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Initial findings of the WHO Phase II IDU RAR-Survey Study in Lagos, Nigeria: Implications for Intervention, Policy and Research

Professor Moruf Adelekan, MD
Department of Behavioural Sciences,
University of Ilorin Teaching Hospital,
Ilorin, Nigeria

A JOINT EFFORT.....

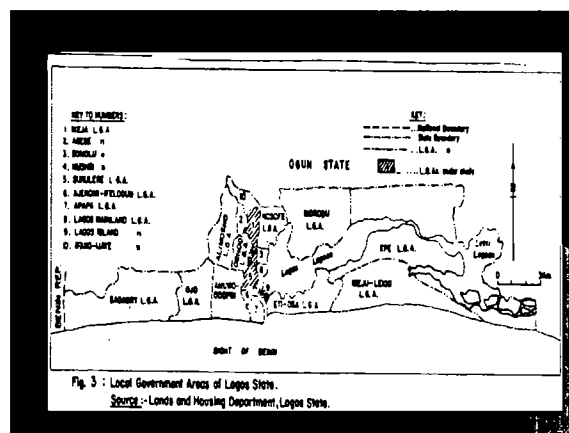
- COORDINATION: WHO, LONDON, NYC
- CENTRAL MANAGEMENT COMMITTEE
 - PROF ADELEKAN
 - DR LAWAL
 - DR AKINTIANMI
 - DR HARUNA
 - DR COKER
 - DR INEM
 - DR EKPO
 - DRS GBOUN/SANI-GWARZO: NATIONAL STD/AIDS CP
 - MR OYENDI/KACHIRU: LAB. SCIENTIST/TECHNOLOGIST
 - MR YAHAYA: STATISTICIAN

FURTHER ACKNOWLEDGEMENTS

- | | |
|--|---------------------------|
| ✓ 6 key informants (ex-users) | ✓ Key officials of 4 LGAs |
| ✓ 8 Field Workers | ✓ Community Leaders |
| ✓ UITH, Ilorin | ✓ Religious Leaders |
| ✓ National Aids Control Programme (NACA) | ✓ Government HCP |
| ✓ Psychiatric Hospital, Yaba | ✓ Private Practitioners |
| ✓ Four T & R NGOs | ✓ NDLEA |
| | ✓ UNDCP |

ABOUT LAGOS STATE.....

- Smallest of the 36 States, but most densely populated... (10 million plus)
- 1308 persons per square km
- Nation's most commercial and industrial city
- Harbours the busiest international air/sea ports
- A melting pot for all Nigerians (no-man's land)
- Several government/private health facilities
- Suffers from urbanization-related problems



THE OBJECTIVES.....

- ❖ TO DETERMINE THE EXTENT OF INJECTING DRUG USE
- ❖ FACTORS ASSOCIATED WITH THE TRANSITION
- ❖ ASSOCIATED RISK FACTORS OF IDU
- ❖ HEALTH CONSEQUENCES -HIV, HEP B/C, OVERDOSE
- ❖ KNOWLEDGE OF USERS ABOUT THE HEALTH CONSEQUENCES
- ❖ SERVICES: AVAILABILITY AND UTILIZATION
- ❖ COMMUNITY AWARENESS: READINESS RESOURCES TO ADDRESS IDU-RELATED PROBLEMS
- ❖ FORMULATE INTERVENTION STRATEGIES TO LIMIT DIFFUSION OF INJECTING AND AMELIORATE HEALTH CONSEQUENCES
- ❖ DETERMINE IMPLICATIONS FOR POLICY CHANGES AND FUTURE RESEARCH

METHODS:PRE-FIELD WORK

- TIME: FEBRUARY – APRIL, 2000
- ETHICAL APPROVAL
- FORMATION OF CMC
- COMMUNITY PENETRATION/ESTABLISHMENT OF LINKAGES
- RECRUITMENT OF RESEARCH TEAM
- TRAINING OF FIELD WORKERS
- PILOT STUDY
- REVIEW OF PILOT STUDY FINDINGS
- CONSOLIDATION OF FIELD STRATEGIES

FIELD WORK: RAR (MAY, 2000)

- INSTRUMENT: WHO RAR GUIDE
- SECONDARY DATA GATHERING
 - Existing Literature
 - NDLEA and UNDCP Reports
 - Reviews of Newspapers
- 17 FOCUS GROUP DISCUSSIONS
- INTERVIEWS WITH 62 KEY INFORMANTS/STAKEHOLDERS I
 - 11 Policy Makers
 - 29 Health Care Providers
 - 16 community-religious/opinion leaders
 - NDLEA
 - UNDCP
 - Four T & R NGOs

METHODS: SURVEY (MAY, 2000)

- INSTRUMENT: WHO PHASE II IDU QUESTIONNAIRE
- 4 LGAS USED BASED ON HIGH LEVEL OF DRUG ACTIVITY
- NO OFFICIAL DATA ON ESTIMATES OF DRUG USERS
- PURPOSIVE, SNOWBALL SAMPLING
- VERBAL CONSENT (REFUSAL OF WRITTEN CONSENT)
- 398 STREET USERS INTERVIEWED: INCLD. 80 INJECTORS
- SELECTION CRITERIA FOR IDUS
- DIFFICULTY IN RECRUITING TREATMENT SAMPLES
- ANONYMITY AND CONFIDENTIALITY
- SCHOOL PREMISES, CHURCHES, CINEMA HALLS, UNCOMPLETED BUILDINGS
- INCENTIVES GIVEN FOR THE 45-60 MINUTES INTERVIEW

METHODS: SEROLOGICAL TESTING

- HANDLED BY 2 EXPERIENCED LAB.SCIENTISTS
- VERBAL CONSENT FREELY GIVEN
- VENOUS BLOOD TAKEN BY TEAM SUPERVISORS
- UNLINKED ANONYMOUS, BUT SEROLOGICAL RESULT LINKED TO QUESTIONNAIRE BY CODE
- 365 GAVE CONSENT/BLOOD, 5 DECLINED
- BLOOD TRANSPORTED TO LAB. QUICKLY
- DOUBLE ELISA TESTS FOR HIV: 175 ANALYZED SO FAR
- HEP. B SURFACE ANTIGEN TESTED IN 175
- ANTI-HCV ANTIBODIES TESTED IN ONLY 68 IDU BLOODS

LIMITATIONS.....

- ❖ No chemical testing for drug presence
- ❖ Questionnaire not translated
- ❖ Limited coverage & non-representativeness
 - ❖ Middle-class elite IDUs/ treatment sample
 - ❖ Other LGAs/States could reveal more
- ❖ Refusal to give formal consent
- ❖ Serological testing not linked to intervention
- ❖ Non-randomness of sampling: no prevalence figures
- ❖ Intervention could not be implemented immediately

BACKGROUND DATA

- 398 street users interviewed
 - 341 males (86%)
 - 57 females (14%)
- Age
 - range 19-57 years
 - mean 36.9yrs +/- 6.3 SD
 - 81% > 30yrs
- 43% had more 12 years of formal education
- 80% from Low SES family
- 97% in Low SES themselves
- 27% were married or co-habiting
- 1 in 3 had been in prison/1 in 5 engaged in drug dealing

IS THERE AN INJECTING PROBLEM?

- 80 Ever-Injectors recruited in one month
- None recruited in 1997, although that was a pilot study to test the RAR instrument
- Injectors were able to invite other injecting colleagues (network exists)
- Some came with their paraphernalia and demonstrated how they inject
- IDUs mentioned other possible IDUs in other areas of Lagos State, and other States
- Other middle-class hard-to-reach IDUs mentioned

EVIDENCE AND RATE OF DIFFUSION

- Initially middle-class, well travelled people, now street users
- 64% first injected around Lagos area
- 35% of IDUs have initiated someone in the past 6/12
- 7% of NIDUs have witnessed injecting practice
- 7% of NIDUs have friends or family members who inject
- 2-year gap between the age of first use of injectable drugs and age of first injecting (25.5 Vs 27.2 yrs)
- Networks: friends/peer group had highest rates in initiation, place of first injection, reason for use

PROFILE OF INJECTORS

- Age of first injecting 27.2 +/- 6.2 years
- Drugs injected: Heroin (63%); Cocaine (19%)
- Frequency: 51% Dly; 19% Wkly; 30% less
- About 50% still combine NIDU methods
- 80% initially used same drugs in NIDU ways
- Most transited to injecting method within 2 yrs
- First injected by Friends (39%); Self (33%); Partner (10%)
- Most (64%) first injected in the Lagos area
- Place first injected: friend's home (25%); joints (24%)

Why they first injected

- Wanted a better high (39%)
- Friends/companions were injecting (38%)
- Peer pressure (20%)
- Curiosity (14%)
- To impress others (8%)
- I was at a party and others were doing it (6%)

RISK FACTORS (THE PRACTICE)

- Non-sterile ways of preparing solution, and injecting
- Risk environment: Many inject in drug joints, roadsides, toilets
- Sharing of injecting equipment
 - 12% had used needles which someone else used
 - 15% had passed on used needles to someone
- Reuse of equipment: Only 70% use new needles
- Sharing containers/common pots
 - 29% share container, filter or rinse water
 - 23% draw solutions from a common pot

RISK FACTORS:SEXUAL PRACTICE

- 51% had had sex with a primary partner in the last six months, with 1 in 4 using condoms
- 3.5% reported sex with someone of the same sex
- Most females admitted to being CSWs
- 27% were married or co-habiting

THE NEVER-INJECTORS

- Use daily heroin (80%); Cocaine (71%); both (21%)
- Why they have always preferred the non-injection method
 - Worried about health consequences of injecting (22%)
 - Accustomed to non-injecting methods (20%)
 - Didn't see themselves as injecting type (19%)
 - Satisfied with high from non-injection method (15%)
 - Fear/dislike for needles/syringes (15%)
 - Worried about hepatitis (1.3%)
 - Avoid law enforcement (0.6%)

KNOWLEDGE ABOUT HIV TRANSMISSION

- Sharing needles/syringes (27%)
- Sharing other injecting equipment/solution (10%)
- Having sex (protection not specified) (46%)
- Having unprotected sex (43%)
- Contact with infected blood (17%)
- Homosexual activities (5%)

HIV RESULTS

- 175 blood samples analyzed
- National Average = 5.4%
- Total blood samples positive (21/175) = 12%
- Ever injectors (6/67) = 9%
- Non-Injectors (15/108) = 14%
- Females in general (11/36) = 31%
- Males in general (10/139) = 7%
- Females, NIDUs (11/31) = 35.5%
- Males, NIDUs (4/77) = 5.2%
- Female IDUs (only 5 tested out of 9, 2 positive)
- Male, IDUs (6/63) = 9.5%

HEPATITIS B RESULTS

- 175 samples tested
- National rate = 7-10%
- Total blood sample +ve (15/175) = 8.6%
- Ever-injectors (7/67) = 10.4%
- Never injectors (8/108) = 7.4%
- Males (12/140) = 8.6%
- Females (3/35) = 8.6%

HEPATITIS C RESULTS

- 57 samples tested (only ever injectors)
- National average: not available
- Current injectors (7/48) = 14.6%
- Ex-injectors (4/19) = 21%
- Males (10/52) = 19.2%
- Females (1/5) = 20%

NON-AVAILABILITY OF SERVICES

- Only 1 in 4 had used a treatment service before
- A third complained of difficulties in accessing services, 85% for financial reasons
- Policy makers, health care providers admit to difficulties in offering services
- Highly marginalized group, negative perception, discriminated against

POLITICAL ENVIRONMENT

- Positive from the HIV/AIDs angle
- Negative from the drugs angle
- Stakeholders already sensitized
- High profile government people involved
- A window of opportunity to focus attention on the neglected drug users in general, and IDUs in particular

INTERVENTION STRATEGIES

- SHOULD START IMMEDIATELY, WHILST THE NEWS IS HOT
- ADVOCACY USING THE RESULTS
- SEMINARS FOR ALL STAKEHOLDERS
- PARTNERSHIP WITH ALL STAKEHOLDERS
- SPECIAL EDUCATIONAL SESSIONS FOR STREET USERS (PEER-GROUP OPTION)
- ESTABLISHMENT OF DROP-IN CENTRES
- MORE RECRUITMENT AND TESTING
- HARM REDUCTION MEASURES (WHICH ONES?)

RESEARCH POSSIBILITIES

- SURVEILLANCE STUDIES URGENTLY NEEDED ON USERS OF INJECTABLE DRUGS, AS WELL AS IDUS
- GREATER COVERAGE FOR LAGOS STATE, AND EXTENSION TO OTHER VULNERABLE STATES
- REPEATED SURVEY FOR TRENDS MONITORING
- ROLE OF ALCOHOL, CSW AND OTHER FACTORS IN SERO-POSITIVITY AMONG DRUG USERS/IDUS
- IN-DEPTH STUDIES OF FACTORS ASSOCIATED WITH DIFFUSION OF INJECTION DRUG PRACTICE
- STUDY OTHER HEALTH CONSEQUENCES IN DEPTH: OVERDOSE, TUBERCULOSIS, MALNUTRITION, QUALITY OF LIFE
- WOMEN USERS AND HEALTH CONSEQUENCES
- CRITICAL REVIEW OF GOVERNMENT POLICIES IN THE FACE OF EMERGING PICTURE
- EVALUATION OF INTERVENTION MEASURES

CONCLUSIONS

- INJECTING IS AN EMERGING PROBLEM
- HIV RATES AMONG INJECTORS HIGHER THAN THE NATIONAL AVERAGE
- HIGHEST RATES FOUND AMONG FEMALE NON-INJECTORS (OTHER FACTORS)
- POOR KNOWLEDGE/AWARENESS ABOUT THE INJECTING PROBLEM AT ALL LEVELS
- URGENT DEFINITIVE ACTIONS NEEDED FOR INTERVENTION, POLICY AND RESEARCH

THE MAIN MESSAGE

THIS STUDY HAS PROVIDED THE GREATEST WINDOW OF OPPORTUNITY EVER FOR RESEARCH TO HAVE IMPACT ON POLICY AND INTERVENTION IN AN ENVIRONMENT THAT IS FAR REMOTE FROM BEING RECEPTIVE TO CHANGES OTHERWISE. WE SHOULD NOT MISS THE GOLDEN OPPORTUNITY!

THANK YOU ALL.

Drug Abuse and HIV transmission in Africa: Emerging and Preventable Trends.

Africa: Heterosexual intercourse is the primary mode of HIV transmission .

Nowhere has the impact of the epidemic been more severe than in Africa. And in Africa, **heterosexual transmission is the primary mode, and overwhelming mode of HIV transmission.** However.

Drug use, particularly non-injection use has been prevalent in Africa and with the **increasing use of crack cocaine and heroin, a sub-epidemic among drug users is occurring.**

Cannabis is by far the most widely used drug in sub-Saharan Africa,

Cocaine (powder and or crack) and heroin have been reported for ten sub-Saharan countries.

Crack-cocaine is most widely used in South Africa, Ethiopia, Ghana, Nigeria, and Zimbabwe

Crack-cocaine users often engage in trading sex for drugs or for money for drugs, resulting in sexually transmitted infections including HIV.

Recently, **injection drug use** has been “reported” Africa, specifically in Nigeria, South Africa and Zimbabwe

Three years ago in A World Health Organization supported study, no drug injection was reported in Lagos, Nigeria. This summer at the Global Research Network on HIV Prevention in Durbin, Professor Adelaken reported that 20% of the 400 drug users interviewed in Lagos now have a history of drug injecting (Global Research Network Meeting Report 1999 and presented in Durbin, South Africa)

Africa is increasingly being used for the trafficking of heroin and cocaine from producer countries to drug markets in North America and Europe (Ball, WHO 2000)

Data clearly indicate that where drug trafficking occurs, countries become transshipment routes, drug injecting follows, and HIV in injection drug users occurs

AIDS outbreaks follow Asia's Heroin Traffic. See Beyer et al for report on overland heroin trafficking routes and HIV-1 spread in South and South-east Asia (Beyer et al. AIDS 2000,14:75-83).

Intervening early before the HIV epidemic reaches 5% in IDUs can and limit the spread of HIV .

