⁵ the largest Nigerian city and commercial centre and focus of international trade. Its population is ethnically and culturally diverse. The Yoruba compose about 70 percent of the population and the remainder is made up from other ethnic groups of Nigeria as well as a significant number of non-Nigerians. Christian, Muslim and indigenous beliefs represent the predominant religious practices of Lagos. Lagos holds economic and occupational advantages over other states, though these are unevenly distributed. The six percent of higher-ranking professionals in the metropolitan population earn 30 times the wages of the 82.5 percent of the workforce which consists mostly of petty traders, labourers, transporters and craftsmen. Lagos contains 20 local government areas (LGAs).⁶

3.2 HEALTH AND FERTILITY

TABLE 3.2 HEALTH AND FERTILITY DATA

Crude birth rate	43
Crude death rate	19
Projected population increase 2006-2050	122%
Life expectancy at birth	44
Life expectancy at birth (male)	43
Life expectancy at birth (female)	44
Total fertility rate (snapshot average family size)	5.9
Ideal family size – women (<i>NDHS, 2003.</i>)	7.3
Ideal family size – men	8.6
Percentage of married/in union women of reproductive age using contraception	12%
Percentage of MWRA using modern contraception	8%
Unmet need for family planning (<i>PSP-One, 2005.</i>)	17%
Age at first marriage (women) (<i>DHS, 2006.</i>)	16.6 years
Age at first sex (women) (<i>DHS, 2006.</i>)	16.2 years
Age at first birth (<i>NDHS, 2003.</i>)	19.3 years

Source: PRB, 2006, unless otherwise stated.

The birth and death rates are high (both higher than average for sub-Saharan Africa) and life expectancy is low, at 44 years. The total fertility rate has declined in recent years but is still among the highest in sub-Saharan Africa. This means the population is expected to more

⁴ FHI, 2001b.

⁵ NDHS, 2003.

⁶ FHI, 2001b.

than double by 2050. The ideal number of children is 7.3 for women and 8.6 for men, showing the importance of fertility in Nigeria. There is an unmet need for family planning of 17 percent, which is relatively low compared to other sub-Saharan African countries. (Unmet need is the proportion of women who say they want to delay or terminate childbearing, but are not using contraception.) There are large variances for desired and actual fertility across the population according to age, level of education, religion and environment (urban/rural). There is a low level of contraceptive use, with 12 percent practising family planning and only eight percent using modern methods.

There is very little reliable state information on health and fertility, particularly for **Kano**. The total fertility rate in **Lagos** is lower than the national average, at 5.4, and the life expectancy is significantly higher than Nigeria as a whole, at 61.5 years, reflecting the relative wealth and education levels within Lagos city.⁷

3.3 GENDER

TABLE 3.3 GENDER DATA

Percentage of women aged 15-24 who are literate (can write a simple sentence)	87%
Literate women as a percentage of literate men	95%
Percentage of women aged 15+ who are economically active	48%
Percentage of men aged 15+ who are economically active	87%
Percentage of women with access to newspaper, TV and radio (<i>DHS, 2005</i>)	10%

Source: PRB, 2005, unless otherwise stated.

Literacy levels for girls are higher than in surrounding countries, both in terms of proportion of literate women and women's literacy as a proportion of men's literacy. However, there are large disparities between economic productivity of men and women, more so than for West Africa as a whole. Only one in 10 women has full access to the media. State-level indicators for gender data are not available.

⁷ FHI, 2000b.

4 HIV LEVELS AND TRENDS

TABLE 4 HIV DATA

HIV prevalence	3.9%
# of people living with HIV (adults and children)	2,900,000
# of children (0-14) living with HIV	240,000
# of adults (15-49) living with HIV	2,600,000
# of adult women living with HIV	1,600,000 (62%)
# of orphans (aged 0-17) due to AIDS	930,000

Source: UNAIDS, 2006.

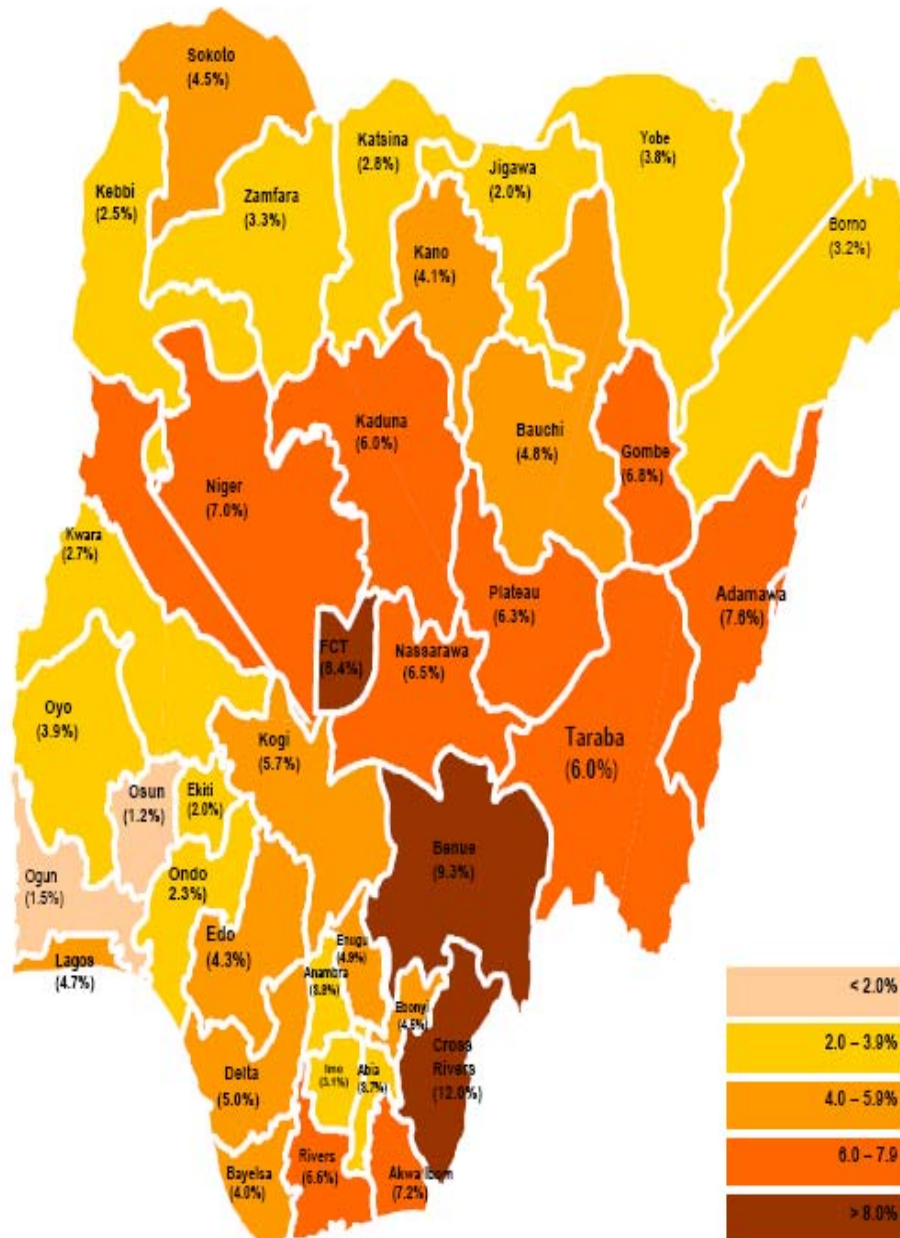
Nigeria is facing a mature, generalised AIDS epidemic. Since the first cases of AIDS were diagnosed in Nigeria in 1986, adult prevalence has increased from 1.8 percent in 1991 to 5.8 percent in 2001.⁸ Since then, it has declined to 5.4 percent in 2004 and was at 3.9 percent in 2006 for those aged 15-49. It is likely that this apparent drop in prevalence between 2004 and 2006 is, to a certain extent, due to new methods in HIV prevalence data gathering and analysis; in Nigeria, sentinel surveillance has increased in quality and coverage to include more remote rural areas, where prevalence is generally lower.⁹ Although the new figure (of 3.9 percent) appears low, Nigeria ranks third in the world in terms of the numbers of people living with HIV, after South Africa and India, with 2.9 million infected people in the country. Women are more vulnerable than men and now account for 62 percent of infections. Nigerian women marry at a very young age (16.6 years) and have their first sexual encounter even younger at 16.2 years (see Table 4.2). There is no reliable standardised or national level information available on HIV incidence, nor prevalence data for high-risk sub-populations.

Nigeria has nearly a million children orphaned by AIDS, one of the highest numbers in the world.

⁸ UNDP, 2004.

⁹ UNAIDS, 2006.

FIGURE 4 STATE HIV PREVALENCE DATA (Source: NACA, 2005)



There are strong state variations in HIV epidemiology across the country, ranging from 1.2 percent to 12 percent and urban areas generally have higher HIV prevalence (see Figure 5). **Kano** has an estimated HIV prevalence of 4.1 percent and **Lagos**, 4.7 percent, both higher than the national average.¹⁰

¹⁰ NACA, 2005.

Risk factors in **Kano** state that contribute to the spread of HIV are: large population size; cosmopolitan and ethnically diverse urban centres; poverty; illiteracy, especially in rural settings; youth unemployment; HIV denial among the population; and a thriving trading culture characterised by free movement of people and goods within Nigeria and to neighbouring countries. It is estimated that 250,000 people are living with HIV in Kano state.¹¹

Several features of a cosmopolitan environment can be found in **Lagos** state, particularly cross-border activities, poverty, drug abuse, and industry. Vulnerable populations include transport workers, female sex workers (FSWs), drug users and young people.

5 HEALTH SYSTEM PROFILE

5.1 DESCRIPTION

The health policy framework is derived from the National Health Policy, the draft National Health Plan, the National Vision 2010 Report and President Obasanjo's health priority statements.

GOVERNMENT HEALTH MANAGEMENT STRUCTURES

The Federal Ministry of Health's (MOH) "Health Sector Reform Agenda" is providing direction for the future of Nigeria's health sector by emphasising the importance of decentralising health services and strengthening primary and secondary level health facilities. The relative independence of states makes pursuing consistent national policies across the country problematic.¹² Responsibilities are as follows:

Local government

The 774 local government areas are largely responsible for the primary health care (PHC) facilities.

State government

The 36 state governments are responsible for funding and administering the primary and secondary level services. The state MOH provides technical assistance to the local government areas.

Federal government¹³

The federal government sets overall policy goals, coordinates activities, ensures quality, training and implements sector programmes such as immunisation. It is also responsible for the tertiary level hospitals (teaching and specialist hospitals). The National Primary Health Care Development Agency (NPHCDA) provides a source of technical knowledge and

¹¹ FHI, 2000a.

¹² DFID, 2006.

¹³ GFATM, 2005; DFID, 2006.

expertise to the provision of PHC delivery on behalf of the Federal Ministry of Health, although capacity is limited.

GOVERNMENT HEALTH SERVICE DELIVERY STRUCTURES¹⁴

Primary health care centres are usually staffed with nurses and community health care workers with the support of the state Ministry of Health. There are estimated to be more than 18,000 primary health care facilities.

Secondary-level hospitals (general hospitals) primarily provide specialised services to patients referred from the primary health care level in the form of general in- and out-patient health care services. However, the referral system is undeveloped and technical support of PHC facilities is almost non-existent. There are more than 3,000 general hospitals.

Tertiary-level hospitals (teaching and specialist hospitals) provide highly specialised care/referral services in all major disciplines. There are 29 tertiary-level hospitals.

Nigeria's health system is weak, poorly coordinated and fragmented, with very little capacity to deliver health services at state and local government levels. At the national level, a number of vertical programmes operate, including sexual and reproductive health, TB, immunisation and ART.¹⁵

5.2 ANNUAL EXPENDITURE

TABLE 5.2 HEALTH EXPENDITURE DATA

Total annual expenditure on health	US\$1.883 billion
Per capita total expenditure on health	US\$20
Per capita government expenditure on health	US\$4
Percentage of government budget spent on healthcare	2.9%
Total expenditure on health as a percentage of GDP (<i>PSP-One</i>).	5%

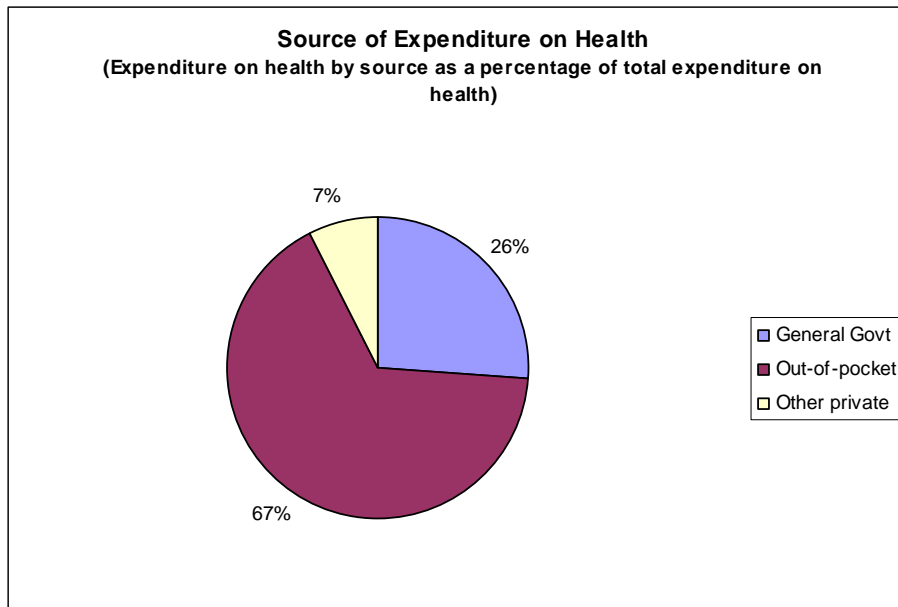
Source: WHO, 2005, unless otherwise stated.

The government spends US\$4 per person on healthcare, and health is only 2.9 percent of its overall budget. The government covers only a quarter of health spending in Nigeria, while two-thirds comes from out-of-pocket expenses (see Figure 6.2).

¹⁴ Ibid.

¹⁵ DFID, 2006.

FIGURE 5.2 (Source: PSP-One, 2005)



5.3 PROPORTION OF DONOR FUNDING

TABLE 5.3 ESTIMATED HEALTH FUNDING SOURCES IN 2003

Funding source	Amount in USD	Percentage
External (donors)	100m	5.3
Domestic	1,783m	94.7
TOTAL	1,883m	100

Source: WHO, 2006.

Donor funding to the health sector is low at 5.3 percent of the expenditure; funding had been steadily decreasing (in proportion to overall budget) between 2000 and 2003.

All donor funding is currently channelled through technical assistance, implementing partners and UN agencies, but the World Bank and DFID have plans to provide budget support at state level within the next two years.¹⁶

5.4 PUBLIC/NOT-FOR-PROFIT/PRIVATE MIX

The private sector delivers at least 45 percent of health services, but this proportion is declining as people struggle to afford the fees.¹⁷ In 2000, the private and traditional medicine settings were estimated to account for 60-80 percent of service provision.¹⁸ A 2001 study in three LGAs of **Lagos** ascertained that two-thirds of health services were privately or

¹⁶ DFID, 2006.

¹⁷ GFATM, 2005.

¹⁸ DFID, 2000.

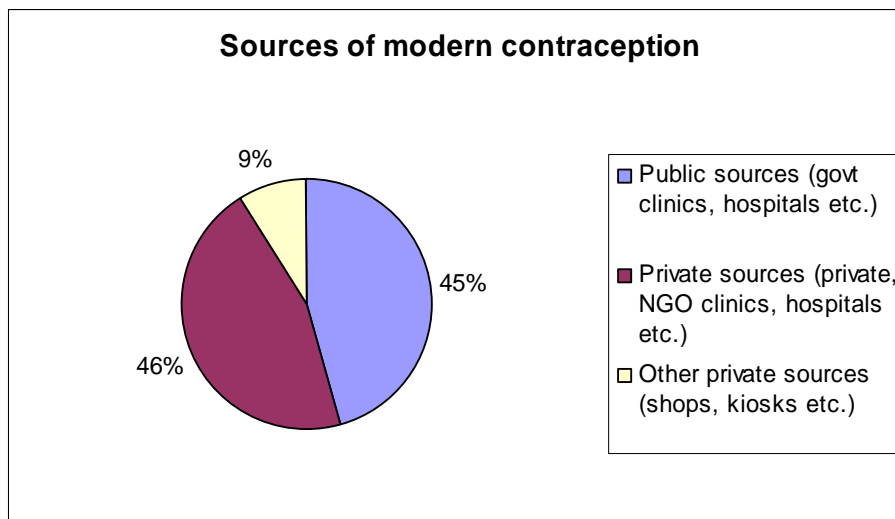
individually owned.¹⁹ An equivalent study in **Kano** suggests the proportion of privately owned facilities to be even higher.²⁰ (These studies are old, but furnish the only data available.)