Drug Abuse and HIV Rapid Assessments and Responses

Sub-saharan countries with limited infrastructure for surveillance, prevention and care have experience with rapid assessment methodology for drug abuse and to a much lesser extent for drug abuse, sexual risk and HIV.

Rapid situational assessment of drug using patterns have been conducted in 10 sub-Saharan countries, namely Cameroon, Cote d'Ivoire, Ghana, Ethiopia, Kenya, Mozambique, Nigeria, Senegal, South Africa, and Zimbabwe

Rapid assessment and response refers to a set of qualitative and quantitative methodologies, community organization and mobilization principles, that permits the collection of data by the community about the current and emerging risk behaviors and changing dynamics of HIV transmission, structures and services that exist, or do not exist, and translating this information into practical, and sustainable low-cost

interventions to prevent the further spread of HIV.
It can complement surveillance efforts and should be
introduced in African countries scheduled for U.S. technical
assistance.

Nigeria, and Professor Adelekan from Lagos, a member of
the Global Research Network on HIV Prevention in Drug
Using populations is an expert. His power point presentation
in Durbin is attached.

C-NISWA

NATIONAL SECURITY COUNCIL

FAX COVER SHEET

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Washington, D.C.
20504

Did you get a complete,
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Chris Keenan at
(202) 456-9394

From: Kenneth W. Bernard
International Health Affairs
Phone: 202 456-9391, Fax: 202 456-9390

To: Nora Dempsey 6-9260
Michael Iskowitz 6-2439
Laura Efros 6-6028

Date/Time: August 10, 2000

No. of pages to follow: 1

FYII

11/4/2000



**PRESS RELEASE
PHOTO AND FILM OPPORTUNITY**

Record-Breaking Giant Mosquito Net – with a Message

Two hundred and twenty-five Nigerian schoolchildren will gather under a giant mosquito bednet - **225 times larger** than the standard insecticide treated nets used to protect against malaria – in an attempt to set a world record.

The bednet measures a massive 20 metres by 20 metres and is three metres high. So far there is no record for the largest bednet. Usually bednets are made to cover the area above a standard double bed. An ordinary net will be positioned next to the record breaking giant.

The event, in Abuja, takes place exactly one week before African Heads of State meet there for the first ever Summit on malaria. It will also act as a reminder that **225** African children die of malaria every two and a half hours. More than 2,173 children under the age of five die of malaria every day.

The record breaking attempt takes place at Eagle Square, Abuja, Nigeria on Tuesday **April 18th** from 9.30am and will be hosted by the country's First Lady, Chief (Mrs) Stella Obasanjo, with an official from Guinness World Records monitoring events.

A group of 30 children from the Drama Club of the Federal Government Girls College Bwari in Abuja will also perform "Roll Back Malaria – Roll in Development" at the special ceremony. The specially written drama includes song, dance and a mock protest with placard wielding "demonstrators", all under 10 years-old, demanding the world wakes up to the scourge of malaria – a preventable disease that increasingly continues to burden dozens of African countries.

The Abuja schoolchildren hope to remind the world that malaria kills more than one million people a year with 9 out of 10 of the deaths in Africa. Unlike some areas of the world, malaria is on the increase in Africa, with under five year olds and pregnant women most at risk.

African Heads of State, Ministers from G8 countries and the Heads of international development agencies are meeting in Abuja a week later on Tuesday April 25th for the African Summit on Roll Back malaria to explore ways to accelerate action to roll back malaria in Africa and rededicate themselves to cutting malaria deaths by at least half by the year 2010.

Once the bednet has been measured and recorded by Guinness World Records it will remain in Eagles Square up until the 24th. On the 24th it will be moved to the Nicon Hilton where it will be used as a dramatic backdrop to the Summit and a constant reminder to Heads of State that malaria deaths can be prevented using cost effective and simple methods like insecticide treated bednets.

-Ends-

Photo/Film Programme - April 18th World Record Attempt
(MC – Nigerian TV celebrity Omotayo Omotosho)

9am

Press arrive.

9.30-9.50am

Arrival of guests at Eagle Square.

9.55am

Nigerian First Lady, Chief (Mrs) Stella Obasanjo, arrives.

10am

National Anthem.

10.10am

Dr Edugie Abebe, Nigeria's Director of Primary Health Care and Disease Control, welcomes press and special guests and introduces the Bednet project.

US Department of State
Office of Emerging Infectious Diseases
and HIV/AIDS
2201 C. Street, NW
Washington DC, 20520

To: Dr Ken Bernard

From: Donovan Maust

Fax: 202-456-2439

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Phone: 202-647-4909

Pages 6 (including cover)

Date: 08/01/00

Dr Bernard,

Please review the attached document, prepared for Assistant Secretary Sandalow's upcoming trip to Nigeria. Please let us know if you have comments.

Thank you.

UNCLASSIFIED**NIGERIA AND HIV/AIDS**Background

- According to the June 2000 UNAIDS report, about 2.7 million Nigerians are living with HIV/AIDS, 11% of all HIV-positive persons living in Sub-Saharan Africa today. At latest estimate, there are 1.4 million AIDS orphans in the country.
- Nigeria's participation in UN peacekeeping makes prevention in their military a key component in slowing the propagation of HIV/AIDS to other regions. USAID estimates that as much as 25% of the military may be infected with HIV.
- Owing to its size and central location in West Africa, combating the epidemic in Nigeria will also be critical in slowing the spread to neighboring countries.
- In FY 2000, USAID funding for Nigeria is \$8.7 million. Efforts have been focused on condom distribution and marketing, changing behavior among high-risk groups, and training of health personnel.
- President Obasanjo participated in the December 1, 1999, HIV/AIDS Awareness Day ceremonies and instructed public health agencies to work closely with donor agencies on prevention issues.
- In the aftermath of a WHO meeting on malaria held in Nigeria, President Obasanjo has suggested holding an African leaders' summit on AIDS in late November or December.
- Nigeria also provides peacekeepers for many of the African war zones. Both U/S Pickering and U/S Larson have met recently with President Obasanjo and other GON officials to discuss HIV/AIDS, particularly in peacekeepers. GON now does post-assignment testing of Nigerian peacekeeping troops, with results of high incidence of HIV/AIDS. However, it is likely that many of the soldiers are infected pre-assignment, and we need to better ascertain their status before assignment to peacekeeping operations.) ?

UNCLASSIFIEDTalking Points

- We commend the effort of President Obasanjo to more actively engage the GON in the fight against malaria, HIV/AIDS and other infectious diseases.
- Stress that the unchecked spread of HIV/AIDS will have a powerful impact on Nigeria's economy, military and society, and that more must be done now to prevent the epidemic from having such an impact.
- We believe the Nigerian government's efforts to confront AIDS will also help the overall effort in West Africa, in particular and Africa as a whole.
- We appreciate Obasanjo's willingness to speak about HIV/AIDS to his people and other African leaders, and urge him to continue to do so.
- We also encourage him to capitalize upon the opportunities offered by the Heads of State meeting to forge commitments to policy changes which can help to institutionalize HIV/AIDS solutions, i.e. destigmatize people living with HIV/AIDS; strengthen public health infrastructure and enhance prevention and voluntary HIV/AIDS testing, especially pre-assignment testing of peacekeepers. *; counseling, ; access to basic care! support.*
- We stand ready to assist the GON through the LIFE initiative and other available programs, and look forward to the new elements of those programs which will have our respective militaries work together on HIV/AIDS prevention.

UNCLASSIFIED**SUB-SAHARAN AFRICA AND HIV/AIDS**Background

- Sub-Saharan Africa is the region which has been most seriously affected by the epidemic: 8 out of 10 AIDS deaths worldwide occur in Sub-Saharan Africa.
- Although only a tenth of the world's population lives in sub-Saharan Africa, over two-thirds of all the people now living with HIV in the world—nearly 24.5 million men, women and children—live in sub-Saharan Africa.
- In many sub-Saharan countries, over 50% of childhood deaths by 2010 will be due to AIDS.
- Life expectancies in many countries have dropped drastically. In Botswana, it has dropped from 71 to near 39, and from 70 to 38 in Zimbabwe. According to the U.S. Census Bureau, Botswana, South Africa, and Zimbabwe will be experiencing negative population growth by 2003, between -0.1 and -0.3%. By 2010, several more countries, including Namibia and Malawi, will have growth rates near 0.
- Left unchecked, AIDS threatens the economic future of nations that ignore its impending devastation. One estimate foresees a reduction in the annual GDP in African nations by 0.8 to 1.4% per year.
- In FY 2000, the administration provided \$225 million towards the global fight against AIDS through the "LIFE (Leadership in Fighting an Epidemic) Initiative" that involves USAID and Centers for Disease Control at HHS. The Administration is asking Congress to up the amount to ~~between \$325 and \$335~~ million for FY 2001.

to include DOL, DHA

UNCLASSIFIEDTalking Points

- We are painfully aware of the devastating impact that HIV/AIDS has wrought upon the nations and peoples of sub-Saharan Africa—not only in terms of human suffering, but as a threat to hard fought gains in development, economic growth, and stability. Information about the pandemic highlighted in the International AIDS Conference in Durban reinforces the extent of the devastation.
- Clearly, more resources are needed for programs for AIDS prevention and care. That's why President Clinton doubled U.S. assistance for these programs over the past two years to \$225 million and called for an additional \$100 million in next year's budget.
- Our efforts are just a start. We are also seeking to mobilize other donors and countries, including the G-8, the multilateral development banks, and the private sector, to increase their contributions and efforts against AIDS.
- But resources alone will not ultimately defeat the AIDS pandemic. The other half of the equation is strong leadership. Leaders throughout the world need to make the fight against AIDS a priority right now by speaking out, launching education campaigns and destigmatizing the disease.
- We hope that President Obasanjo's meeting of African leaders will help to develop the needed commitment to address this serious crisis.
- We ^{or reducing} are encouraged by the progress made by Uganda and Senegal in suppressing their national HIV-infection rates. We urge that the lessons learned there be taken to heart and shared with all African nations and other nations who may also be vulnerable to an acceleration of AIDS.
- We stand ready to assist you in providing scientific expertise and other technical support. Confronting the epidemic is not only a national priority for you, but a priority for the entire community of nations.

UNCLASSIFIED

Drafted by: OES/EID:NCarter-Foster/DMaust
x72435
H:/Working Documents/maustdt/AIDS Subs for
Sandalow3

Clearances: OES/EID: NCarter-Foster (ok)
OES: KBrill
G: JChow (subs)
P: EBarks-Ruggles (subs)
E: APence
AF/W: AMartschenko
AID/G: AGetson
NSC: KBernard
DOD: LPahland

From: Lee Barnes

BUSINESS ROUNDTABLE LIST (as of MAY 1999)		
Name	Company/Address	Telephone/Fax Numbers
AAB, Randy Managing Director	M-I Nigeria Limited 13A A.J. Marinho Drive 6th Flr., The Octagon Victoria Island Annexe Lagos	Tel 261-8517/8518 261-855 Fax 261-5247
ACCAD, Michel Managing Director	Citibank Commerce House, 1 Idowu Taylor Street Victoria Island, Lagos	Tel 261-0687 (D/L) 261-2000-9 Fax 262-3960 262-3334
ACKERT, David General Manager	Schlumberger/Anadrill (Nigeria) Ltd. 5th & 8th Floor, ICON House Plot 999F, Idejo Danmole Street Victoria Island, Lagos	Tel 261-9200/5275/4442 262- 5681 Fax 262-3669 PH Fax 084-228-267
ADENIRAN, David G. Managing Director	Minnesota Nigeria Ltd. Isolo Expressway, Mushin P.O. Box 10380 Marina, Lagos	Tel 524-117 (D/L) 452-0590 Fax 452-1491
AGEE, John Vice President	HUFFCO 259 Etim Inyang Street Victoria Island, Lagos	Tel 261-9712 Fax 261-8373
ALOS, A. (Prof.) Director General	Lagos Business School 25, Adeola Hopewell Street Victoria Island, Lagos	Tel 262-0993 Fax 262-0996
APP, Bruce Managing Director	Global & Henkels Nigeria Ltd 59, Awolowo Road Ikoyi, Lagos	Tel 269-2328 Fax 269-4161
ATALLAH, N.F. General Manager	GORI (Nig.) Ltd. 3, Danmole Street, Plot 1621 P.O. Box 71914 Victoria Island, Lagos	Tel 261-4975 261-0986 Fax 261-4808

HIV/AIDS Profile: Nigeria

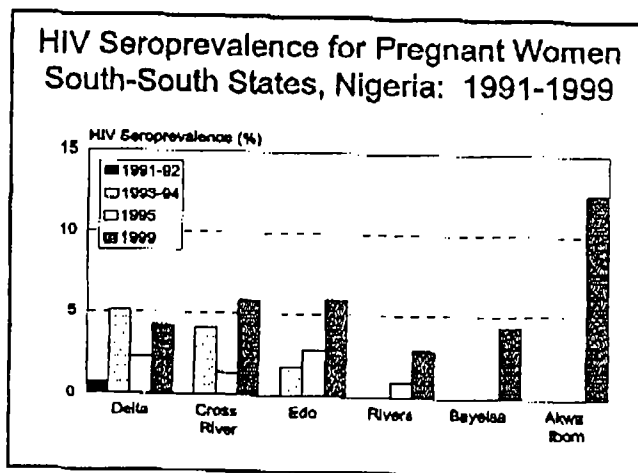
	with AIDS	without AIDS	with AIDS	without AIDS
Population (1000s)	123,338	124,890	Growth Rate (%)	2.7 % 3.0 %
Crude Birth Rate	40	40	Crude Death Rate	14 11
Infant Mortality Rate			Life Expectancy	
Both Sexes	74	69	Both Sexes	52 57
Male	77	72	Male	52 56
Female	71	66	Female	52 58
Percent Urban	36		Total Fertility Rate	5.7
Note: Above indicators are for 2000.				
Estimated % of adults living with HIV/AIDS, end 1999				
Cumulative AIDS rate (per 1,000) as of 6/30/99				
Cumulative AIDS cases as of 6/30/99				
Sources: U.S. Census Bureau, UNAIDS, Population Reference Bureau, World Health Organization.				

Epidemiological Data

Epidemic State: Generalized

National prevalence has been steadily increasing from 1.8 percent in 1990 to 5.4 percent in 1999. The difference between HIV seroprevalence in urban and rural areas is not large, indicating that the AIDS problem in Nigeria is not strictly an urban one. In 1999, Nigeria was ranked third after South Africa and Ethiopia by UNAIDS as the nations in Africa with the largest number of HIV infected people.

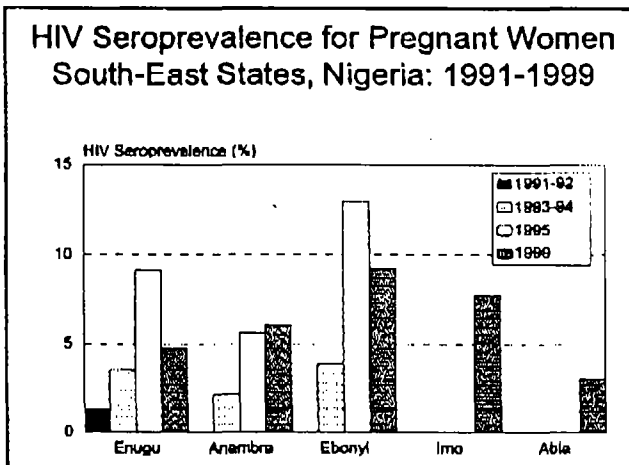
- HIV seroprevalence for pregnant women in the South-South varied by state. HIV prevalence in 1999 ranged from 3 percent in Rivers State to 13 percent in Akwa Ibom State, the second highest HIV prevalence among pregnant women in Nigeria in 1999.



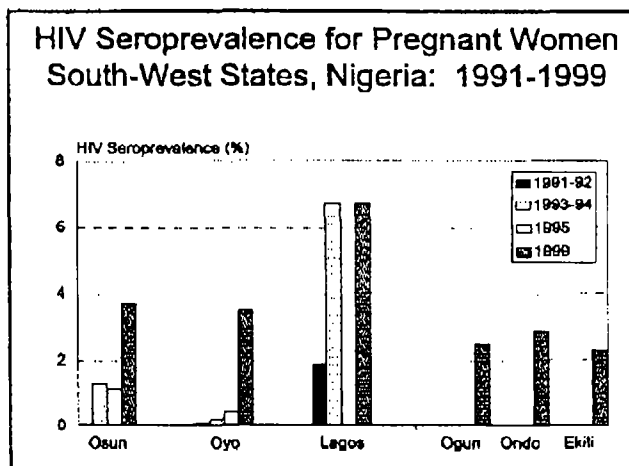
Source: International Programs Center, Population Division, U.S. Census Bureau, HIV/AIDS Surveillance Data Base, June 2000.