The private sector consists of for-profit and not-for-profit organisations, such as faith-based missions and companies running their own health facilities for staff. The Christian Health Association of Nigeria (CHAN) is the coordinating body for all church-sponsored health care work in Nigeria and provides the largest healthcare infrastructure after the government. It has a network of 358 hospitals and has provided healthcare in most parts of Nigeria for 30 years. CHAN has over 4,000 health facilities at different levels of the healthcare system.²¹

Public/private mix for family planning

The private/non-profit sector plays an important role in contraceptive service delivery and has a greater share of the market compared to the average for West Africa and a much greater share than for Africa as a whole (see Figure 6.4.2).

FIGURE 5.4.2



Source: PRB, 2002.

¹⁹ FHI, 2001b.

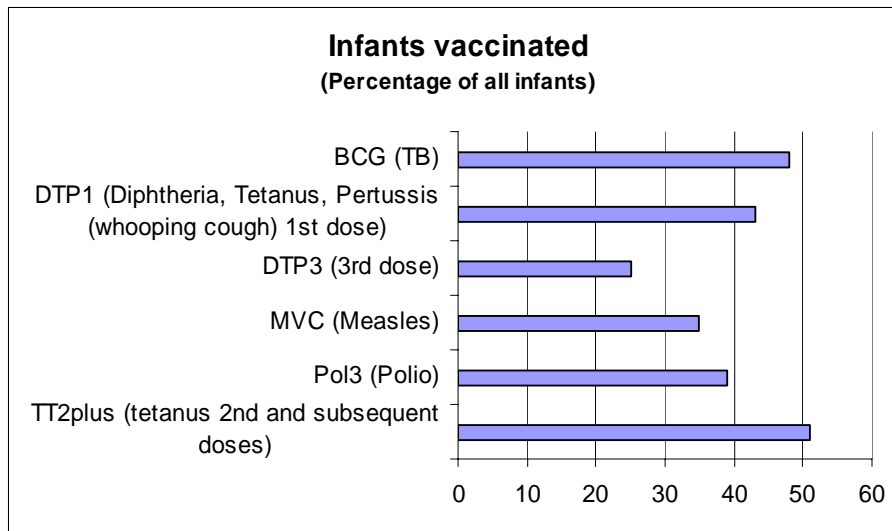
²⁰ FHI, 2001a.

²¹ GFATM, 2005.

5.5 KEY HEALTH INTERVENTIONS

5.5.1 KEY VACCINES

FIGURE 5.5.1



Source: UNICEF, 2006b., TT is administered for pregnant women.

Infant vaccinations are all under 50 percent. This means that only 13 percent of children aged 12-23 months can be considered fully immunised, a low vaccination rate even among African countries.²²

5.5.2 CONTRACEPTIVE COVERAGE

Just one in 12 women uses modern family planning methods in Nigeria (see Table 5.5.2.1). This proportion has increased since 1990, when only 3.5 percent used them.²³ The pill and injectable contraception are the most common methods. A high proportion of women use traditional methods. The 2003 DHS showed that knowledge of contraception is varied amongst men and women. Interestingly, knowledge of contraception is higher among men than women; on average women knew of four methods of family planning while men knew five methods. Modern methods are better known than traditional methods among women (77 percent versus 43 percent), with the condom and pill being the best known. Knowledge increases with age and level of education, and is higher for urban areas and the southern parts of the country.

²² NDHS, 2003.

²³ UNFPA, 2006.

TABLE 5.5.2.1 CONTRACEPTIVE METHOD MIX (2002)
(Selected methods, married/in union women of reproductive age, 15-49)

Modern methods	Pill	2.4%
	Injection	2.4%
	Condom	1.2%
	Female sterilisation	0.3%
	Male sterilisation	No data
	Other modern methods	2.3%
	Total	8.6%
Traditional methods	Total	5.8%
No method	Total	85.6%

Source: PRB, 2002.

5.5.3 ESSENTIAL MEDICINES

There is an absence of national data on the availability of essential medicines. A recent study undertaken in Enugu state compared access and use of essential drugs between PHCs that have adopted the Bamako Initiative (BI) and those that hadn't. The Bamako Initiative was championed by WHO and UNICEF in the 1990s and has since been largely superseded by health sector reforms. The BI focused on decentralisation of decision-making to the health district, introduction and reinforcement of systems of co-management and co-financing with communities, and procurement and distribution of essential drugs. The study found that the BI centres had better availability (an average of 35 essential drugs were available in the BI health centres compared with 15.3 in non-BI centres) and stock (BI centres had on average six weeks' supply compared to one week's supply for non-BI centres). However, the BI was said to have given rise to irrational over-prescribing of essential generic drugs.²⁴

In Nigeria, a JSI/Deliver rapid assessment in 2001/02 revealed high levels of stock-out of contraceptives in the public sector – three-quarters of facilities visited lacked oral contraceptives, 60 percent lacked condoms, and half lacked injectables. However, since then there has been a great improvement of availability at service delivery points and there is now availability above 75 percent at all levels. Cost is also a major barrier to essential medicine access, particularly in the private sector. Nigeria's cost-recovery policy in the public sector involves charging a fee to all clients visiting public health facilities, regardless of socio-economical status. But these costs are lower than the private and NGO sectors.²⁵

²⁴ Benjamin S.C. Uzochukwu, Obinna E. Onwujekwe and Cyril O. Akpala, 2002.

²⁵ Ibid.

6 REGULATORY CAPACITY

The Nigerian National Agency for Food and Drug Administration and Control (NAFDAC) was set up in 1992 by the Ministry of Health. The systems maintained by NAFDAC are country-wide. Nigeria has had difficulties with corruption in the health sector and fake drugs are a major problem, although the situation has improved considerably in the last few years due to a major crackdown on corruption. This has been so controversial that the head, Dr. Dora Nkem Akunyili, even faced an assassination attempt in December 2003.

While NAFDAC is 15 years old, it is only recently that the system has become more robust.

NAFDAC functions include:

- Regulating and controlling the import, export, manufacture, advertising, distribution, sale and use of drugs or devices, bottled water, and chemicals.
- Conducting appropriate testing and ensuring compliance with standard specifications designated and approved by the country, control of quality of food, drugs, cosmetics, medical devices, bottled water and chemicals and their raw material as processes in factories and other establishments.
- Undertaking appropriate investigation into the production premises and raw materials for food, drugs, cosmetics, medical devices, bottled water and chemicals.
- Undertaking inspection of imported food, drugs, cosmetics, medical devices, bottled water and chemicals.
- Compiling standard specifications and regulation and guidelines for the production, import, export, sale and use of drugs, cosmetics, medical devices, bottled water and chemicals.
- Undertaking the registration of drugs, cosmetics, medical devices, bottled water, and chemicals.
- Controlling the export of food, drugs, cosmetics, medical devices, bottled water and chemicals and issuing quality certifications for all items on the list.
- Establishing and maintaining relevant laboratories or other institutions in strategic areas of Nigeria.

Ports of entry. In addition, NAFDAC has two directorates of ports Inspection and enforcement to watch all ports of entry. Finally, NAFDAC has the authority to close down any sellers who cannot produce the proper documents for their drugs. It has exercised this authority in the past.

Fast-tracking of HIV drugs. ARVs are given preferential treatment by the government in the registration process and special funds are set aside for procurement. NAFDAC approves importation, distribution and use of HIV medicine before local registration, if drugs are already

WHO-approved. NAFDAC also waives other regulation requirements, such as mandatory local clinical trials, if trials have been held elsewhere to international standards.

7 LOCAL MANUFACTURING CAPACITY

Nigeria has considerable manufacturing capacity. A short history of drug production in Nigeria is included as well as a list of the major manufacturers.

History. There was no local manufacturing of modern pharmaceutical products before 1957 and everything was imported. Between 1957 and 1980, many multinational companies established Nigerian production plants (Glaxo, Pfizer, Wellcome, SmithKline Beecham, and Hoechst to name a few). In 1978, an indigenisation policy forced most of these multinationals to sell 60 percent of their companies to Nigerian investors. Nigerian indigenous companies also began to set up in the early 1980s. The government introduced an import licence for all imported goods, including drugs, and pharmaceutical products became scarce. Fake drugs began to flood the country. However, as a result, the proportion of drugs locally manufactured increased to approximately 40 percent. In the 1990s, the industry was characterised by indigenous manufacturers controlling the majority of the industry. Asian-owned companies controlled about one-fifth, Anglo-American companies control about one-sixth, and the remaining proportion is controlled by the Government. Somewhat surprisingly, there is still no raw materials manufacturing plant in Nigeria.

Major manufacturers. Currently, there are over 50 pharmaceutical manufacturing plants with varying degrees of sophistication. Many major European and American pharmaceutical manufacturers have plants here. For example GlaxoSmithKline, Pfizer and Evans Medical. Also, major Indian manufacturers, such as Ranbaxy and Cipla, have plants in Nigeria. Other key players include SwissPharma, Drugsfield and Bayer-Gemini. However, the majority of the plants are indigenous organisations. The level of sophistication is reflected in the four sterile manufacturing plants capable of producing injections and infusions – one able to produce rectal and vaginal suppositories, and four ARV manufacturing plants.