Nigeria

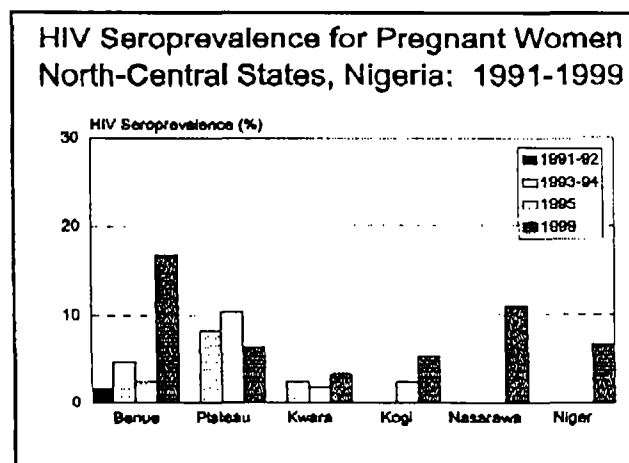
- In 1999, HIV seroprevalence for pregnant women in the South-East zone ranged from 3 percent in Abia State to 9 percent in Ebonyi State.



- In the area of Nigeria comprising the South-West, the state that contains one of the worlds' largest cities, Lagos, had an infection rate of 7 percent among pregnant women in 1999. HIV prevalence in other states of the South-West ranged from 2 to 4 percent.



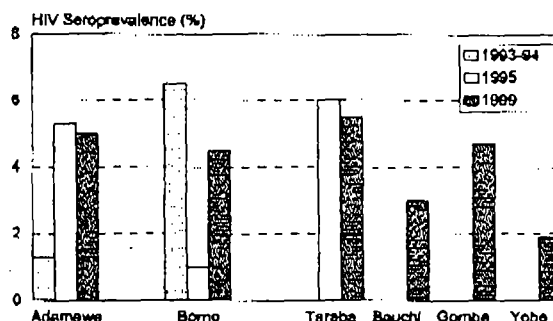
- In 1999, prevalence rates among pregnant women in states of the North-Central area of Nigeria ranged from 3 percent in Kwara State to 17 percent in Benue State. Benue State had the highest infection level in 1999 among pregnant women.



Nigeria

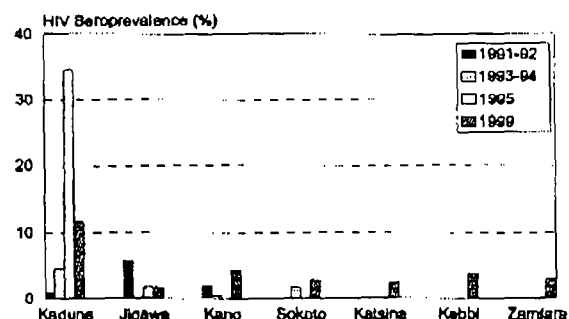
- In the North-East states, HIV prevalence among pregnant women ranged from 2 percent in the newly created state of Yobe to 6 percent in Taraba State.

HIV Seroprevalence for Pregnant Women
North-East States, Nigeria: 1991-1999



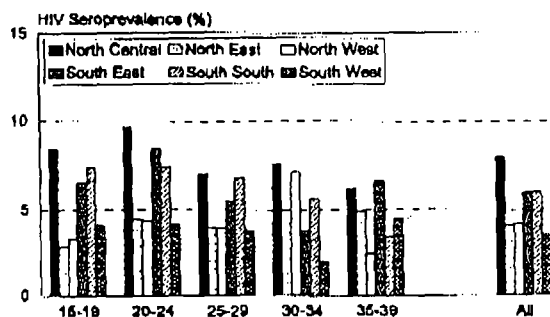
- In 1999, HIV prevalence among pregnant women in the North-West states ranged from 2 percent in Jigawa to 12 percent in Kaduna.

HIV Seroprevalence for Pregnant Women
North-West States, Nigeria: 1991-1999



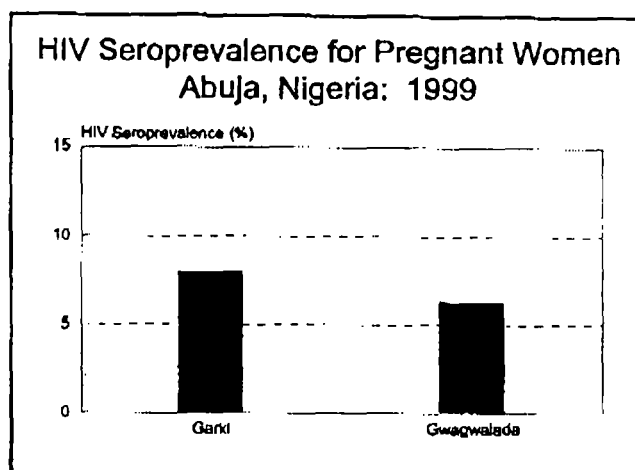
- In 1999, HIV seroprevalence among pregnant women in six zones of Nigeria ranged from 3 percent among 15-19 year olds in the North East zone to nearly 10 percent among 20-24 year olds in the North Central zone. Across the various age groups, the North Central zone tended to have the highest prevalence levels among pregnant women.

HIV Seroprevalence for Pregnant Women
by Age in the Six Zones of Nigeria: 1999

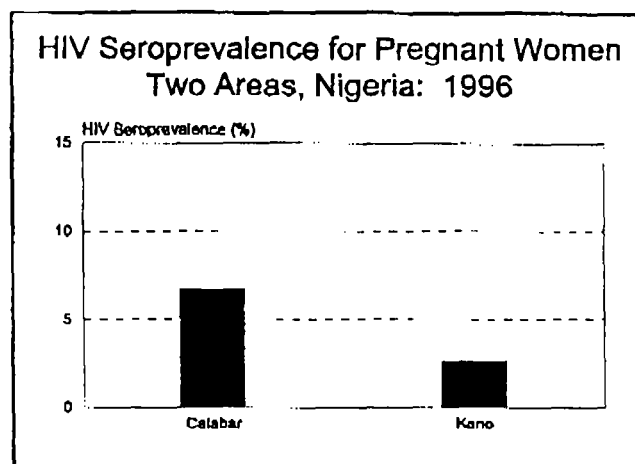


Nigeria

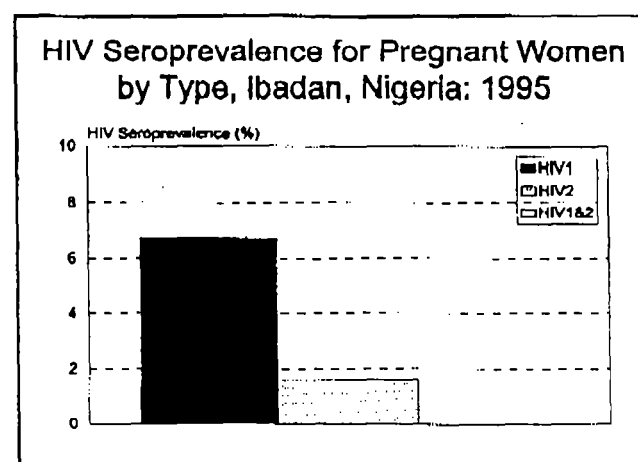
- HIV seroprevalence among pregnant women in Abuja, the capital city, is 8 percent at the Garki site and 6 percent at the Gwagwalada site.



- Seroprevalence among pregnant women in 1996 varies in different parts of the country. By 1996, infection levels had reached 7 percent in Calabar, a city near the Cameroon border in the south and 3 percent in Kano, a city near the Niger border in the northern region.

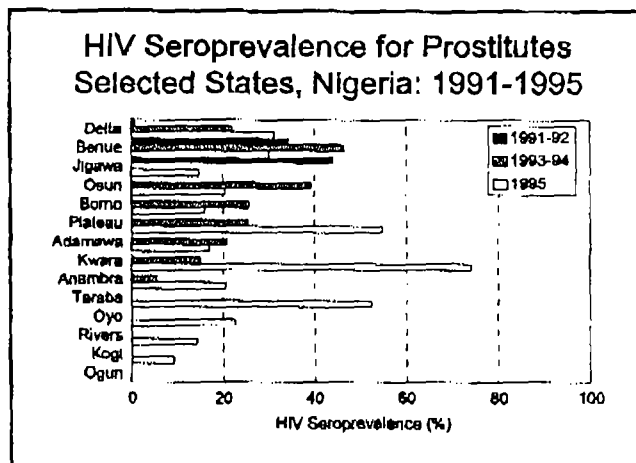


- As is the case in most countries of West Africa, HIV1 prevalence is substantially higher than HIV2. Surveillance data from Ibadan does not show evidence of dual infection. Two percent of pregnant women tested positive for HIV2 versus 7 percent for HIV1.

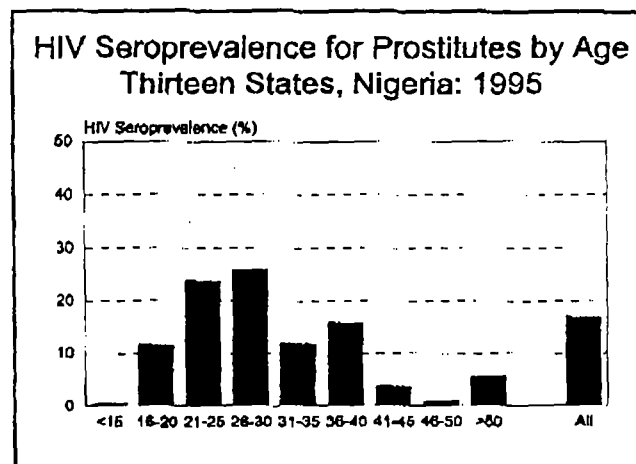


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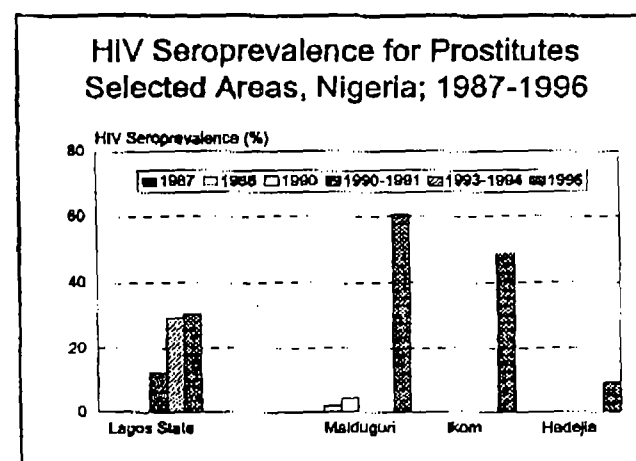
- In 1995, HIV seroprevalence among prostitutes from selected states varied from 0 percent in Ogun to 74 percent in Kwara. While infection levels in some states rose from 1993-1994 to 1995, others declined.



- HIV seroprevalence among prostitutes is highest for the 26-30 year age group, 26 percent, and lowest for the <15 year group, less than one percent. For these thirteen states, the average prevalence is 17 percent.

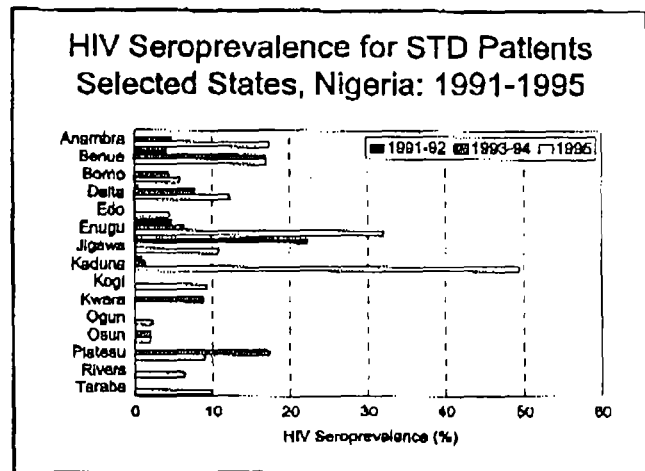


- In 1996, HIV seroprevalence among prostitutes for selected areas of Nigeria ranged from 9 percent in Hadejia to 61 percent in Maiduguri.

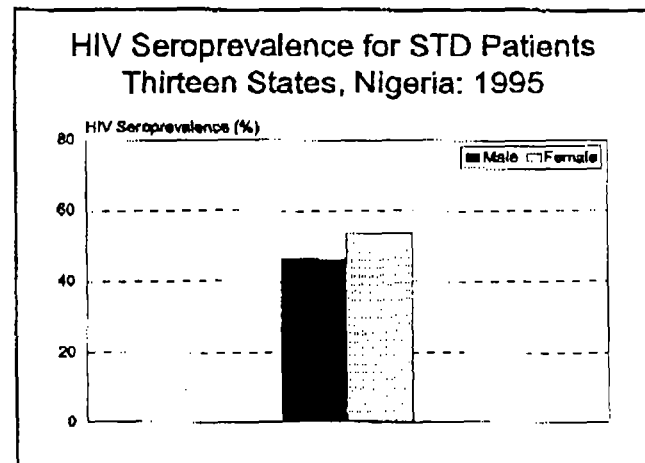


Nigeria

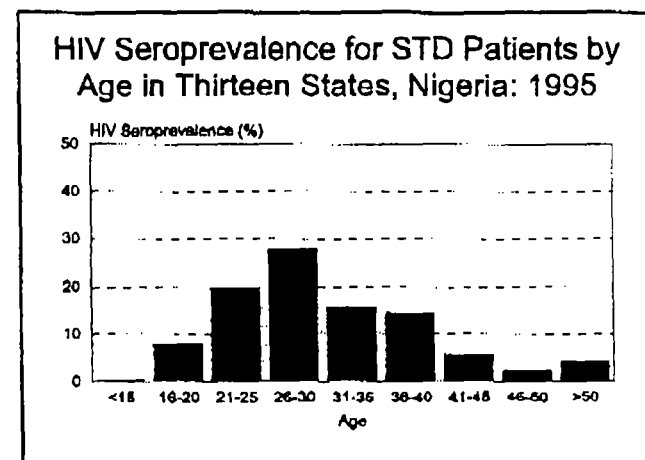
- Between 1991-1992 and 1995, HIV infection levels among STD clinic patients rose in most states shown except Osun, where prevalence remained the same and Plateau, Jigawa and Kwara, where prevalence fell. In 1995, HIV prevalence among STD patients tested ranged from no evidence of infection in Kwara to 50 percent in Kaduna.



- HIV seroprevalence for female STD clinic patients is somewhat higher than for men. Fifty-four percent of female STD patients tested positive versus 46 percent of male patients.



- Among STD clinic patients in thirteen states, adults ages 26-30 had the highest level of HIV infection, reaching 28 percent in 1995. Patients below the age of 15 had the lowest prevalence levels with less than one percent of the sample infected.



NIGERIA

- . 2.7 million PLWA**
- . 5.06 % prevalence**

TANZANIA

- . 1.3 million PLWA**
- . 8.1 % prevalence**

(as of
8/26/00)

NIGERIA

06/01/00

Socio-Economic Data

Total population (thousands), 1997	118,369	UNPOP
% of population urbanized, 1996	41	UNPOP
Infant mortality rate (per 1,000 live births), 1996	114	UNICEF/UNPOP
Maternal mortality rate (per 100,000 births), 1990	1000	WHO/UNICEF
Life expectancy, 1996	52	UNPOP
Per capita GNP (US\$), 1995	260	World Bank
Human Poverty Index Value (HPI)	41.6	UNDP

Status of the Epidemic

Prevalence – Year	Trend
4.12 – 1997	Extensive new surveillance round in 1999 suggests that there is a widespread and slowly growing epidemic in all areas of Nigeria.

National Response

- The new head of Nigeria has expressed his political commitment to respond to HIV/AIDS. In his first address to the country, AIDS was cited among the major priorities. The Minister of Health is very dedicated to intensifying the response to HIV/AIDS;
- The Petroleum (Special) Trust Fund (PTF) allocated NGN 850 million (US\$10 million) towards HIV/AIDS activities in 1999, which were used to purchase HIV test kits.
- The PTF sponsored a national conference on HIV/AIDS in December 1998. This brought together major stakeholders, government, non-governmental organizations, people living with HIV/AIDS and the donor community;
- Most of the external HIV/AIDS-related support in Nigeria is channelled directly to non-governmental organizations.

UN Theme Group on HIV/AIDS

Chair: UNICEF Representative

Members: UNICEF, UNDP, UNFPA, UNESCO, UNDCP, ILO, UNHCR, WHO and World Bank

UNAIDS Personnel: A Country Programme Adviser will shortly be recruited. DFID will support an interim Country Programme Advisor as of end January 2000

Technical Working Group (TWG) of the UN Theme Group on HIV/AIDS

The TWG has developed a framework to identify the roles and responsibilities of the Theme Group members in support of the national response.

Support from UN System Agencies for HIV/AIDS activities in 1998-1999

<i>Organization</i>	<i>Amount US\$</i>
WHO	50,000
UNDP	125,000
UNFPA funds are integrated into their RH programmes. This is the estimated amount that will go towards HIV/AIDS activities.	150,000
UNICEF	100,000
UNAIDS	400,000
Total	825,000

NIGERIA AND HIV/AIDS

Country Profile

Nigeria is sub-Saharan Africa's most populous nation, with about 122 million inhabitants, or roughly 14 percent of the region's entire population. The country has major political and economic influence throughout Africa—particularly in West Africa—and plays a peacekeeping role in the region. Although rich in natural resources, Nigeria has experienced rapid population growth and uneven economic development, resulting in an increasing poverty rate that has outpaced the Nigerian government's ability to provide adequate health and social services.

Among the development challenges facing Nigeria are the instability of its political environment, regional cultural and religious diversity (more than 250 ethnic groups), and the spread of HIV/AIDS.

More than a decade of economic decline has had a devastating impact on maternal and child health.

Nigeria's rates of infant mortality (91 per 1,000 live births) and maternal mortality (800 to 1,500 per 100,000 live births) are among the highest in the world, and immunization coverage has dropped below 30 percent. The mortality rate for children under age 5 is 192 deaths per 1,000. By the year 2000, more than 149,000 women will die every year from pregnancy complications.

From the mid-1980s to 1996, the GDP per capita declined from \$1,000 to an estimated \$250. A 1996 national survey revealed that 49 percent of Nigerians are living below the poverty line of \$8 or less in monthly household income.

HIV/AIDS in Nigeria

HIV/AIDS has become a major public health problem in Nigeria since the first case was reported in 1986. The 1998 HIV-prevalence rate estimated by the government was 4.5 percent, but health workers think the real figure is twice that. Although the HIV prevalence rate is lower in Nigeria than in some other African countries, the absolute numbers of people affected are larger. As the epidemic grows, many fear that it will spread throughout West Africa.

- At least 5.5 million Nigerians are living with HIV—more than 13 percent of Africa's 1998 HIV-positive population.
- The number of AIDS cases reported by the Nigerian government increased 840 percent from April 1994 to November 1997. An estimated half a million people became infected in 1998.
- Almost 72 percent of HIV infections are among adults younger than 40.

AIDS has already claimed many lives in Nigeria. About 590,000 people have died of AIDS-related diseases since the beginning of the epidemic—150,000 of those in 1997.

- Due to AIDS, the crude death rate in Nigeria will be 20 percent higher in the year 2000 than it was in 1990.
- The National AIDS and STD Control Program (NASCP) estimates that 1.4 million Nigerians will have died from AIDS by 2002.
- Between 1995 and 2015, Nigeria is projected to have one of the highest numbers of AIDS deaths in Africa, second only to South Africa and equal (4.3 million) to Kenya.
- By the year 2000, life expectancy will have dropped from 55 to 50 as a result of AIDS.

In 1998, 1,500 Nigerians became infected with HIV every day—more than one new infection per minute.

Several factors contribute to the rapid spread of HIV in Nigeria, including high prevalence of other sexually transmitted diseases (STDs), low use of condoms, poverty and poor health status, the low status of women, and silence and denial due to the stigma of AIDS. The country's size and great regional religious and cultural differences also pose formidable challenges, requiring that strategies be developed region by region.

HIV/AIDS will strain an already inadequate healthcare system. Approximately 60 percent of

Nigerians have no access to any form of health services.

But additional healthcare demands and costs are only part of the epidemic's broad impact. The economies of families, communities, businesses, and the country itself will also suffer as Nigeria loses people in their most productive years, after society has invested in their health and social development and before they can contribute to national development.

Women and HIV/AIDS

Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at high risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound this vulnerability.

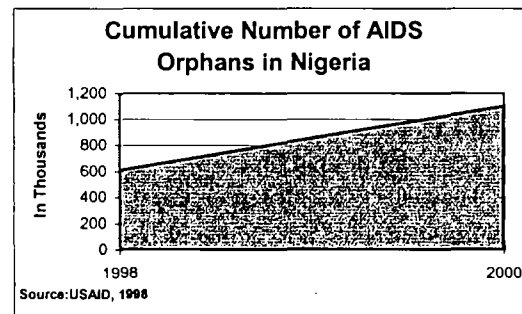
- The 1996 HIV prevalence rate for pregnant women in urban areas was 7 percent and the national average was 4.5 percent.
- A 1996 NASCP survey found that 35 percent of sex workers were HIV-positive.

Children and HIV/AIDS

The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others.

- Forty-six percent of the total Nigerian population (nearly 59 million people) is under age 15.
- Approximately 30 to 40 percent of infants born to HIV-positive mothers in Nigeria will also become infected with HIV, and most will die within two years.
- In 1998, 4 percent (140,000) of the people living with HIV/AIDS (PLWHA) in Nigeria were under age 15.

- Nearly 184,000 children were orphaned by AIDS in 1998. Since the beginning of the epidemic, more than 600,000 children have lost parents to the disease.



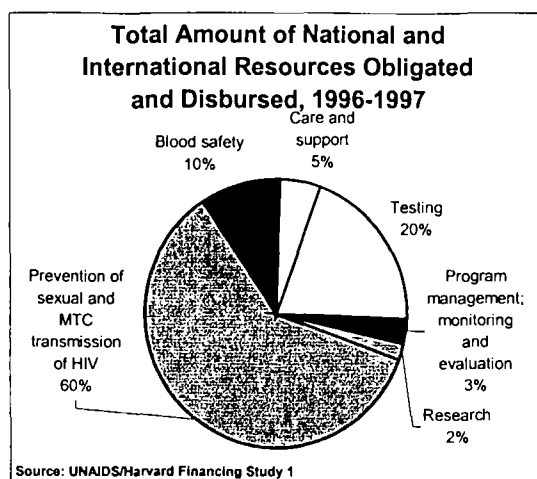
Youth and HIV/AIDS

Youth are at greatest risk of HIV infection, particularly young women. This is partly due to the physiological immaturity of the young female reproductive system, and partly due to partnering with higher-risk, older men.

- Almost 19 percent of HIV infections among women attending antenatal clinics nationwide occur among those ages 16 to 20.
- More than 5 percent of all 16- to 20-year-olds are HIV-positive.

Many of the next generation of Nigerian workers are losing opportunities to receive an education. When a family loses adults to AIDS, girls are taken out of school for care giving and boys for income production. Others are dropping out because they cannot afford school fees. Many young people have also become responsible for supporting their families.

Interventions



To date, HIV/AIDS interventions in Nigeria have been supported in three ways: (1) through funding and implementation of direct HIV/AIDS and STD projects; (2) through integration of HIV/AIDS and STD activities into maternal-child health (MCH), reproductive health, and health education projects; and (3) through support for social and economic projects that are intended to reduce people's vulnerability to HIV.

According to a UNAIDS/Harvard study, total 1996-1997 financing of the response to HIV/AIDS in Nigeria from national and international resources, including the estimated value of in-kind donations, are summarized in the following table:

Funding Source	US\$ Amount 1996	US\$ Amount 1997
National		
HIV/AIDS projects	9,756	
International		
HIV/AIDS projects	825,951	3,238,074
HIV/AIDS portion of integrated projects	2,719,186	2,663,222
In-kind Donations	207,627	1,019,925
TOTAL	3,762,520	6,921,221

National Response

The National AIDS Prevention and Control Program (NACP) was initiated in 1986. In January 1989 a multidisciplinary National AIDS Committee (NAC) was developed. Also in 1989, state AIDS committees were formed and a three-year Medium Term Plan (1990-1992) for the prevention and control of HIV/AIDS was developed.

The NACP and National Sexually Transmitted Disease (STD) Program merged in 1992 to become the National AIDS and STD Control Program (NASCP). A second Medium Term Plan (1993-1997) was developed, focusing on preventing sexual transmission of HIV through

Nigerians finally began to realize that AIDS can kill anyone when then Minister of Health Ransom Kuti, the brother of popular music star Fela Kuti, announced to a stadium full of mourners in 1997 that Fela had died of AIDS

behavioral change interventions and STD case management. The NASCP is located in the Department of Primary Health Care and Disease Control. HIV/AIDS and STD activities are decentralized to the state and local government area levels through the primary health care (PHC) delivery system. The NASCP approach to

NIGERIA AND HIV/AIDS

HIV/AIDS is designed to be multidisciplinary and multisectoral, with active participation from the ministries of Health, Women's Affairs, Defense, and National Planning. NASCP endorsed a national policy on HIV/AIDS in December 1998.

HIV/AIDS activities are being integrated into MCH programs, and more focus is being placed on adolescent health and sexuality. Increased attention is also being paid to tuberculosis (TB) and STD management.

Several private multinational companies working in Nigeria have funded NASCP HIV/AIDS activities. Chevron, for example, has supported training in STD management, and Glaxo-Welcome has funded AIDS case management. Janssen Drugs has supplied miconazol and ketonazole for

treating candida, a common opportunistic infection.

Few states require HIV screening before blood transfusion. In 1998, the Petroleum (Special) Trust Fund (PTF) invested \$10 million in a blood initiative, providing HIV screening reagents to selected government facilities in every state. The PTF—a quasi-autonomous federal agency set up in 1993 to administer proceeds from Nigeria's oil sales in collaboration with the Federal Ministry of Health—also organized and sponsored a national conference on HIV/AIDS in December 1998.

The Nigerian Institute of Medical Research (NIMR) and the National Pharmaceutical Research and Development Institute (NIPRD) are involved in AIDS treatment research.

Donors

Sanctions imposed on the Nigerian government by Western countries in the mid-1990s have limited donor activity in Nigeria. According to a study by UNAIDS and Harvard University, two bilateral

organizations and two foundations contributed the following amounts, including in-kind donations, in 1996-1997 and 1998:

Donor	US\$ Amount
DIFD	8,640,002 (1996-1997)
USAID	5,424,390 (1996-1998)
Ford Foundation	1,210,000 (1994-1998)
MacArthur Foundation	587,000 (1996-1999)
Total	15,861,392

Bilateral organization contributions 1996-1999

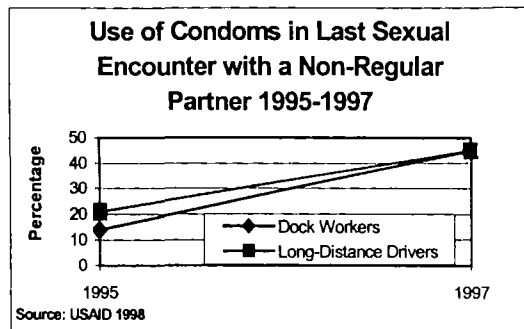
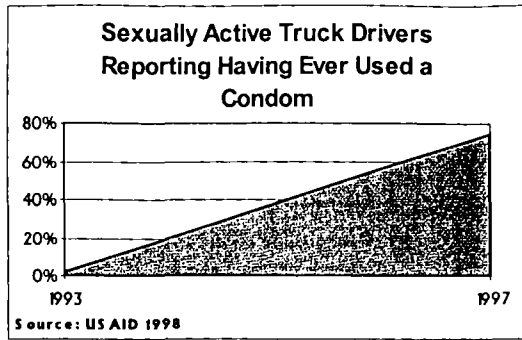
External assistance was often given through nongovernmental organizations instead of to the government, and donors provided considerable in-kind contributions.

USAID's HIV/AIDS funding for FY 1998 was \$3.8 million. In addition, a Special Objective to improve HIV/AIDS prevention and control was allocated \$1 million in 1998.

Since 1994, due to sanctions against the Nigerian government, USAID has been providing support through waivers and working exclusively through NGOs. The current strategy combines efforts to strengthen NGO management and build

sustainability with technical support in child survival, family planning, and HIV/AIDS prevention. To address women's lack of power in sexual situations and the vulnerability of youth, the program provides peer support and training in negotiation skills for women and young people.

HIV/AIDS activities of the Special Objective have focused on condom social marketing; behavior change communication (BCC) strategies targeting high-risk groups; behavioral research on sexuality and STDs in adolescents; training to improve treatment and prevention of STDs; support for community- and home-based care; and



involvement of PLWHA in BCC at the community level.

Building on these efforts, USAID is also working through Family Health International to strengthen the private sector response to HIV. Another area of emphasis is improving the monitoring and evaluation of HIV/AIDS prevention, care, and support activities in Nigeria.

The Department for International Development (DFID) supports prevention and care activities through NGOs. The Society for Family Health (SFH), the local affiliate of Population Services International, implements a three-year, \$5.9-million social marketing project. In Benue State, Pathfinder International targets in-school youth,

sex workers, and PLWHA. DFID provided in-kind donations of HIV antibody testing kits and reagents, STD laboratory reagents, condoms, and needs assessments for ELISA machines. Current projects include HIV/AIDS counseling training for Christian health institutions, training sex workers as peer educators, and maintenance and repair of testing equipment.

The Ford Foundation provides capacity building for NGOs and supports HIV prevention work through NGOs, targeting in-school youth, poorly educated women, and prisoners. The foundation has sponsored AIDS research, information dissemination, and community-based education.

The John D. and Catherine T. MacArthur Foundation supports educational efforts to prevent and control the spread of HIV/AIDS and STDs through the STOPAIDS organization. It also funded research to investigate how to improve STD treatment and service utilization among teenagers. The foundation sponsored a project on sexuality education and STD prevention for young people by the Association for Development Options in Nigeria (ADON) and an HIV/AIDS awareness program for men and sex workers by the Nigerian Popular Theater Alliance. It worked with the Nigerian Network on AIDS Prevention, Support, and Care (Ife-Ife) to educate parents and teachers about preventing the spread of HIV among adolescents.

UNAIDS' coordinating theme group in Nigeria, chaired by UNICEF, includes representatives from UNICEF, UNDP, UNFPA, UNESCO, WHO, and the World Bank. Support from the UNAIDS cosponsors in 1996-1997 and 1998-99 included:

Donor	Amount US\$ 1996-97	Amount US\$ 1998-99
UNDP	676,680	125,000
UNAIDS	225,000	400,000
WHO	188,000	50,000
World Bank	42,500	100,000
UNFPA*		150,000
Total	1,132,180	825,000

UNAIDS cosponsor support 1996-1999

*Estimated amount of UNFPA's reproductive health program funds that go toward HIV/AIDS.

WHO provided testing equipment and supplies; collected HIV/STD prevalence data among prisoners; sponsored a workshop on sterilization procedures for traditional circumcision and tribalmark practitioners and cosmetologists;

supported (with Chevron) HIV/AIDS prevention and control activities in primary and secondary schools; and sponsored workshops on community home-based care of PLWHA and syndromic management of STDs.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

A number of PVOs implement activities in Nigeria, funded as cooperating agencies (CAs) for multilateral and bilateral donors and foundations. Major USAID CAs include Family Health International, Population Services International, Pathfinder International, and the Center for Development and Population Activities. *See attached preliminary chart for PVO, USAID cooperating agencies, and NGO target areas*

of HIV/AIDS activities. This list is evolving and changes periodically.