Finally, the Nigerian company Evans Medical works with one of the two big India generic manufacturers of ARVs (Cipla), supplying ARVs from inside Nigeria (with the imported product). Crown Agents contracts with Evans Medical for all of the Global Fund ARVs.

TEN LARGEST PHARMACEUTICAL COMPANIES: NIGERIA

Rank	Company	Turnover in USD millions	Capacity Tablets	Capacity (syrup/suspension)
1	Glaxosmithkline GSK	75		
2	May & Baker Nig Plc	25	2 billion	50 million bottles
3	Nigeria German Chemical Ltd. NGC	25		
4	Evans group	25		
5	Neimeth International Ltd.	15	150 million	2.5 billion bottles
6	Swiss Pharma Nigeria Limited	25	140 million	80,000 L
7	Emzor Pharmaceutical Ltd.	25		
8	Juhel Nigeria Limited	25		
9	Vitabiotics group	15		
10	Fidson	25	750 million	10 million bottles

Source: Crown Agents, Nigeria.

8 PROCUREMENT SYSTEMS

With Nigeria's large size, the need and demand for pharmaceuticals has always been enormous. Formerly self-sufficient in its drug needs, Nigeria has become increasingly dependent on donor funding in recent years. While there are many overarching regulations and frameworks, procurement is done on a state-by-state basis. The procurement system is extremely complex and the systems are not transparent.

8.1 PUBLIC

In general, procurement of commodities is largely decentralised to hospitals at the tertiary level for the primary health care (PHC) system in Nigeria. Each one of the 36 states has a state medical store that undertakes some procurement and distribution of commodities. Also, facility-based procurement by secondary level PHC institutions is common. UNFPA procures all public sector contraceptives.

Essential Drug List. WHO aids Nigeria in reviewing and updating the EDL every two years. Drugs are selected according to cost-effectiveness in each drug category. The EDL specifies that drugs on this list for use in government institutions should satisfy the health needs of the majority of the population. ARVs are currently being processed for inclusion in the EDL.

Kano State Drugs Management Agency (DMA) makes pharmaceutical commodities available at all government health facilities and local government authority medical stores

within the state. Cost recovery is achieved through a revolving fund. In addition, the DMA distributes pharmaceuticals to 65 drug retail outlets. The drug management agency has no major problems that affect the movement of pharmaceuticals through the procurement and distribution system. The main needs are the training of staff in information technology. **Kano** state will adopt the DFID health reform programme, PATHS model Drug Revolving Fund (DRF), in 2006. This model is similar to the Bamako Initiative and has been piloted successfully in Ekiti state already.

Procurement and distribution of pharmaceutical commodities in **Lagos** state is decentralised to health facility level. Each facility's drug purchase committee is given funds by the MOH. With Lagos state, the Pharmaceutical Services Directorate of the MOH conducts central purchasing through tenders. Major supply challenges include inadequate funding, inventory, storage and transport facilities. Staff also requires training in inventory and stores management (Source: Crown Agents).

8.2 DONOR

There is considerable donor-funded procurement in Nigeria and, in most cases, it is handled through external procurement assistance. DFID uses Crown Agents as their procurement agents working from their office in Abuja and through Crown Agents, UK. Crown Agents is encouraged to purchase as much as possible within Nigeria using local suppliers who have been registered and approved by NAFDAC, although purchases are also made internationally. Crown Agents also manages several large projects for the Global Fund. USAID manages procurement through their own offices and own systems. Crown Agents is one of several implementing agencies for PEPFAR funds. The World Bank, in contrast, has encouraged local procurement working at state level and has been successful in some areas, depending on the capabilities of the local staff.

While this procurement is externally managed, there are elements of local capacity building in most cases.

8.3 NOT-FOR-PROFIT/MISSION

There is considerable healthcare provision offered through faith-based organisations. The Christian Health Association of Nigeria (CHAN) is the co-ordinating body for all church-sponsored health care work in Nigeria and provides the largest healthcare infrastructure after the government. There is no government support of CHAN and they are actually in competition for staff and patients. In recent years, there have been considerable problems with CHAN's drug supply system. The member institutes, formerly dependent on CHANPharm for their drugs, have been forced to use alternative sources of supply, even the open market. This has resulted in the purchase of fake and inefficient drugs and empty shelves.

In 2004, DFID provided assistance to CHAN to improve the capacity of the CHAN network. One main component of this work was to help in the development of CHANPharm, the drug channelling arm of CHAN and a substantive, separately managed and business-oriented concern. Now CHANPharm's capacity has exceeded CHAN's needs and they are considering providing services to other clients. It should be noted, however, that CHANPharm does not stock or supply contraceptives (including condoms). CHAN has an AIDS policy but does not promote condoms (although at facility-level, practice may vary).

8.4 PRIVATE

There is an enormous private health sector in Nigeria, as stated previously, with 60 percent of Nigerians receiving their medicines from private channels. Local agents and stockists import directly from overseas. This area will have considerable relevance to microbicides and will have to be considered seriously. The microbicide field should proceed with caution and locate a reliable local partner.

DFID carried out a four-country study on contraceptive commodity security in 2006. The box gives an overview of what they found in Nigeria. The microbicide field would be wise to keep abreast of the developments within the Strategic Pathways to Achieving Reproductive Health Commodity Security (SPARHCS) programme mentioned in the box (<http://www.maqweb.org/sparhcs>). Nigeria is the first country to implement this strategy.

'Strategic Pathways to Achieving Reproductive Health Commodity Security': (SPARHCS) in Nigeria

Nigeria's recent efforts to strengthen the contraceptive supply system in the public sector are positive. These efforts can be in part attributed to the legacy of the pre-1999 military government. The withdrawal of USAID as the major funder in 1995, following the international de-certification of Nigeria, had a profound and devastating impact on RHCS, and brought questions of finance and sustainability to the fore. The federal ministry's RH Unit director made a request for Nigeria to be the first country to adapt the Strategic Pathway to RHCS process, following the 2001 Istanbul commodity security conference.

The process resulted in four major outputs:

- A thorough assessment and understanding of the problems and challenges for the six components of RHCS (finance, policy, logistics, service delivery, demand and coordination).
- A consensus among the major government and development partners about short- and medium-term actions needed, with special focus on redesigning and reintroducing the Commodity Logistics Management System (CLMS).
- An RHCS strategy – the Strategic Plan for Reproductive Health Commodity Security

2003–2007, plus projections to 2015.

- New funding from CIDA, supplemented by commodities financed by the UNFPA country programme and global trust fund.

Its initial success was due to the combination of strong government leadership by the RH Unit, coordinated technical inputs provided by JSI, Deliver and UNFPA, and by the engagement and involvement of stakeholders across public, civil society and social marketing sectors. The RHCS Stakeholder Group continues to be consulted on major issues.

In terms of results, there have been improvements in availability at service delivery points – availability of most commodities is above 75 percent at all levels. This is in contrast to an assessment in 2001/02, which revealed equally high stock-out levels.

Concerns about donor dependence and sustainability also led to the introduction of a four-level cost recovery system, which is enabling the ring fencing of funds at each level to support purchase from the next level, as well as transport and supervision. At national level, a small reserve fund is accumulating. Discussions about use of the funds are in process – for example as a revolving purchase fund, a reserve in case of donor withdrawal, support for infrastructure development or the introduction of new commodities.

However, there are also serious challenges. The focus has been on supply systems, with less emphasis on the enabling policy environment and demand creation. There is limited funding for training in some states, and the new ‘pull’ system with its associated reporting burden is demanding on facility staff. Reporting and stock management at all levels are weak, which severely limits accurate forecasting and appropriate stocking. Funding shortfalls are likely, unless other donors support procurement and capacity building. Overall, government capacity to forecast, budget and plan for commodity supply is growing, but still has limitations. There is no national budget line, and national donor funding is not sufficient to meet needs. UNFPA draws on international sources through its global funds.

Source: DFID, 2006a.