Journalists Against AIDS (JAAIDS) Nigeria, formed in 1997 after the death of Fela Kuti, trains journalists and journalism students to encourage accurate HIV/AIDS reporting and publishes a monthly e-mail bulletin. Its members also advocate for improved policy responses to the epidemic.

Challenges

Major constraints to HIV/AIDS control in Nigeria include the following:

- Misconceptions about the epidemic. A growing number of people believe that one can contract HIV from public toilets, mosquitoes, casual contact, or sharing food with PLWHA.
- Lack of government political commitment and financial support. NASCP budgeted \$555,488 for HIV/STD projects in 1996 but disbursed only \$9,756.
- Inadequate supplies of HIV testing kits, accessible and affordable condoms, and drugs for treating STDs and opportunistic infections.
- Limited capacity of the Nigerian government to care for the growing number of PLWHA.
- The NASCP's small technical staff.
- The Petroleum (Special) Trust Fund conducts HIV/AIDS activities instead of channeling funds through the NASCP.
- Sociocultural limitations on sex education.
- Nonfunctioning state-level HIV/AIDS committees, because some states do not have full-time AIDS control coordinators.
- The minimal scale and coverage of prevention efforts, with pilot activities which reach only a small proportion of the population.

- Failure to adequately address specific areas, such as HIV and drug use, female condoms, research, access to antiretroviral treatment, and HIV transmission among men who have sex with men.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Nigeria.

- The HIV/AIDS surveillance system needs to be improved so that the epidemic can be accurately measured.
- A strategic plan has not been developed for the national program since the expiration of the medium term plan in 1997.
- Lack of effective STD services.
- Voluntary counseling and testing (VCT) is not available to most Nigerians.
- There are no programs to prevent vertical transmission of HIV or to support orphans.
- Less than two percent of health institutions provide clinical services for HIV/AIDS patients.
- Lack of coordination with other government programs.
- Lack of involvement of PLWHA in programs.

The Future

Driven by external support and managed by a national body with little power and few resources, Nigeria's prevention efforts have not kept pace with a relentless epidemic. Military rule constricted the environment and motivation for an adequate response. With the new democratic government, greater political support, expansion of participation, and coordination of the national response to HIV/AIDS should be possible.

Strong leadership is required to strengthen prevention and care programs, promote better risk perception and behavior change, and reduce stigma and discrimination against PLWHA.

Giving NASCP autonomy and more funding and technical staff would help achieve these goals. The Nigerian government could involve business by

"The way forward is to call on the Head of State to make a public statement acknowledging that HIV/AIDS is among us, and for the highest office in the land to place HIV/AIDS high on the nation's agenda. It is then and only then that this country will make significant strides in the prevention and control of the epidemic." --Dr. Kenneth Ofose-Barko, UNAIDS Country Programme Advisor (CPA) in Nigeria

providing tax incentives for establishing HIV/AIDS prevention and care programs for employees, their families, and surrounding communities or by establishing laws requiring such programs.

Important Links and Contacts

1. UNAIDS: c/o UNDP Resident Coordinator, 11 Oyinkan Abayomi Drive, Ikoyi, Lagos. Tel: (234 1) 269 2141-3/3396; email: kenneth.ofosubarko@undp.org.ng
2. Journalists Against AIDS, Omolu Falobi, Box 56282 Falomo, Lagos. Tel: (234 1) 497 2815; email: editorial@punch.com.ng
3. The Petroleum (Special) Trust Fund, Chairman/Chief Executive Major-General Muhammadu Buhari and Deputy Director Health Dr. M.D. Ibrahim, Plot 802, Airport Road, Central District P.M.B. 5007, Wuse, Abuja. Tel: (234 9) 5236691-8



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**Population, Health and Nutrition
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Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health



**Implementing AIDS Prevention
and Care (IMPACT) Project**
Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516-9779
Fax: (703) 516-9781
URL: www.fhi.org

NIGERIA AND HIV/AIDS

Key Talking Points

Although Nigeria's HIV prevalence of 4.5 percent is lower than those of many other African countries, the absolute number of people affected is much larger:

- About 5.5 million Nigerians are living with HIV/AIDS.
- Thirteen percent of all HIV-positive Africans live in Nigeria.
- An estimated half a million people became infected in 1998.

AIDS Deaths AIDS has killed more than a half million Nigerians—150,000 of them in 1997. From 1995 to 2015, more people are expected to die of AIDS in Nigeria than in all other African countries except South Africa and Kenya. The epidemic will reduce life expectancy from 55 to 50 by the year 2000.

HIV in Women In 1996, 7 percent of pregnant women in urban antenatal clinics and 4.5 percent of women in all antenatal clinics tested positive for HIV. A 1996 survey of female sex workers found that 35 percent were HIV-positive.

HIV in Youth Almost 19 percent of HIV infections among women attending antenatal clinics are in 16- to 20-year-olds. More than 5 percent of all people in this age group are HIV-positive.

Children and HIV/AIDS In 1998, 140,000 children were living with HIV/AIDS. More than 600,000 have lost parents to AIDS—184,000 of them in 1998.

Socioeconomic Impact Almost 72 percent of HIV infections are among adults younger than 40. The illness and deaths caused by AIDS among people in their most productive years will have a devastating effect on families, communities, businesses, and the struggling national economy.

USAID is one of a few donors to HIV/AIDS programs in Nigeria. In fiscal year 1998 it allocated \$4.8 million for HIV/AIDS, including a \$1-million Special Objective to improve prevention efforts. Due to sanctions against the Nigerian government, the mission has provided all support through waivers and has worked exclusively through nongovernmental organizations.

National Response Driven by external support, constrained by military rule, and managed by a national body with little power and few resources, Nigeria's response to HIV/AIDS has fallen far behind the epidemic. Democratic rule may provide opportunities for greater political support, expanded participation, and improved coordination of the national response. The national HIV/AIDS program needs more autonomy and resources to strengthen prevention and care programs, promote positive behavior change, and reduce stigma and discrimination against people living with HIV/AIDS.



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Nigeria

■ **Epidemiological Fact Sheet**
on HIV/AIDS
and sexually
transmitted
diseases



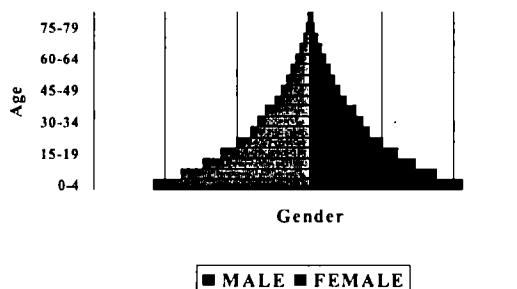
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**World Health
Organization**

Country information

Population pyramid, 1997



UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance

Global surveillance of HIV/AIDS and sexually transmitted diseases (STDs) is a joint effort of WHO and UNAIDS. The UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance, initiated in November 1996, guides respective activities. The primary objective of the working group is to strengthen national, regional and global structures and networks for improved monitoring and surveillance of HIV/AIDS and STDs. For this purpose, the working group collaborates closely with national AIDS programmes and a number of national and international experts and institutions. The goal of this collaboration is to compile the best information available and to improve the quality of data needed for informed decision-making and planning at national, regional and global levels. The Epidemiological Fact Sheets are a first output of this close and fruitful collaboration across the globe.

Following a series of consultations, the working group and its partners established a framework standardizing the collection of data deemed important for a thorough understanding of the current status and trends of the epidemic, as well as patterns of risk and vulnerability in the population. Within this framework, the Fact Sheets collate the most recent country-specific data on HIV/AIDS prevalence and incidence, together with information on behaviours (e.g. casual sex and condom use) which can spur or stem the transmission of HIV. The data include prevention indicators developed by WHO's Global Programme on AIDS, which aim to measure trends in knowledge of AIDS, relevant behaviours, and a host of other factors influencing the epidemic. Additional indicators – for example, on care and support – will be included when available.

Not unexpectedly, information on all of the agreed-upon indicators was not available for many countries in 1997. However, the fact sheets do contain a wealth of information which allows identification of strengths in currently existing programmes and comparisons between countries and regions. The fact sheets may also be instrumental in identifying potential partners when planning and implementing improved systems.

The fact sheets can be only as good as information made available to the UNAIDS/WHO Working Group on Global HIV/AIDS and STD Surveillance. Therefore, the working group would like to encourage all programme managers as well as national and international experts to communicate additional information to the working group whenever such information becomes available. The working group also welcomes any suggestions for additional indicators or information proven to be useful in national or international decision making and planning.

Indicators	Year	Estimate	Source
Total Population (thousands)	1997	118,369	UNPOP
Population Aged 15-49 (thousands)	1997	53,188	UNPOP
Annual Population Growth			
% of Population Urbanized	1996	41	UNPOP
Average Annual Growth Rate of Urban Population	1980-1996	6	UNPOP
Net Migration Rate			
GNP Per Capita (US\$)	1995	260	World Bank
GNP Per Capita Average Annual Growth Rate	1985-1995	1	World Bank
Human Development Index Rank (HDI)		141	UNDP
Real GDP Per Capita Rank - HDI Rank		1	UNDP
Gender Related Development Index Rank		121	UNDP
Gender Empowerment Measure Rank			
Human Poverty Index Value (HPI)		41.6	UNDP
% Population Economic Active			
Unemployment Rate			
Total Adult Literacy Rate			
Adult Male Literacy Rate			
Adult Female Literacy Rate			
Male Secondary School Enrollment Ratio	1990-1995	33	UNESCO
Female Secondary School Enrollment Ratio	1990-1995	28	UNESCO
Crude Birth Rate (births per 1,000 pop.)	1996	43	UNPOP
Crude Death Rate (deaths per 1,000 pop.)	1996	14	UNPOP
Maternal Mortality Rate (per 100,000 live births)	1990	1000	WHO/UNICEF
Life Expectancy at Birth	1996	52	UNPOP
Total Fertility Rate			
Infant Mortality Rate (per 1,000 live births)	1996	114	UNICEF/UNPOP
Under Five Mortality Rate (per 1,000 live births)	1996	191	UNICEF/UNPOP
% Population Access to Safe Water			
% Population Access to Adequate Sanitation			

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Estimated number of people living with HIV/AIDS

In 1997 and during the first quarter of 1998, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates on people living with HIV/AIDS. These calculations are based on the previously published estimates for 1994 (WER 1995; 70:353-360) and recent trends in HIV/AIDS surveillance in various populations. Epimodel 2, a microcomputer programme originally developed by the WHO Global Programme on AIDS, was used to calculate the new estimates on prevalence and incidence of AIDS and AIDS deaths, as well as the number of children infected through mother-to-child transmission of HIV, taking into account age-specific fertility rates. An additional spreadsheet model was used to calculate the number of children whose mothers had died of AIDS.

The current estimates do not claim to be an exact count of infections. Rather, they use a methodology that has thus far proved accurate in producing estimates which give a good indication of the magnitude of the epidemic in individual countries. However, these estimates are constantly being revised as countries improve their surveillance systems and collect more information. This includes information about infection levels in different populations, and behaviours which facilitate or impede infection.

Adults in this report are defined as women and men aged 15 to 49. This age range covers people in their most sexually active years. While the risk of HIV infection obviously continues beyond the age of 50, the vast majority of those who engage in substantial risk behaviours are likely to be infected by this age. Since population structures differ greatly from one country to another, especially for children and the upper adult ages, the restriction of the term adult to 15-to-49-year-olds has the advantage of making different populations more comparable. This age range was used as the denominator in calculating adult HIV prevalence.

Estimated number of adults and children living with HIV/AIDS, end of 1997

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 1997

Adults and children	2300000		
Adults (15-49)	2200000	Adult rate (%)	4.12
Women (15-49)	1100000		
Children (0-15)	99000		

Estimated number of AIDS cases

Estimated number of AIDS cases in adults and children that have occurred since the beginning of the epidemic:

Cumulative no. of AIDS cases	590000
-------------------------------------	---------------

Estimated number of deaths due to AIDS

Estimated number of adults and children who died of AIDS since the beginning of the epidemic:

Cumulative deaths	530000
--------------------------	---------------

Estimated number of adults and children who died of AIDS during 1997:

Deaths in 1997	150000
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Estimated number of orphans

Estimated number of children who have lost their mother or both parents to AIDS (while they were under age 15) since the beginning of the epidemic:

Cumulative orphans	410000
---------------------------	---------------

Estimated number of children who have lost their mother or both parents to AIDS and who were alive and under age 15 at the end of 1997:

Current living orphans	350000
-------------------------------	---------------

HIV Sentinel surveillance

This section contains information about HIV prevalence in different populations. The data reported in the tables below are mainly based on the HIV data base maintained by the United States Bureau of the Census and are a compilation of data from different sources, including national reports, scientific publications and abstracts. To provide for a simple overview of the current situation and trends over time, summary data are given by population group, geographical area (Major Urban Areas versus Outside Major Urban Areas), and year of survey. Studies conducted in the same year are aggregated and the median prevalence rates (in percentages) are given for each of the categories. The maximum and minimum prevalence rates observed, as well as the total number of surveys/sentinel sites, are provided with the median, to give the reader an overview of the diversity of HIV-prevalence results in a given population within the country.

The differentiation between the two geographical areas Major Urban Areas and Outside Major Urban Areas is not based on strict criteria, such as the number of inhabitants. For most countries, Major Urban Areas were considered to be the capital city and – where applicable – other metropolitan areas with similar socio-economic patterns. This distinction assumes that capital cities in many countries have specific characteristics related to the prevalence of higher risk behaviour and a concentration of HIV infections. The term Outside Major Urban Areas considers that most sentinel sites are not located in strictly rural areas, even if they are located in somewhat rural districts. Site/study-specific data on which the medians were calculated are printed in an annex at the end of this fact sheet.

HIV prevalence in selected populations in percent

Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Pregnant women	Major Urban Areas	N_Sites			1			1		2	1		1			
		Minimum			0			1		0.8	1.9		6.7			
		Median			0			1		3.15	1.9		6.7			
		Maximum			0			1		5.5	1.9		6.7			
Pregnant women	Outside Major Urban Areas	N_Sites				1	1	1	1		10	15				
		Minimum				0	1.7	0	0.2		0	0.21				
		Median				0	1.7	0	0.2		0.84	2.42				
		Maximum				0	1.7	0	0.2		5.77	8.15				
Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Sex workers	Major Urban Areas	N_Sites						1		1			1			
		Minimum						1.7		12.3			29.11			
		Median						1.7		12.3			29.11			
		Maximum						1.7		12.3			29.11			
Sex workers	Outside Major Urban Areas	N_Sites				1	1		1		7	10				
		Minimum				0.5	0.5		3.9		0.9	5.53				
		Median				0.5	0.5		3.9		13.4	23.71				
		Maximum				0.5	0.5		3.9		44.12	46.52				
Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Injecting drug users	Major Urban Areas	N_Sites														
		Minimum														
		Median														
		Maximum														
Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
STD patients	Major Urban Areas	N_Sites														
		Minimum														
		Median														
		Maximum														
Group	Area		1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Truck drivers	Outside Major Urban Areas	N_Sites									1		1			
		Minimum									1.6		4			
		Median									1.6		4			
		Maximum									1.6		4			

Assessment of epidemiological situation

Assessment of country epidemiological situation

Some HIV seroprevalence information among antenatal clinic attendees has been available since the mid-1980s from Nigeria. However, reporting from more than one or two sites per year did not begin until 1991-92. By 1993-94 10 major urban sites were reporting HIV prevalence among antenatal clinic women. HIV prevalence remained low for many years in Nigeria. But, by 1988-90, 1 percent of antenatal women in the major urban areas tested positive for HIV. By 1993-94, a median of nearly 4 percent of antenatal women in major urban areas tested positive. Among these sites, rates ranged from a low of 0.2 percent to 10 percent of antenatal women tested.

By 1991-92, 20 sites from 10 states outside of the major urban areas were reporting HIV prevalence from sentinel surveillance of antenatal women. In 1993-94 the number of sites had increased to 33 from 14 states. HIV prevalence among antenatal women tested at these sites increased from less than 1 percent in 1991-92 to over 2 percent in 1993-94. However the range of HIV prevalence rates went from no evidence of HIV infection to 13 percent of antenatal women tested.