9 HIV PROGRAMMING

9.1 LEVEL OF POLITICAL COMMITMENT

The level of effort in the national response to HIV/AIDS is above average for the region (Futures Group, 2003) and the following frameworks are in place:

- The National Action Committee on AIDS, which emphasises a multisectoral approach, was established in early 2000 and reports directly to the president. It involves ministry representatives, the private sector, NGOs and networks of PLWHA. There should be 36 state and 774 local action committees, although not all of these are in place yet, particularly at local government level;
- The HIV Emergency Action Plan 2000-2004 was introduced at the same time to guide this work and the health sector response was integrated into this multisectoral response. This has now been superseded by the 2005-2009 National Strategic Framework, which was developed with consultation with over 200 members from stakeholder organisations (including international representatives) and in line with UNGASS and other international targets;
- The government has recently finalised the Health Sector Strategic Plan on HIV/AIDS 2006-2010, which has seven major health sector responses and is being further operationalised in an accompanying implementation plan;
- The National Antiretroviral Scale-up Plan was launched in December 2004;
- The Nigeria National Response Information Management System is being rolled out in many states;
- HIV is addressed in Nigeria's poverty reduction framework, the National Economic Empowerment Development Strategy (NEEDS). This includes health system strengthening, improvement of availability and management of financial, human and management resources for health, reducing the disease burden, improving access to health services, increasing consumer awareness of health rights and obligations, and developing collaboration with all health actors.

The national HIV/AIDS response has been constrained by lack of capacity, especially at the state level.²⁶ Data for Kano and Lagos were too dated to include.

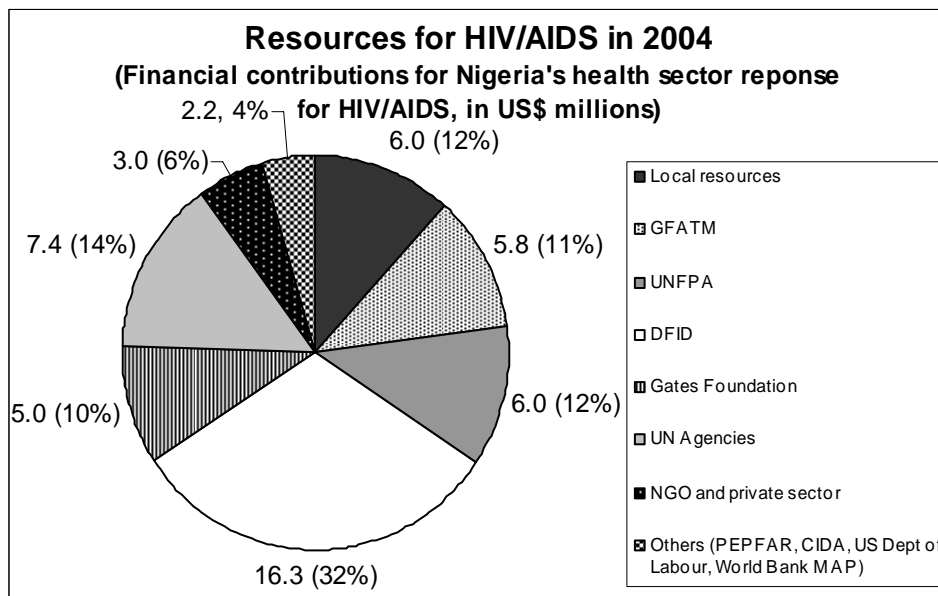
²⁶ WHO, 2005.

9.2 FUNDING FOR HIV/AIDS

There are no data available on overall funding of the HIV response. The health sector response was US\$51.7 million in 2004 and is set to rise as more funds are committed (particularly from the Global Fund). Currently, the government contributes 12 percent of the overall budget (see Figure 10.2). PEPFAR has the largest programme, with a USAID grant of \$193m to Family Health International for a five-year project called the Global HIV/AIDS Initiative Nigeria (GHAIN). DFID is the second largest donor.

Funds needed for the Health Sector Strategic Plan on HIV/AIDS 2004-2009 (with extension until 2010) and provide ART for one million people according to the NASCP ARV plan were US\$148 million in 2004, rising to US\$770 million in 2010, indicating a significant shortfall.²⁷

FIGURE 9.2



Source: GFATM, 2005.

[NOTE: This chart does not include the most recent PEPFAR project: GHAIN]

9.3 COVERAGE OF HIV/AIDS INTERVENTIONS

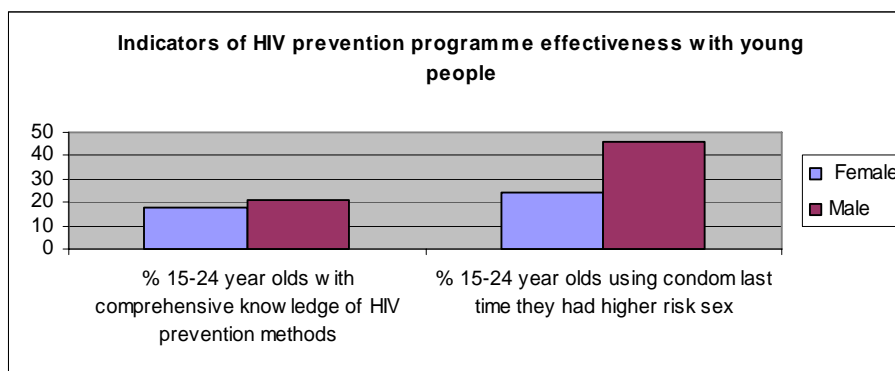
Prevention coverage

Knowledge of HIV prevention (being able to correctly identify condom use and limiting sex to one uninfected partner as major ways of preventing the sexual transmission of HIV, being able to correct two of the most common misconceptions about HIV, and knowing that a healthy-looking person can transmit HIV) is fairly low – 18 percent for young women and 21 percent for young men (see Figure 10.3.1). This, and relatively low condom use, especially for women, indicates a need for expanded prevention programmes.

²⁷ GFATM, 2005.

Many Nigerians support abstinence for HIV prevention and there are barriers to the promotion of condoms and contraceptives. Radio advertisements promoting condoms were suspended for four months in 2001 by the Advertising Practitioners Council of Nigeria, a Nigerian government organisation, and restrictions are particularly seen in states under Shari'a. faith-based organisations (FBO) supply 40 percent of health services, but the national supplier, CHANPharm, does not stock or supply contraceptives or condoms. Facility level practice, however, varies considerably and contraceptives and condoms are available at some FBO-run facilities.²⁸ (See next section for social marketing coverage.)

FIGURE 9.3.1



Source: WHO, 2005.

Blood safety, universal precautions and injection safety need to be improved, especially in the private and unregulated sector.²⁹ Anecdotal evidence suggests that over 70 percent of blood transfusions are undertaken in the private sector where government regulation is weak. Fifty percent of health providers reported having a needle prick in the previous year and only six percent were offered post-exposure prophylaxis.³⁰

Care coverage

Care is difficult to measure as most care in Africa takes place in the home. Often, this care is provided by NGOs/CBOs/FBOs, with many keeping poor records.

Treatment coverage

Treatment was first started in 2002 in 25 tertiary institutions. As of June 2005, 71 sites were delivering antiretroviral therapy services in Nigeria. As of September 2004, 13,579 people were reported to be receiving antiretroviral therapy in Nigeria through the public sector. By September 2005, this figure increased to 31,694. In addition, at least 5,000 people are

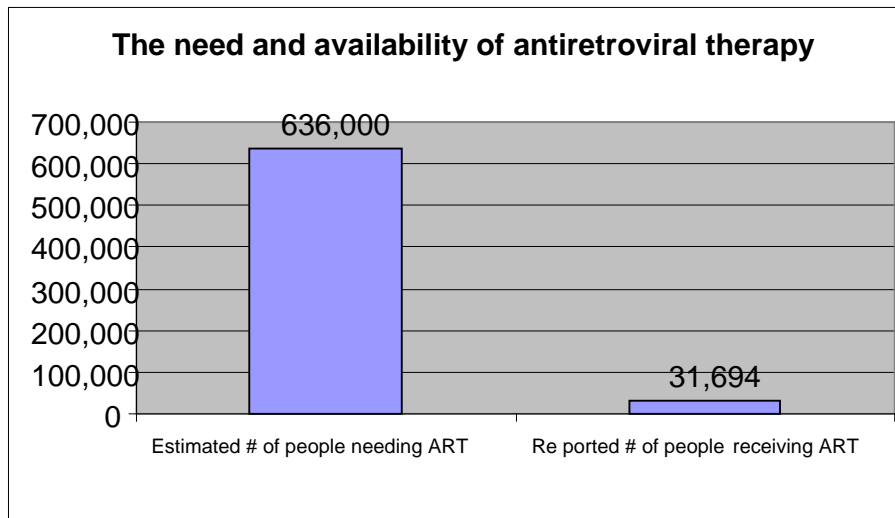
²⁸ DFID, 2006.

²⁹ WHO, 2005.

³⁰ GFATM, 2005.

estimated to be receiving antiretroviral therapy through the private sector in 2005.³¹ This covers only five percent of people in need of ART (see Figure 10.3.3). However, the government's latest Five-Year Consolidated Treatment Report from June 2006 shows that 72,650 were receiving ART, double the coverage of the previous year, and all but one of the 36 states had at least one ART facility.³²

FIGURE 9.3.3



Source: WHO, 2005.

In 2001, the government announced a programme to provide antiretroviral therapy at subsidized rates to 10,000 adults and 5,000 children living with HIV/AIDS, within the context of the National HIV/AIDS Emergency Action Plan and the National Health Sector Plan for HIV/AIDS. Under the National Health Sector Plan for HIV/AIDS, the government will commit to ensuring that everyone has access to quality health care and adequate treatment or management of their conditions, including the provision of antiretroviral therapy. Antiretroviral therapy must be medically supervised and governed by established effective guidelines that are regularly updated with findings from research.

Manuals for TB management and HIV/AIDS clinical guidelines were not in place in health facilities in **Kano** state in 2000.³³ By June 2006, there were two government ART centres in Kano.³⁴ At the same time, in **Lagos** there was found to be limited comprehensive care and support for PLWHA, which was compounded by the low capacity of health workers and NGOs. There were also high levels of stigma and discrimination against PLWHA among

³¹ WHO, 2005.

³² JAAIDS, 2006.

³³ FHI, 2000a.

³⁴ JAAIDS, 2006b.

health workers, even in government referral centres.³⁵ However, there is some indication that the level of stigma has been reduced since 2000. There were 11 ART centres operating by June 2006.³⁶

MEASURING THE EFFORT

Prevention

The Government of Nigeria states in its UNGASS report that it is committed to the development of new HIV prevention technologies, including microbicides.³⁷

Voluntary counselling and testing coverage and access remain a major challenge. There are 228 VCT centres in the country, which equates to only 1.7 per one million population (see Table 9.3.2). The 2003 National HIV/AIDS and Reproductive Health Survey (NARHS) indicated that seven percent of Nigerians had been tested for HIV.³⁸

There are only 33 PMTCT centres currently operating as part of the national PMTCT programme, which is highly insufficient coverage given the number of people needing this service. However, there are also a number of additional sites supported by NGOs and state governments. There are signs that PMTCT coverage has increased since 2005; latest figures from the Five-Year Consolidated Treatment Report show that 100,000 women are accessing PMTCT services.³⁹

TABLE 9.3.2 USE OF HEALTH SERVICES FOR HIV PREVENTION

# of VCT sites	228
# of VCT sites per 1,000,000 population	1.7
# of sites providing PMTCT services	33
Percentage of HIV-positive pregnant women receiving PMTCT	0.2%

Source: NACA, 2005.

Microbicides clinical trials

Two different microbicide organisations carried out clinical trials in Nigeria. Both trials had to be stopped for different reasons. One trial for a microbicide called Savvy was halted in August 2006 by FHI because the incidence of HIV in the trial population was too low to see any difference between the two trial arms. A second trial of a product called cellulose sulphate had to be stopped in January 2007 because trials in other countries (not Nigeria) showed a small increased incidence of HIV infection in the product arm. This result, in Benin, India,

³⁵ FHI, 2000b.

³⁶ JAAIDS, 2006b.

³⁷ NACA, 2005.

³⁸ NACA, 2005.

³⁹ JAAIDS, 2006.

South Africa and Uganda, meant that the trials were quickly closed. No data in Nigeria showed an increased HIV risk, but FHI (also running this trial) felt that closing the Nigeria trial was the best course of action.

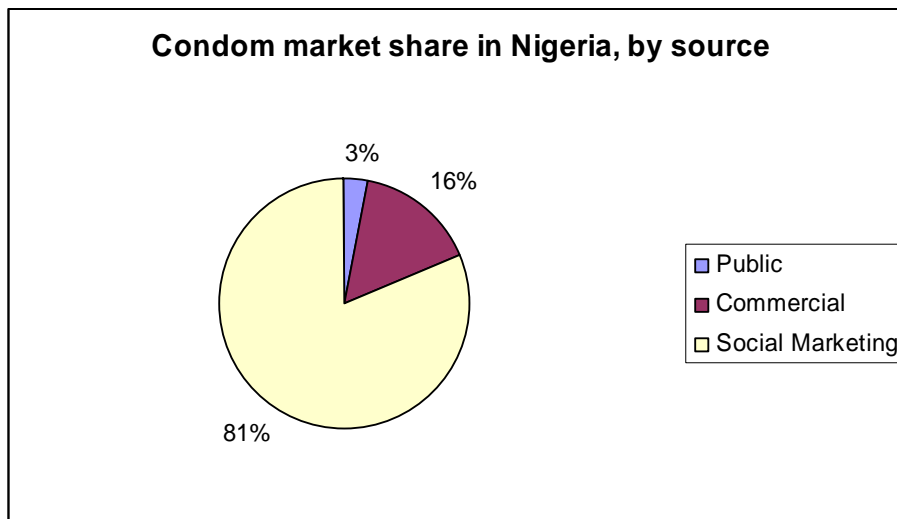
9.4 SOCIAL MARKETING

The sole socially marketed condoms in Nigeria are:

Organisation	Product	Details
Society for Family Health (PSI partner)	“Gold Circle” – male condom	Gold Circle introduced 1990. In 2005 it provided 74 percent of the total condom market share in Nigeria. SFH plans to introduce the mid-priced Lifestyles Condoms into the Nigerian market in 2006. This will provide an alternative segment of the condom market. SFH promotes its condoms for dual protection (family planning and HIV prevention).

Source: PSI, 2006.

TABLE 9.4



Source: DFID, 2006.

For condoms, social marketing makes up over 80 percent of reported condom use in Nigeria, compared to only three percent for public sector distribution. SFH in Nigeria is regarded as one of the most efficient social marketing programmes in the world. It has over 40 registered private sector distributors, and 16 detailers (promoters and trainers), working out of nine depots. It uses a cash-and-carry system, with no credit provided to retailers. Although it provides training to providers, this does not amount to a formal accreditation scheme.

Over 10 brands are registered with the national regulatory agency and over 60 are present in the market.⁴⁰

The Society for Family Health (SFH) is funded by DFID and USAID. Commodities are purchased by PSI. Some condoms will soon also be supplied by the World Bank (DFID, 2006a).

9.5 SCALE-UP PLANS

3-BY-5 INITIATIVE

The government declared a national treatment target of reaching 100,000 people by the end of 2005 and scaling up to 250,000 by the end of 2006. In June 2005, between 28,000 and 48,000 people were being provided treatment (four to eight percent of total need).⁴¹ The National Antiretroviral Scale-up Plan aims to scale up access to antiretroviral therapy to one million people in need of treatment by 2009. It plans to do this through expanding treatment services from tertiary-level institutions to secondary and primary-level health services in all 37 states and territories.

Challenges to scaling up treatment include the high cost and weak processes for procurement and supply chain management, the low availability of and delays in the delivery of antiretroviral drugs and limited access to entry-point services.⁴²

GLOBAL FUND

Nigeria submitted a successful Round 1 proposal to the Global Fund, with total funding of US\$70.7 million. As of December 2005, US\$17.9 million had been disbursed; however Nigeria lost its funding due to low disbursement. Global Fund financing would have allowed expansion of access to antiretroviral therapy and would have reduced some of the financial barriers to accessing treatment, for example by offering laboratory testing free of charge. Nigeria also submitted a successful proposal to Round 5 of the Global Fund for a total of US\$180.6 million to support scale-up of comprehensive HIV/AIDS treatment, care and support.⁴³

The six main objectives of the Global Fund's fifth round funding are:

1. To scale up comprehensive HIV/AIDS treatment, care and support for people living with HIV/AIDS to all 37 states and territories in the country.

⁴⁰ DFID, 2006.

⁴¹ WHO, 2005a.

⁴² WHO, 2005.

⁴³ Ibid.

2. To expand access to HIV testing and counselling services to cover all 37 states and territories in the country.
3. To strengthen the role of the community, civil society organisations and networks of PLWHA in providing and supporting HIV/AIDS treatment and care.
4. To increase access to care and support services for orphans and vulnerable children (OVC) in all 37 states and territories.
5. To increase capacity of the private sector to implement workplace programmes for HIV/AIDS in 12 states.
6. To strengthen capacity of implementing institutions to deliver effective programme management, coordination, monitoring and evaluation.⁴⁴

10 IMPLICATIONS FOR A FUTURE MICROBICIDE

Two Nigerian consultants interviewed a range of key stakeholders, asking them what might have an impact or influence on a future microbicide. Here are some of the results of their informed speculation.

DELIVERY

Microbicide delivery will be through **multiple channels**. If, in Nigeria, one of the main targets will be primary partnerships, ways to reach these women will have to be carefully considered. One such way is through existing reproductive health and family planning programmes. Not only are women already at these clinics receiving services, they are already used to thinking about health prevention (albeit preventing births), and are empowered to the extent they would seek family planning. This might also make them more open to the concept of preventing disease, safe sex and using a condom or a microbicide. Family planning use may also mean that these women will have already talked to their partners about health-seeking behaviour.