There is some limited information available on HIV prevalence among sex workers starting in the mid-1980s. Testing of sex workers in Lagos began in 1988-89. Two percent of sex workers tested at that time were HIV positive and increased to 12 percent in 1990-91. By 1993-94, 6 major urban sites were reporting information on HIV prevalence among sex workers including Lagos, and Kano. At that time, a median of 22 percent of sex workers tested were HIV positive with a range of 10 to 46 percent.

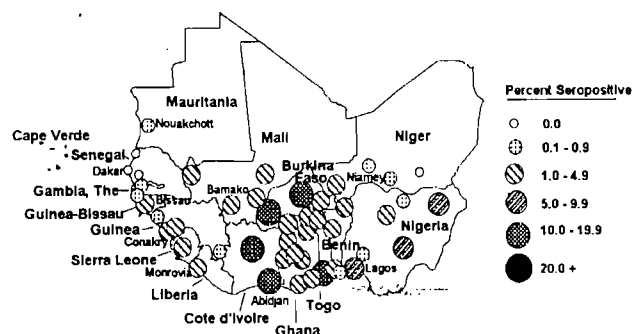
In 1986, less than 1 percent of sex workers tested in Borno State were HIV positive, by 1989-90, 4 percent of sex workers tested HIV positive. In 1991-92, 14 sites outside of the major urban centers were reporting information on HIV prevalence among sex workers. At that time, a median of 12 percent of sex workers tested were HIV positive, the prevalence among these sites ranged from no evidence of HIV infection to over 50 percent of sex workers tested. In 1993-94, 16 sites were reporting a range of prevalence among sex workers of no evidence of infection to nearly 60 percent of sex workers tested.

There is no information available on HIV prevalence among male STD clinic patients.

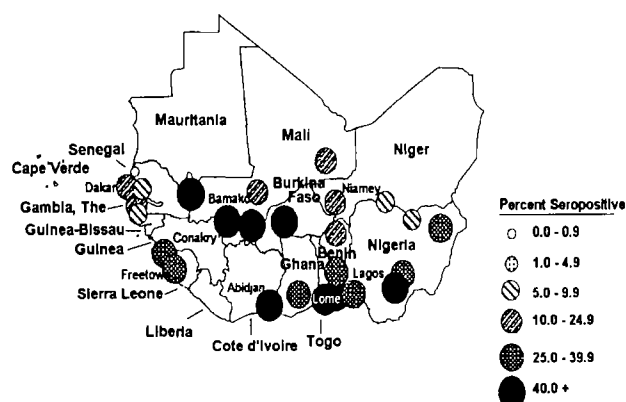
In 1993-94, 4 percent of long distance truck drivers tested in Anambra State were HIV-1 infected.

Regional maps

Seroprevalence of HIV-1 for Pregnant Women in West Africa



Seroprevalence of HIV-1 for Sex Workers in West Africa



Reported AIDS cases

AIDS cases by year of reporting

1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total	Unknown
0	0	0	0	0	0	0	2	2	3	52	146	206	412	719	2048	5378	3527	4571		17266	

Date of last report: 30-Aug-1997

AIDS cases officially reported to WHO. Due to gaps in diagnosis, underreporting, and reporting delays, officially reported AIDS cases represent only a portion of all cases in a country. Completeness of reporting varies substantially from one country to another, from less than 10% in some countries with fewer resources to more than 80% in most industrialized countries (please also compare with the section on estimates). Therefore, distribution by age, sex and modes of transmission may not be representative for all people living with AIDS in a given country.

AIDS cases by mode of transmission

Hetero: Heterosexual contacts.

Homo/Bi: Homosexual contacts between men.

IDU: Injecting drug use. This transmission category also includes cases in which other high-risk behaviours were reported, in addition to injection of drugs.

Blood: Blood and blood products.

Perinatal: Vertical transmission during pregnancy, birth or breastfeeding.

NS: Not specified/unknown.

Sex	Trans. group	<94	94/<95	1995	1996	1997	1998	Unkn.	Total	%
All	All									
	Hetero									
	Homo/Bi									
	IDU									
	Blood									
	Perinatal									
	Other known									
	Unknown									
Male	All									
	Hetero									
	IDU									
	Blood									
	Other known									
	Unknown									
Female	All									
	Hetero									
	IDU									
	Blood									
	Other known									
	Unknown									
NS	All									
	Hetero									
	IDU									
	Blood									
	Perinatal									
	Other known									
	Unknown									

AIDS cases by age and sex

Sex	Age	<1994	94/<95	1995	1996	1997	1998	Unkn.	Total	%
All	All			5201						
	0-4			33						
	5-14			25						
	15-19			141						
	20-29			1015						
	30-39			547						
	40-49			212						
	50-59			71						
	60+			41						
	NS			3116						
Male	All			2184						
	0-4			20						
	5-14			8						
	15-19			49						
	20-29			470						
	30-39			308						
	40-49			103						
	50-59			20						
	60+			26						
	NS			1180						
Female	All			1665						
	0-4			9						
	5-14			7						
	15-19			87						
	20-29			431						
	30-39			175						
	40-49			71						
	50-59			44						
	60+			10						
	NS			831						
NS	All									
	0-4									
	5-14									
	15-19									
	20-29									
	30-39									
	40-49									
	50-59									
	60+									
	NS									

Curable STDs

Control and prevention of sexually transmitted diseases (STD) have been recognized as a major strategy in the prevention of HIV infection and ultimately AIDS. Consequently, monitoring different components of STD control can also provide information on HIV prevention within a country. One of the cornerstones of STD control is adequate management of patients with symptomatic STDs. This includes diagnosis, treatment, and individual health education and counselling on disease prevention and partner notification.

Estimated incidence and prevalence of curable STDs

STDs	Incidence				Prevalence			
	Year	Male	Female	All	Year	Male	Female	All
Chlamydia trach.					1994			
Gonorrhoea					1994			18.03
Syphilis					1994			2.28
Trichomonas					1994			
Comments	Rate in percent (%).							
Source								

STD Incidence, men

Prevention Indicator 9: Proportion of men aged 15-49 years who reported episodes of urethritis in the last 12 months.

Year	Area	Age	Rate	N=
n/a				
n/a				

Comments:

Sources:

STD Prevalence, women

Prevention Indicator 8: Proportion of pregnant women aged 15-24 years attending antenatal clinics whose blood has been screened with positive serology for syphilis.

Year	Area	Age	Rate	N=
1994	All		3.8	

Comments:

Sources: Evaluation of the impact of AIDS/STD Control Programme interventions in Nigeria.

STD Case management (counselled)

Prevention Indicator 7: Proportion of people presenting with STD or for STD care in health facilities who received basic advice on condoms and on partner notification.

Year	Area	Age	Rate	N=
n/a				
n/a				

Comments:

Sources:

STD Case management (treatments)

Prevention Indicator 6: Proportion of people presenting with STD in health facilities assessed and treated in an appropriate way (according to national standards).

Year	Area	Age	Rate	N=
n/a				
n/a				

Comments:

Sources:

Health service indicators

HIV-prevention strategies depend on the twin efforts of care and support for those living with HIV or AIDS, and targeted prevention for all people at risk or vulnerable to the infection. These efforts may range from reaching out to vulnerable communities through large-scale educational campaigns or interpersonal communication; provision of treatment for STDs; distribution of condoms and needles; creating an enabling environment to reduce risky behaviour; voluntary testing and counselling; home or institutional care for persons with symptomatic HIV infection; and preventing perinatal transmission and transmission through infected needles or blood in health care settings. It is difficult to capture such a large range of activities with one or just a few indicators. However, a set of well-established health care indicators -- such as the percentage of a population with access to health care services; the percentage of women covered by antenatal care; or the percentage of immunized children -- may help to identify general strengths and weaknesses of health systems. Specific indicators, such as access to testing and blood screening for HIV, help to measure the capacity of health services to respond to HIV/AIDS-related issues.

Access to health care

Indicators	Year	Estimate	Source
% of Pop. with access to health services - total:			
% of Pop. with access to health services - urban:			
% of Pop. with access to health services - rural:			
Contraceptive prevalence rate (%):			
% of births attended by trained health personnel:			
% of pregnant women immunized against tetanus:	1995-1996	36	UNICEF
% fully immunized - Tuberculosis:	1995-1996	49	UNICEF
% fully immunized - DPT:	1995-1996	28	UNICEF
% fully immunized - Polio:	1995-1996	32	UNICEF
% fully immunized - Measles:	1995-1996	45	UNICEF
Proportion of blood donations tested:			
% of ANC clinics where HIV testing is available:			
HIV/AIDS Hospital Occupancy Rate (Days):			

Latex condoms are the only technology available that can prevent sexual transmission of HIV/STD. Persons needing protection in situations that carry risk should have consistent access to high quality condoms. National AIDS Programmes implement activities to increase both availability of and access to condoms. The two condom availability indicators below are intended to highlight areas of strength and weakness at the beginning and at the end of the distribution system so that programmatic resources can be directed appropriately to problem areas.

Condom availability (central level)

Prevention Indicator 2: Availability of condoms per capita in the country over the last 12 months (central level).

Year	Area	N	Rate
1994			1.5

Comments:

Sources: Evaluation of the impact of AIDS/STD Control Programme interventions in Nigeria.

Condom availability (peripheral level)

Prevention Indicator 3: Proportion of people who can acquire a condom (peripheral level).

Year	Area	N	Rate
n/a			

Comments:

Sources:

Knowledge and behaviour

Information on knowledge and behaviour related to HIV/AIDS is essential in identifying populations at risk for HIV infection. It is also critical in assessing changes over time as a result of prevention efforts. Guidelines and recommendations have been published in the publication: "Evaluation of a National AIDS Programme: A methods package. 1. Prevention of HIV infection. WHO/GPA/TCO/SEF/94.1 Geneva, 1994".

Knowledge of HIV-related preventive practices

Prevention Indicator 1: Proportion of people citing at least two acceptable ways of protection from HIV infection.

Year	Area	Age group	Male	Female	All
n/a		15-19			
n/a		20-24			
n/a		25-49			
n/a		15-49			

Comments:

Sources:

Reported non-regular sexual partnerships

Prevention Indicator 4: Proportion of sexually active people having at least one sex partner other than a regular partner in the last 12 months.

Year	Area	Age group	Male	Female	All
1990	South-Western	15+			18

Comments: A very large proportion of the sample refused to answer to that question (N=2327, 31% of the sample).

Sources: KABP/Behavioural Studies - GPA, 1992

Reported condom use in risk sex (gen pop)

Prevention Indicator 5: Proportion of people reporting the use of a condom during the most recent intercourse of risk.

Year	Area	Age group	Male	Female	All
1994	All	15-49			7.5
n/a		15-19			
n/a		20-24			
n/a		25-49			

Comments:

Sources: Evaluation of the impact of AIDS/STD Control Programme interventions in Nigeria.

Knowledge and behaviour

■ Ever use of condom

Percentage of people who ever used a condom.

Year	Area	Age group	Male	Female	All
1990	All	15-19		1.6	
1990	All	20-24		4.6	
1990	All	25-29		3.8	
1990	All	30-34		1.9	
1990	All	35-39		1.6	
1990	All	40-44		1	
1990	All	45-49		1	
1990	All	Total		2.5	

Comments: All women

Sources: Demographic and Health Survey

■ Median age at first sexual intercourse

Median age of people at which they first had sexual intercourse.

Year	Area	Age group	Male	Female	All
1990	All	20-24		16.6	
1990	All	45-49		16.5	
n/a		25-49			

Comments:

Sources: DHS/1990

■ Adolescent pregnancy

Percentage of teenagers 15-19 who are mothers or pregnant with their first child.

Year	Area	Age group	Rate	N
1990	All	15	13.1	373
1990	All	16	20.8	322
1990	All	17	30.2	326
1990	All	18	39.3	333
1990	All	19	42.8	259

Comments:

Sources: DHS/1990

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Annex: HIV Surveillance data by site

Group	Area		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Pregnant women	Outside Major Urban Areas	Adamawa									1.26				
		Anambra									2.11				
		Benue								1.63	4.62				
		Borno									6.45				
		Cross River								0	4.08				
		Delta								0.76	5.13				
		Edo								0	1.8				
		Enugu								1.35	3.68				
		Jigawa								5.77					
		Kaduna								0.92	4.64				
		Kano								1.93	0.52				
		Kwara									2.42				
		Maiduguri			0	1.7	0	0.2							
		Osun								0	1.29				
		Oyo								0.12	0.21				
		Plateau									8.15				
		Sokoto									1.63				
	Major Urban Areas	Ibadan		0					5.5						
		Lagos					1		0.8						
		Lagos state								1.9		6.7			
Sex workers	Outside Major Urban Areas	Adamawa									20.94				
		Anambra									5.53				
		Benue								34.6	46.52				
		Borno									25.68				
		Borno state			0.5	0.5		3.9							
		Cross River								13.4					
		Delta								0.9	21.94				
		Edo								1.6					
		Enugu								18.1	40.32				
		Jigawa								44.12					
		Kano								10.5	6.23				
		Kwara									15				
		Osun									39.33				
		Plateau									25.48				
	Major Urban Areas	Lagos					1.7								
		Lagos state							12.3		29.11				
Injecting drug users	Major Urban Areas														
STD patients	Major Urban Areas														
Truck drivers	Outside Major Urban Areas	Anambra state									4				
		Not specified								1.6					

Notes:

AUG 24 2000 12:32 PM FR LONG ALDRIDGE & NORMAN 24 1298 TO *448790419,45624 P.01

D- Pigula

LONG ALDRIDGE & NORMAN^{LLP}

ATTORNEYS AT LAW

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FROM:	Karen Anderson	SENDER'S PHONE NUMBER:	202/624-1246
DATE:	August 24, 2000		
NUMBER OF PAGES (INCLUDING COVER):	3		

MESSAGE:

Sandy - I made some quick revisions, my apologies.

Thanks

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BIOTECHNOLOGY IN NIGERIA

The Need for Biotechnology

Through the development of staple crops that can withstand disease, use fewer pesticides and produce higher yields on less land, biotechnology may become a valuable tool in combating malnutrition and environmental degradation on the African continent. Furthermore, innovations such as Vitamin A-enriched foods can help protect future generations from debilitating illnesses such as river blindness, and could even work as nutritional supplements in the fight against infectious diseases such as malaria and HIV/AIDS.

Background

President Obasanjo, a farmer by trade, has been an outspoken advocate for biotechnology in Nigeria since his inauguration last year. Key priorities of his administration include improving agricultural productivity and bettering the nutritional content of mainstay diets. Once admired throughout the African continent, Nigerian agriculture fell into disarray during the years of military rule.

In an effort to promote productivity, President Obasanjo has recently engaged in dialogue with the Carter Center's Sasakawa Global 2000 campaign, the Donald Danforth Plant Science Center in St. Louis, Monsanto Company, and DuPont/Pioneer regarding new technologies, including biotechnology, for Nigeria's agricultural sector.

In April 2000, at the written request of President Obasanjo, Monsanto hosted a 12-member delegation to the U.S. for the purpose of learning more about biotechnology and our domestic regulatory structure. The delegation, led by the Minister of Science and Technology, visited Monsanto Headquarters in St. Louis, the Missouri Botanical Gardens, and the Donald Danforth Plant Science Center to meet with scientists on this issue. Furthermore, the delegation traveled to D.C. and met with various members of Congress, Science Advisor Neal Lane, USDA Deputy Secretary Richard Rominger, and numerous other officials at USDA, FDA and EPA about U.S. regulatory policy toward biotechnology. As a follow-up to that visit, Nigeria's Minister of Science and Technology invited U.S. business representatives to Ibadan in May to discuss biotechnology's potential for the Nigerian seed industry.

More recently, Ambassador Andrew Young visited Abuja in August with U.S. biotechnology industry representatives for in-person meetings with President Obasanjo and members of his cabinet to discuss opportunities for technology transfers, scientist training and other support for promoting biotechnology in Nigeria. President Obasanjo has written to President Clinton in response to these meetings to request U.S. government assistance in bringing biotechnology to Nigeria. Specifically, President Obasanjo is seeking support for the development of Vitamin A-enriched maize for Nigeria, similar to the "golden rice" which has been developed for Asia.

Current Activity

There are already numerous biotechnology applications in Sub Saharan Africa, which are successfully producing food and cash crops. Examples of these include:

- ⇒ In South Africa, pest resistant cotton and maize are in production;
- ⇒ In Zimbabwe, field trials of pest resistant cotton are underway; and
- ⇒ In Kenya, virus resistant sweet potatoes were recently approved for field trial and approval is pending for pest resistant maize.

In Nigeria, consultation is underway with Monsanto and the Danforth Plant Science Center to test a virus resistant cassava developed through biotechnology.

From a regulatory perspective, the Ministry of Justice has developed draft biosafety guidelines, which are currently undergoing inter-ministerial and legislative review, which will allow for the commercial introduction of biotechnology applications in Nigeria.

Healthy Harvest Foundation

At the request of Ambassador Young, President Obasanjo has agreed to serve on the Board of Advisors for a foundation called "Healthy Harvest," which is in the process of being established with the support of U.S. biotechnology interests. Ambassador Young's goal with this project is to find a mechanism for developing capacity for biotechnology in Africa. In addition to President Obasanjo, President Moi of Kenya, President Museveni of Uganda, and Vice President Atta-Mills of Ghana have agreed to lend their support for Healthy Harvest.

Healthy Harvest, which will be established as a public charity in the U.S. through diverse contributions, has a targeted three-fold mission:

1. to provide an institutional mechanism for sharing proprietary technologies with African countries through an independent technology transfer mechanism;
2. to establish information-sharing and scientific training initiatives for improving the decision-making and regulatory capacity of African countries; and
3. to establish a grant-making initiative for supporting research and development, training and technical partnerships between African institutions and advanced laboratories abroad, and improved infrastructure for the development of locally relevant biotechnology products.

Ambassador Young has already talked with officials of Monsanto Company and asked that their initial contribution of proprietary technology to Healthy Harvest potentially focus on the development of beta-carotene enhanced crops to reduce Vitamin A deficiency on the African continent. Such a donation would be similar to Monsanto's ongoing initiative in India with a local not-for-profit research partner to improve the beta-carotene content of mustard oil. The mustard oil project was undertaken as part of First Lady Hillary Rodham Clinton's global Vitamin A partnership program with the Tata Energy Research Institute in New Delhi.

HIV/AIDS

IN

NIGERIA:

SITUATION / RESPONSE

Presentation of the

NATIONAL ACTION COMMITTEE ON AIDS

THE PRESIDENCY

*ROOM 3A 1.148, FEDERAL SECRETARIAT, SHEHU
SHAGARI WAY, ABUJA. E-mail: naca@inct-global.com*

AUGUST 25 – 27, 2000.

Presentation of the National Action
Committee on AIDS to the Technical and
Business Subcommittee on the Visit of
President Clinton to Nigeria.

August 25 – 27, 2000

By

Prof. Ibironke Akinsete

INTRODUCTION

- *Nigeria is a West African country with a population of 108.2 million (1996 estimate) and an annual growth rate of 2.83% spread over 250 ethnic groups. The country which for over 25 years was under military rule elected a democratic government one year ago. It is divided into 36 states with a Federal Capital Territory and 774 Local Government Areas (LGAs). These are grouped into 6 geopolitical zones.*

SITUATION ANALYSIS/THE RESPONSE

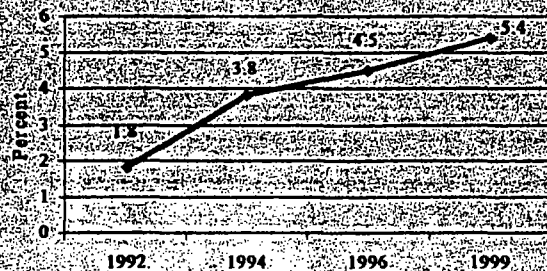
- * The first case of AIDS was formally reported in 1986 and since then the trend of the epidemic indicates a consistent increase in HIV prevalence rate from 1.8% in 1993, to 3.8% in 1994, to 4.5% in 1996 and to 5.4% in 1999.*
- * The highest prevalence rate is in the young age group, 19-24 years. It is estimated that already 2.6 million adults are infected (about 8% of the global burden).*

The situation Analysis carried out in January 2000 in the six zones showed that STD/HIV/AIDS has unfortunately not been sufficiently addressed in the past due to:

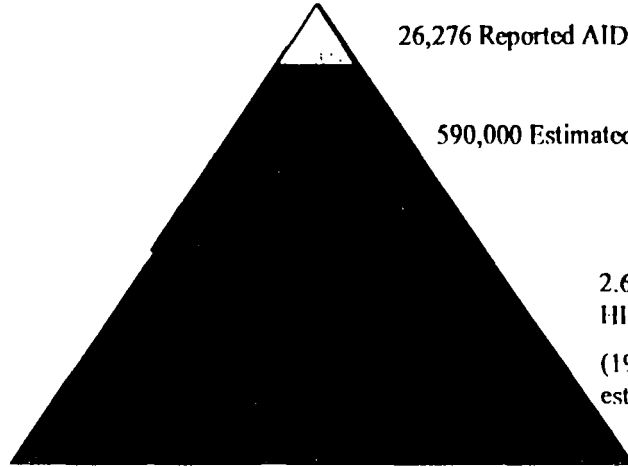
- * Unstable political situation
- * Lack of political will, commitment and involvement
- * Competing priorities in other areas
- * Lack of multi-sectoral approach as major interventions so far are in the area of healthcare delivery.
- * Centralization of the program with little involvement of states, local government and communities
- * Major intervention programs are donor driven and not sufficiently coordinated.
- * Weaknesses in general planning and programming

- Poor financial support
- Weaknesses in management issues and systems
- Insufficient nationwide awareness
- Discrimination against PLWHA
- Human rights issues not sufficiently addressed
- AIDS is still regarded entirely as a health problem
- Behavioural, cultural and economic sectors not addressed
- NGOs and CBOs work not sufficiently documented

Prevalence Increase 1992-1999



The HIV/AIDS Pyramid

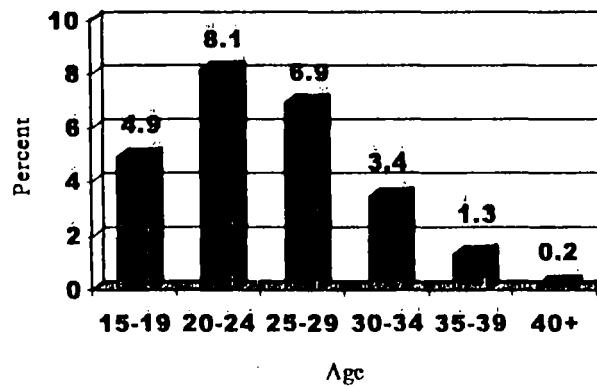


26,276 Reported AIDS Cases (June, 1999)

590,000 Estimated Actual AIDS Cases

2.6 million Adults with HIV Infection
(1999 Sentinel Survey estimate)

HIV Prevalence and Age, 1999



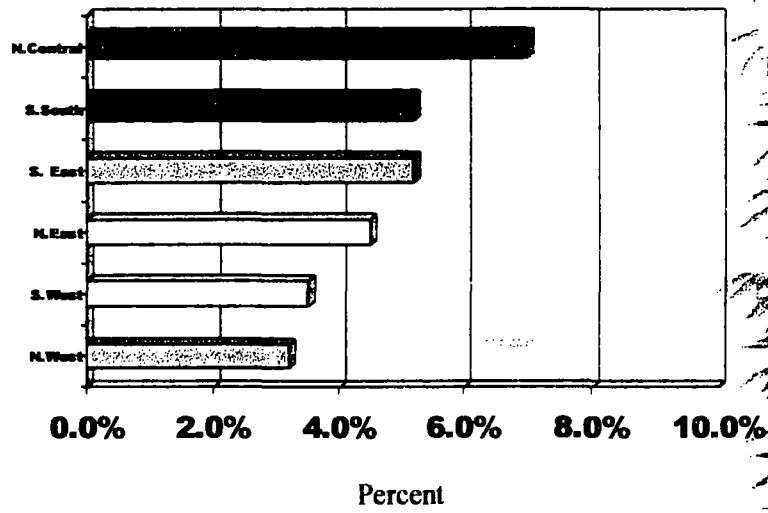
Zonal hotspots

Zone	Prevalence rate in youth (20-24)	Hotspot state	Prevalence Rate in Hotspot State
S. East	8.4	Ebonyi	11.1
S West	4.3	Osun	4.7
N West	4.5	Kaduna	15.0
N. Central	9.5	Benue	21
N. East	3.6	Taraba	7.0
S. West	3.5	Lagos	7.0
S. South	6.8	Akwa Ibom	13.3

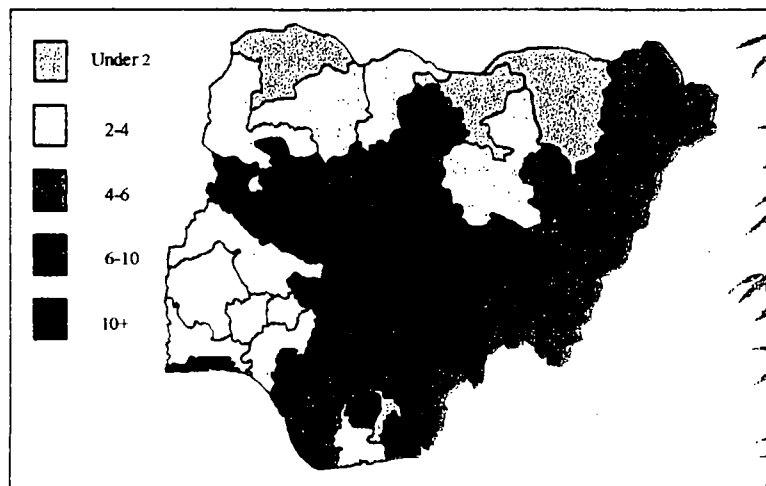
NATIONAL PREVALENCE AMONG SPECIFIC SENTINEL GROUP

Sentinel Group	1991/92	1993/94	1995	1999
Antenatal Clinic Attendees	1.4%	3.8%	4.5%	5.4%
STD Patients	4.6%	8.9%	14.1%	-
T.B Patients	2.2%	7.9%	13.1%	-
CSWs	17.5%	22.5%	34.2%	-

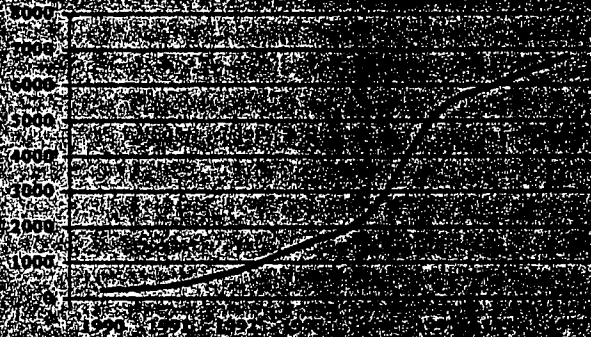
HIV Prevalence by Zone, 1999



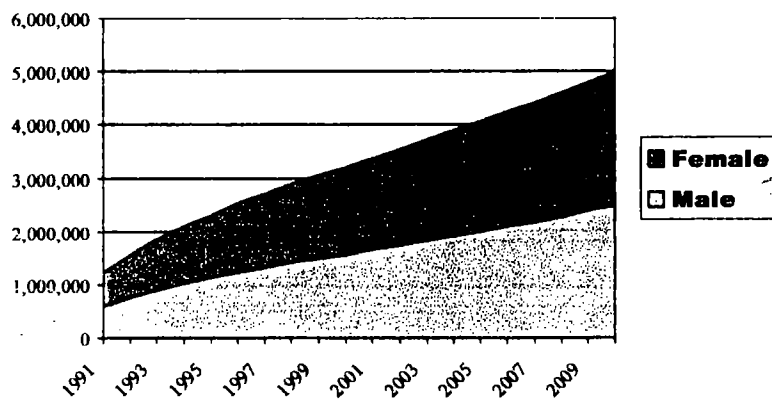
HIV Prevalence by State, 1999



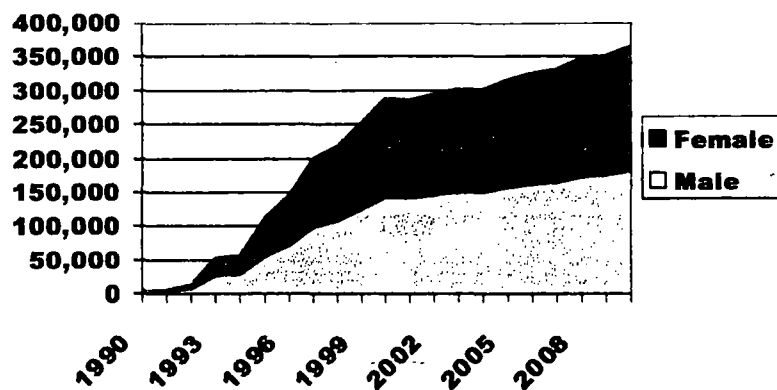
Cumulative Reported AIDS Cases: 1990 - 1997



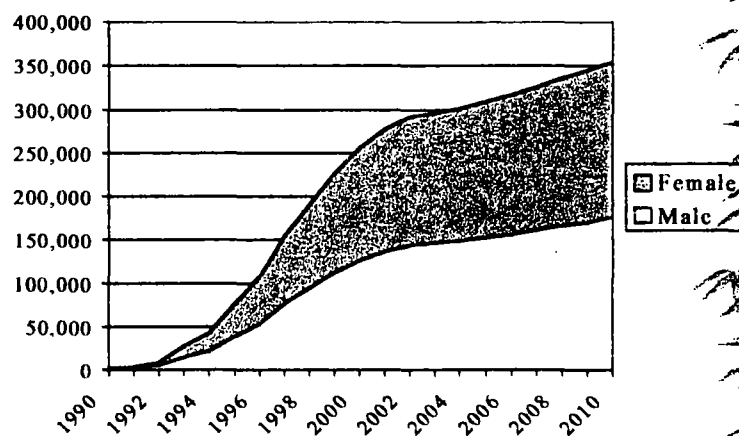
Projected HIV + Population Aged 15 -49



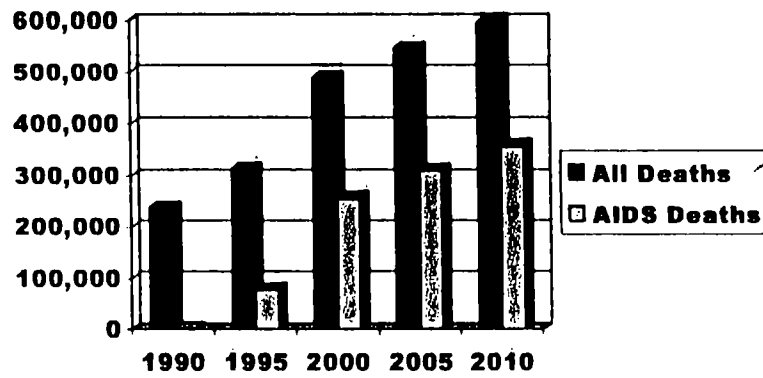
Projected Annual Number of New AIDS Cases