Private sector. Sixty per cent of Nigerians receive their medicines from private sources. This has massive implications for the introduction of microbicides, and a private-sector launch might be preferable to a public-sector introduction in the first instance.

Social marketing. Microbicides, if available over the counter, could be made available through social marketing programmes. Once women have learned how to use a microbicide, they could obtain their re-supply through social marketing outlets. Nigeria has one of the strongest social marketing programmes in the world.

HIV and SRH communities. There is currently little collaboration between these two communities, although there is increasing recognition of the need to integrate efforts. State

⁴⁴ GFATM, 2005.

Nigeria Country Profile

and primary healthcare centres all provide family planning and could be excellent for use as microbicide entry points.

Female condom in Nigeria. Condoms were championed by civil society, including the IPPF affiliate PPFN. The barriers to their use included: a) the need for male involvement; b) the need to train providers to teach women how to use the product; c) the product was seen as noisy or oily; d) it is not widely available; and e) it was seen to be expensive and bulky.

REGULATORY

Categorisation of microbicides within the regulatory system is still an issue. Currently, it is unclear whether a microbicide would be considered as a drug or as a cosmetic. (A second generation of microbicides would most certainly be categorised as a drug.)

Quality control. If microbicides become popular and their production can't keep up with demand (or even if it can), it is possible that someone will try to sell fake microbicides. Despite recent improvements by NAFDAC, the problem of poor quality control is still persistent in Nigeria. Issues to consider will be packaging, number of accredited manufacturers, quantities distributed, and the clinical monitoring of their use and evaluation.

ADVOCACY

The media are strong opinion shapers in addressing HIV/AIDS issues. The influential networks include: Journalists Against AIDS (JAAIDS), DEVCOMS, Internews, the National Union of Journalists (JUJ) and the National Association Women Journalists (NAWOJ). The latter focuses on stigma and discrimination. Many of these groups already work with the Nigeria HIV Vaccine and Microbicides Advocacy Group (NHVMAG) on new prevention technology (NPT) issues.

STAKEHOLDER OUTREACH

The Association of Pharmacists or the Medical Association can be major product endorsers. They also have a strong political voice. Any health professionals' doubts will need to be promptly addressed or product uptake will be slowed.

The Nigeria HIV Vaccine and Microbicides Advocacy Group (**NHVMAG**) is a **key ally**. This is the national coalition body for all advocates and activists for New Prevention Technologies. Nigeria is unique in having an advocacy group so oriented toward prevention technology. Initial poor understanding of NPTs was hindering the NAFDAC approval process for microbicides research. Training from the Nigeria HIV Vaccine and Microbicides Advocacy Group (NHVMAG) has clarified many misconceptions on microbicides. Indigenous groups carry considerable credibility within Nigeria.

Traditional healthcare providers reach more people at the grassroots level and may be crucial to community level microbicide introduction as they are often strong opinion leaders. Traditional healers could be crucial to microbicides introduction at the community level. Community advocates for microbicides could begin to engage this population as product availability nears.

Religious leaders can shape consumer demand and their endorsement is valuable. Attempts should be made by community groups to engage religious leaders.

Leaders' spouses at the state level are often involved in health issues and are respected as opinion leaders. These are the spouses of the state governors and are influential for product uptake.

Make NAFDAC an ally. NAFDAC's approval will be essential in getting microbicides registered for use in Nigeria. Early communication with the agency will facilitate the registration process.

Use the National Action Committee on AIDS (NACA) to help with registration and introduction of microbicides. NACA is the National Action Committee on AIDS and is the national coordinating body for all responses to the pandemic. It answers directly to the president. They could make a difference with subsidies, waivers, and duties and taxes, and also expedite the regulatory process.

The Federal Ministry of Finance can play a role in affordability through tax waivers and positive tariff determination. (This is currently provided for ARVs.) This ministry can fast-track imported products through the Customs and Excise Department of the Ministry of Internal Affairs. (All these require authorisation from the Presidency.)

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ANNEX – SUMMARY INSTITUTIONAL MAPPING

HIV/AIDS AND SEXUAL AND REPRODUCTIVE HEALTH

This section includes summary information on key agencies working in HIV/AIDS and sexual and reproductive health, including their responsibilities, main programmes and activities as well as names and contacts.

ANNEX - TABLE 1

NATIONAL KEY AGENCIES WORKING IN HIV AND SEXUAL AND REPRODUCTIVE HEALTH

	Organisation	Responsibilities/activities	Names and contacts
Government agencies	National Action Committee on AIDS (NACA)	Overall multisectoral coordination of the response to HIV/AIDS in Nigeria, works directly with the president.	Prof. Babatunde Osotimehin – Chairman, bosotimehin@naca.gov.ng
	Federal Ministry of Health – National	Leadership to the health-sector response. Overall M&E of health programmes and operational research.	Dr. O. Salawu – National Coordinator, tofsal@yahoo.com
Bilaterals	USAID	Supports national responses in social marketing, BCC and PMTCT. Support for implementing HIV/AIDS sentinel surveillance through ENHANSE project.	Dr. Polly Dunford – Team Leader, HIV/AIDS & TB, Abuja, pdunfor@usaid.gov
	US-CDC	Infrastructure and capacity development, primary prevention, care and treatment, support for implementing HIV/AIDS sentinel surveillance.	
	DFID	National BCC and social marketing programme. Also Strengthening the National Response (SNR) programme for SACA capacity-building BBC WST - HIV media programme.	Abuja (office opening in Kano shortly).

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	PEPFAR	ARVs supplied to 350,000 people by 2008, prevention, care and support. Palliative care to 97,101 PLHA through Catholic Relief Services (CRS), the Global HIV/AIDS Initiative in Nigeria (GHAIN), Columbia University and the Institute of Human Virology Nigeria (IHVN).	
	US-Department of Labor	SmartWork Project, which supports workplace programmes.	
	CIDA	PMTCT, reproductive health and HIV/AIDS prevention and care for youth, TB/HIV.	
Other donors	Packard Ford MacArthur Foundation	All active in SRH/HIV in Nigeria.	
Multilateral agencies	UNAIDS	Strengthening NACA, support for strategic planning, resource mobilisation, advocacy, MSM and CSW issues, partnership development, M&E and health sector response, implementation of the “Three Ones.”	Dr. P. M’pele – Country Coordinator, Pierre.mpele@undp.org
	UNDP	Focus on human rights issues, formation of support groups through Ambassadors of Hope, income generation through microcredit schemes for PLHA.	
	UNICEF	Supports ART procurement, PMTCT in eight states,	E.I. Gemade – Project Officer (Health),

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		OVC, preventative services to girls and young women.	egemade@unicef.org
	WHO	Provides technical assistance in health sector reform, developing treatment policies, guidelines and strategies, support for implementing HIV/AIDS sentinel surveillance.	Dr. Belhocine – Country Representative, Abuja, aweayo@yahoo.co.uk
	UNFPA	Support for VCT and PMTCT in six states.	Dr. Abba Z. Umar, abba@unfpa.org
	UN Office on Drugs and Crime (UNDOC)	Supports interventions on injecting drug use relating to HIV control in two cities and six universities, mainstreaming of HIV/AIDS into drug control programmes.	
	ILO	Supporting NACA in work and public-private partnership.	
	UNESCO	Supporting NACA with a focus on the education response and religious and cultural dimensions to the epidemic.	
	World Bank	Evaluates national programmes, addresses the need for capacity-building and resource management, PMTCT support.	
	UNIFEM	Supporting NACA in PMTCT programming.	
NGOs	Christian Health Association of Nigeria (CHAN)	A network of more than 4,000 health facilities across the country, including ART provision (but not condoms or contraception).	

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	Médecins sans Frontières (MSF)	ART to 29,000 people in Lagos.	
	AIDS Prevention Initiative in Nigeria – Harvard School of Public Health	Supports PMTCT, diagnosing HIV/AIDS and ART monitoring at three sites.	
	Constella Futures (with USAID)	The Enabling HIV/AIDS+TB and Social Sector Environment (ENHANSE) Project - focus on national level policy development and planning, assists the Nigerian government to better link national, state and local programme delivery efforts.	Dr. Jerome Mafeni, Chief of Party, Abuja, jmafeni@constellafutures.com
	Planned Parenthood Federation of Nigeria (IPPF affiliate)	IPPF member association; dual protection programme (with Association of Reproductive and Family Health).	ppfn@intracom.net.ng
	Family Health International	Support for implementing HIV/AIDS sentinel surveillance SNR - DFID GHAIN – Pefar.	
	Society for Family Health (SFH) (with PSI)	Joint responsibility, with NACA, for implementation of Global Fund grant. Condom social marketing, youth BCC media campaigns.	Godspower Omoregie, gomoregie@sfnigeria.org
	Civil Society for HIV/AIDS in Nigeria	Coordinates an enabling environment for member organisations working on	Dr. John Jinung – National Moderator, ciscghan@yahoo.com

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	CiSHAN)	HIV/AIDS in Nigeria, capacity-building, networking, gender and rights mainstreaming. Acts as focal organisation for other six similar organisations (NARN, SWAAN, NYNETHA, MAE, NEPWHAN, Interfaith Coalition).	
	Interfaith Coalition on HIV/AIDS	Coordinates a network of 51 FBOs representing both Christians and Muslims. Set up an Advisory Council that advises NACA on faith based responses.	Rev. Kaine Nwashili, interfaithorg@yahoo.com
	Media Arts and Entertainment Network MAE)	Coordinates media and entertainment sector to promote appropriate an accurate representation of HIV issues and reduction of stigma.	
	Nigerian AIDS Research Network (NARN)	The research arm of the civil society response. Ensures the HIV programmes implemented by partners are evidence-based, advocated for policy to be evidence-based	Prof. John A. Idoko – President, jonidoko@yahoo.com
	Network of People Living With HIV/AIDS in Nigeria (NEPWHAN)	Ensures greater and meaningful involvement of PLHA in the response at all levels. Acts as an umbrella body for over 360 support groups.	Dr. Pat Matemilola – Coordinator, newpwhan@nepwhan.com
	National Youth Network on HIV and AIDS (NYNETHA)	Prevention, care, support and impact mitigation among youth, spearheading the establishment of youth-	Dr. Umar T. Yakasai, utykasai2000@yahoo.com

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		friendly SRH/HIV facilities.	
	Nigerian Business Coalition Against AIDS (NIBUCAA)	Facilitates private sector responses that focuses on strengthening workplace policy implementation.	Mr. Smart Falana
	Society for Women and AIDS in Africa, Nigeria (SWAAN)		Mrs. Funmi Doherty, swaanigeria@yahoo.com
	Nigeria HIV Vaccine and Microbicides Advocacy Group (NHVMAG)	Advocacy work for microbicides research and development – working with medical practitioners, PLHA and at risk populations to raise awareness and support.	
	Journalists Against AIDS (JAAIDS)	Behaviour change communication through advocacy and communication in the media – with the public and policy environment, including training media professionals.	

Source: GFATM, 2005; NACA, 2005; WHO, 2005, JAAIDS.

Part of the efforts of the national response in building partnership includes coordination and harmonisation of the donor support to the country. The Donor Coordinated Group – consisting of USAID, DFID, CIDA, GTZ, JICA, French Cooperation, World Bank and NACA – takes decisions on joint donor actions and support to the national government, as well as support action plans for civil society, PLWHAs, the private sector and political institutions.

The UN Theme Group, chaired by the UN resident coordinator, includes all UN agencies in Nigeria. The group works in partnership with government to provide technical advice and support in areas of mandate and expertise (the roles of the main UN agencies within this groups are described above).

NACA has created a forum to develop partnerships with local NGOs, CBOs and FBOs as well as SACAs for successful grassroots programme implementation. These include: the Nigeria HIV/AIDS Partnership Forum (for NGO collaboration), NACA/SACA forum (for engaging government structures) and the Constituencies Coordinating Entities (CCEs) for umbrella organisations.

The CCM was just recently reconstituted in line with requirements from the Global Fund. Present on the CCM board are constitutionally elected representatives of the 10 identified community constituency entities (CCE), representative of NACA, the UN Theme Group and the Donor Coordinated Group. The reconstituted CCM had its first meeting in June 2006 and are still putting structures together. Constituted committees within the CCM include the M&E committee, the technical committee, the finance committee, the task team for malaria renewal process, the task team on HIV/AIDS and the task team on PR selection.

ANNEX - TABLE 2

KANO KEY AGENCIES WORKING IN HIV AND SEXUAL AND REPRODUCTIVE HEALTH

	Organisation	Responsibilities/activities	Names and contacts
Government agencies	Ministry of Health	Planning, implementing and monitoring HIV/AIDS activities in the state. Priorities include IEC, safe blood transfusion and HBC. Works through the Ministry of Education, labour organisations and other NGOs in HIV/AIDS.	
	State AIDS and STI Control Programme (SASCP)	State management of health sector response. However, there is no SACA in Kano. Plans, implements and monitors HIV/AIDS activities and coordinates groups involved in such activities.	
	Ministry of Information	Responsibility for public awareness around HIV/AIDS. Tours LGAs for advocacy and strategy visits. Produces IEC materials. Lack of funds means limited implementation.	

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	Ministry of Education	Participates in public HIV awareness campaigns, particularly throughout the formation of clubs and associations in schools. Hampered by inadequate funding.	
Donors	USAID	Supports FHI's GHAIN.	
	DFID	Opening office in Kano in 2006. PSRHH SNR BBC WST	
Multilateral agencies			
NGOs	Family Health International	The Global HIV/AIDS Initiative Nigeria (GHAIN Project – USAID). PMTCT; OVC; VCT; Palliative Care; Prevention initiatives targeting vulnerable populations.	Ekong Emah
	Muslim Sisters Organisation (MSO)	Prevention interventions.	
	Society for Women and AIDS in Africa, Nigeria (SWAAN)	Prevention, care and support interventions.	
	Council of Positive People (COPOP)	Prevention, care and support interventions.	
	Youth Society for the Prevention of Infectious Diseases and Social Vices	Prevention interventions.	

	(YOSPIS)		
	Islamic Medical Association (ISMA)	Prevention, care and support interventions.	
	Ansarudeen Medical Women's Association	Prevention, care and support interventions.	
Research Organisations	Muritala Mohammed Specialist Hospital.		Dr. A.S. Mukhtar, Kano city

Source: FHI, 2000a; FHI, 2001a.

SWAAN is the only NGO in Kano that focuses exclusively on HIV/AIDS. The general tendency is for civil society organisations to programme HIV/AIDS alongside other programmes, such as SRH, micro-credit and healthcare.

ANNEX - TABLE 3

LAGOS KEY AGENCIES WORKING IN HIV AND SEXUAL AND REPRODUCTIVE HEALTH

	Organisation	Responsibilities/activities	Names and contacts
Government agencies	Ministry of Health	Relates with NACA for IEC materials and other HIV/AIDS supplies, conducts training for healthcare workers.	
	Lagos State HIV/AIDS Foundation (LSHAF)	Multisectoral committee and autonomous body. Coordinates multisectoral response including various ministries and NGOs.	
	Ministry of Youth, Sports and Social Development	HIV/AIDS awareness campaigns, collaborating with MOH LSHAF and NGOs. Runs orphanages, refers young positive prison inmates for counselling and prevention education to Mother Theresa home.	
	Ministry of	Annual training programme	

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	Education	for 84 teachers across state for incorporation of family health education issues in the curricula of selected school subjects, but lack of monitoring.	
Donors	Yet to be filled		
Multilateral agencies	Yet to be filled		
NGOs	Family Health International	BCC interventions with FSWs, workplace and churches. Development of VCT centres, establishment of support groups, OVC care, quality of care (especially confidentiality).	
	Life Link Organisation (LLO)	Behaviour change intervention amongst FSWs (with FHI).	
	National Union of Banks Insurance and Financial Institutions Employers (NUBIFIE)	Workplace BCC programme (with FHI).	
	Redeemed Christian Church of God (CCG)/ The Redeemed AIDS Programme Action Committees (RAPAC)	Faith-based HIV interventions	
Research organisations	National Institute for Medical	Key player in AIDS-related research in Nigeria. Houses Phase III SAVVY microbicide	Dr. Idigbe, Director General, Dr. Onwujekwe (research on microbiology), Dr. O. Ezechi

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	Research Lagos	trial. One of the first ART centres. Service site for PEPFAR ART programme.	(research on Obstetrics and Gynaecology), Dr. Odunukwe (Medicine), Ms. Rosmary Audu (leads laboratory medicine-focused research)
	Lagos University Teaching Hospital	Houses some key national figures in HIV research. Hosts a Phase II microbicide trial site. No organised HIV/AIDS research team.	Prof. I. Akinsete (haematologist, first Chairperson of the NACA, active in haematological profiling of PLHA), works with Dr. Ajose-Coker, Dr. A.S. Akanmu, Dr. C.C. Okpara, Prof. C.C. Okany. Dr. Ekanem (prominent HIV statistician, heads biennial HIV surveillance survey). No behavioural researchers.
	University of Ibaden, Oyo State (100km from Lagos)		Prof. Charles Uwakwe (works with Dept. of Guidance and Counselling, prominent in HIV behavioural research.

Source: FHI, 2000b; FHI, 2001b.