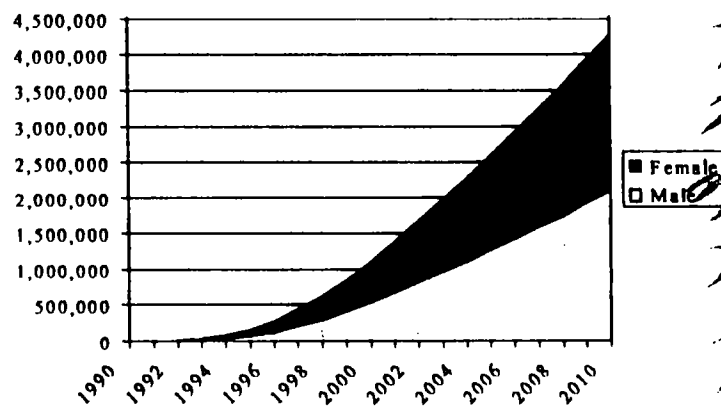
Projected Annual AIDS Deaths



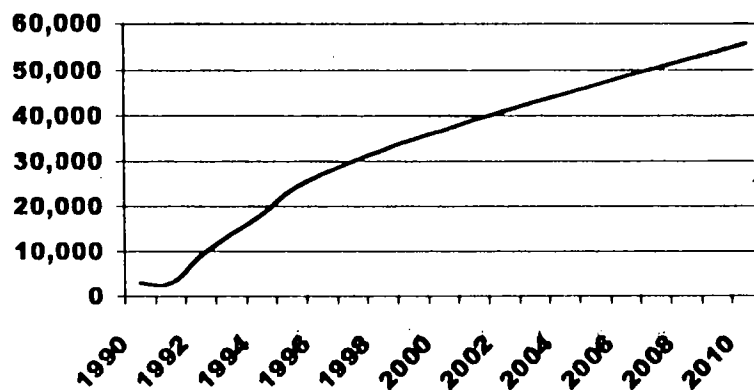
AIDS Deaths vs. All Deaths Among the Population 15-49



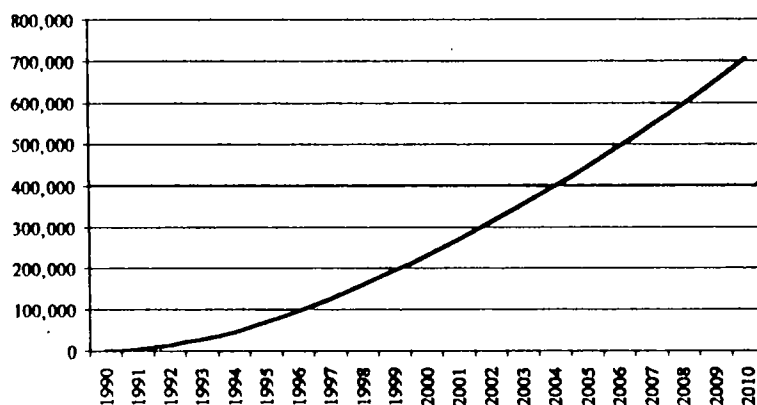
Projected Cumulative Deaths due to AIDS



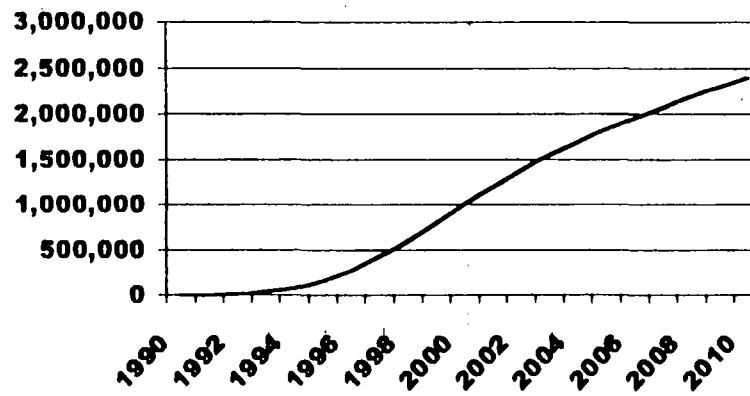
Projected Annual Child Deaths due to AIDS



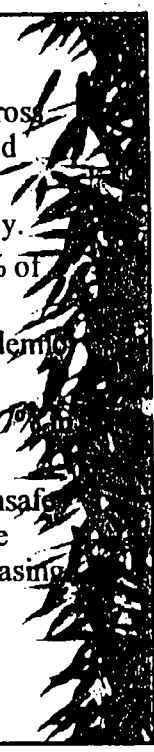
Projected Cumulative Child Deaths due to AIDS



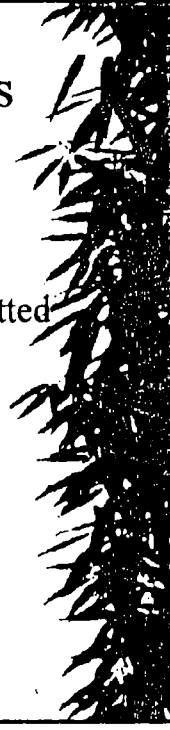
Projected Number of AIDS Orphans



The Implication of the Statistics?

- 
- Nigeria is the first populous country in the world to cross the 5% prevalence mark. This is a significant threshold based on the epidemiological experience elsewhere.
 - At this point the epidemic tends to take off explosively.
 - In Nigeria 2.6M adults are already infected. (9 – 10 % of the global burden)
 - HIV/AIDS epidemic further complicated by dual epidemic of TB and AIDS.
 - Rising prevalence of HIV among TB patients from 8.7% in 1994 to 13.6% in 1996.
 - Principal mode of Transmission, 80% sexual, 10% unsafe blood transfusion, mother to child transmission on the increase and drug injecting populations are also increasing

Factors driving national epidemics

- 
- Safety of blood products
 - Prevalence of tuberculosis
 - Prevalence & incidence of sexually Transmitted infections
 - Commercial sex industry
 - National and individual awareness and commitment
 - Access to Health education and Primary prevention
 - Access to quality care and treatment

- Low perception of risk especially among Men and youth
- Cultural attitude affecting Women
- Worsening economic situation
- Deteriorating health services
- Level of education and poverty in community
- Conflict situation e.g Wars, Migration

An Effective response versus the consequences of inaction

Elements of an effective national response	Potential Consequences of inaction in Nigeria
• Government commitment, attention and funding.	• Rapid increase in HIV prevalence
• Integration of HIV/AIDS into Poverty Reduction Strategy at the Goal Level	• Deepening poverty
• National prevention based on evidence of what works	• Reversal of development gains: reduced life expectancy, increased adult death rates and increased infant mortality rates
• Affordable care, support and impact mitigation	• Loss of skilled personnel: crisis in the public and private sectors as well as the armed forces
• Locally relevant scientific research • Policy changes to mitigate public and private impact	• Over-stretched health care system

Socio-economic burden

- Decreased life expectancy
- Deteriorating child survival
- Orphan hood
- Cost of screening
- Cost of care
- Scale of infected and affected persons
- Cost of medical care
- Death of prime-age persons
- Large ancillary cost
- National stability

The Response in the past focused on

- • *advocacy,*
- • *establishment of national, state and LGA control programmes,*
- • *IEC targeting specific groups and the general population,*
- • *blood safety,*
- • *sentinel sero-prevalence studies,*
- • *Institutional strengthening and capacity building of health workers, condom social marketing,*
- • *development of national policy on HIV/AIDS/STI control,*
- • *guidelines on counseling,*
- • *case management,*
- • *STI syndromic management,*
- • *Integration of HIV/AIDS/STI control activities into Primary Health Care, Initiation of multi-sectoral approach,*
- • *Involvement of rural extension workers,*
- • *development of materials for schools (primary and secondary), establishment of NGO and PLWA networks.*

These attempts did not adequately address the problem due to

- * • *Unfavourable political climate,*
- * • *Lack of political will and commitment,*
- * • *Competing priorities,*
- * • *inadequate implementation of multi-sectoral approach,*
- * • *Lack of effective coordination mechanism at government, NGO and donor levels,*
- * • *Poor funding (donor driven)*
- * • *Limited coverage and lack of decentralization.*

The current response, strengthened by political commitment at the highest level of government, has adopted a two track approach:

- * • *an Interim Action Plan (IAP) to undertake activities in the next 18-24 months*
- * • *establishment of a highly participatory mechanism to prepare a National Strategic Plan (NSP). To implement these,*

The Political Commitment at the highest level has resulted in the inauguration of:

(a) An inter-ministerial committee, the Presidential Action Committee on AIDS (PAC) with the President himself as chairman. Its terms of reference include:

- * • Advocacy***
- * • Resource mobilization***
- * • Policy formulation***

(b) A multi-sectoral National Action Committee on AIDS (NACA) in which the following sectors are represented: Public sector (ministries), private sector, NGOs and People Living With AIDS (PLWAs). It's terms of reference include:

- advocacy***
- policy formulation***
- coordination of all sectors***
- resource mobilization***
- supervision***
- monitoring and evaluation***
- capacity building (formation of "critical mass" in each sector)***

***THE INTERIM ACTION PLAN (IAP) has
prioritized key areas as :***

- • *Removal of barriers to large scale response*
- • *Promotion of behaviour change*
- • *National mobilization*
- • *Targeted advocacy*
- • *Legislation*
- • *Generation and utilization of technical information*
- • *Ensuring adequate resources*
- • *Improving accountability and transparency*
- • *Improving availability of drugs and materials*
- • *Developing institutional capacity*
- • *Care and support of persons infected (PLWAs) and affected by HIV/AIDS*
- • *Implementation of the national blood transfusion policy*
- • *Development of strategy for voluntary counseling and testing*
- • *Prevention of maternal-child transmission*

THE NATIONAL STRATEGIC PLAN (NSP)

The process for developing the NSP involves

- *• The Situation Analysis***
- *• Analysis of the Response***

These have been completed and widely circulated. Comments are being received and will be utilized in the formulation of the NSP. The development of NSP will be done concurrently with the IAP which will also fit into it.

DECENTRALISATION

- *A multi-sectoral approach will also be adopted at the State and LGA levels to form the State Action Committee on AIDS (SACA) and the Local Government Action Committee on AIDS (LACA).*

To do this, the following will be required:

- *Visits to states to advocate for the formation of a multi-sectoral committee to implement the IAP and NSP.*
- *Guidelines from NACA on composition e.g. the Governor as the chairman or on rotational basis with other members who are commissioners of all sectors. Since states are autonomous there will be flexibility to allow what is achievable and sustainable. Other members will include the private sector, Non-governmental Organisations (NGOs), and PLWAs.*
- *At the LGA level, the LGA chairman may head the committee comprising supervisory councillors of all sectors, private sector, NGOs, Community Based Organisations (CBOs) and PLWAs.*

MANAGEMENT

- * • *Funding: Government at all levels will provide funds and source for funds (e.g. debt relief at the Federal level, other sources of funds e.g. international and local donors). This will be channeled and coordinated through Ministries of Finance and LGA Accountant by NACA, SACA and LACA at the different levels respectively. HIV/AIDS will be integrated into the National Poverty Reduction Plan.*
- * • *Capacity building: Implementation of the IAP and NSP will be through the "critical mass" of each sector at all levels. Guidelines on the composition of these bodies will be provided by NACA.*

- **Monitoring and Evaluation according to specific indicators will be implemented by NACA, SACA, LACA and external evaluators.**
- **Research: Community based surveys, behavioural studies, as well as clinical trials using acceptable scientific methods will be done at all levels.**
- **Theme group or Expanded Theme Group: comprising NACA, International Donor Agencies, and the private sector will be coordinated by NACA. The group will give NACA technical support in the areas of:**
 1. **planning,**
 2. **advocacy,**
 3. **mobilization of partners,**
 4. **capacity building,**
 5. **resource transfer,**
 6. **coordination of UN systems and other donors' response,**
 7. **translation of government policies into action.**

Challenges

- • **Sustaining the political commitment at all levels; there is a need for continuous advocacy.**
- • **Coordination capacity to implement, strengthen and sustain the multi-sectoral approach.**
- • **Implementation of decentralization which will require policy guidelines, legal framework, and administrative structure**
- • **Resource mobilization and establishment of financial management systems and accounting at all levels**
- • **Resource flow to sectors, NGOs and CBOs**
- • **Capacity building which will involve both human and resource development as well as institutional development**
- • **Monitoring and evaluation and operational research**
- • **Legal and human rights issues**
- • **Support for the growth and capacity building of PLWAs.**

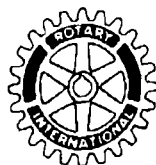
Obstacles and constraints

- * • *Civil disruptions*
- * • *Under funding*
- * • *Cultural barriers*
- * • *Religious barriers*
- * • *False claims of cure*
- * • *Denial and stigmatization*
- * • *Inadequate human resource in various sectors*
- * • *Competing priorities*
- * • *Lack of accountability*

We need a response that is commensurate with the scale of the disease. A response of partnership among all actors in Government, Business, International organizations, NGOs and the Community. A response of action on all fronts.

HOW THE USA CAN FACILITATE THE CONTROL EFFORTS

- Funding for the Interim Action Plan which includes:
- Education on HIV/AIDS, Targeting youths in and out of school and other vulnerable groups e.g..Women, commercial sex workers, Long distance drivers, uniformed forces
- Promotion of behaviour change
- Generating and using Technical information
- Developing institutional capacity
- Care and support for persons living with and/ or affected by AIDS (specifically:access to anti - retroviral drugs and anti - TB)Trust fund for AIDS orphans
- Capacity building for research in and outside the country (including upgrading of Laboratories)
- Programme to prevent mother- to-Child Transmission
- Capacity building for voluntary counseling and confidential testing
- Debt relief to reduce poverty (Nigeria's debt burden is 28billion dollars, Amount cancelled could be channeled into HIV/AIDS programmes.)
- Assistance with blood safety programs

**ROTARY INTERNATIONAL**

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Evanston, IL 60201-3698 USA

FAX MESSAGE**FAX:** 847 866-0269**Phone:** (847) 866-3304**E-Mail:** diamondm@rotaryintl.org

Handwritten: Muro
F-T
-Ken

TO: Dr. Ken Bernard, National Security Council

FAX NUMBER: 1 (202) 456-9390

CITY/STATE/COUNTRY: Washington, D.C.

DATE: 31 July 2000

FROM: Michael Diamond, Manager, PolioPlus Division, The Rotary Foundation

Dear Ken: Here is some information on Rotary International's activities in Nigeria for polio eradication:

NIGERIA – STATUS REPORT ON POLIO ERADICATION:

Nigeria is THE MOST IMPORTANT COUNTRY for the global Polio Eradication Program. With a population of over 115 million 45% of which are under 15, and an immunization coverage in 1988 of only 22%, Nigeria continues to be the world's largest reservoir of wild polio virus. In spite of tremendous cooperative efforts of partner organizations with the Government, including WHO, UNICEF, Rotary International, US. Centers For Disease Control and Prevention, USAID, there have been substantial problems in providing oral polio vaccine to children under 5 in all 36 states.

All of these States are at high risk and are now targeted for special attention. With the recent change in Government, President Obasanjo has been a real leader for polio eradication, both within Nigeria and in helping to encourage all 18 West African leaders in an synchronized effort to coordinate National Immunization Days.

There is a widespread feeling that the last case of polio in the world may occur in Nigeria unless continued encouragement, support and resources are made available to the Government of Nigeria. In spite of substantial Nigerian and Government and partner support, there remains a substantial shortfall. After a recent WHO/UNICEF technical mission, several major problems have been identified and CDC will be sharing these concerns with you directly.

A few Rotary facts:

1. President Obasanjo is a former Rotarian.
2. Rotary has been active in Nigeria since 1961 and there are currently 174 Rotary Clubs in Nigeria with a membership of 2,736.
3. Since 1985, Rotary International has contributed a total of US\$ 8,600,000 to Nigeria for Polio eradication activities. In addition, Rotary International has contributed US\$109 million for polio eradication activities in Africa.
4. Jonathan Majiyagbe, a lawyer from Kano, is the Chairman of the Rotary Polio Sub-Saharan Africa Regional Committee. He is also a past Director of Rotary International and a past Trustee of The Rotary Foundation. Mr. Majiyagbe recently chaired a delegation of Rotarians which met with President Obasanjo immediately after his

election. As a direct result of that meeting President Obasanjo committed US\$15 million for polio eradication activities. His telephone number is: 234 64 631 261

Fax: 234 64 647-146

5. Adedehin Adefeso is our Chairman of the Rotary Polio Nigeria National Committee and a member of the Nigerian InterAgency Coordinating Committee. He resides in Lagos. His telephone number is: 234 1 496 3470 Fax number: 234 1 496 3470.

Additional concerns which would benefit from President Clinton's attention:

- 1) Sierra Leone: We understand that it would be helpful to encourage Nigerian President Obasanjo continue his work with Charles Taylor of Liberia to promote days of tranquility in Sierra Leone to allow for the immunization of all children.

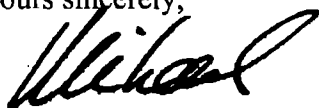
It may be useful to contact Representative Donald Payne (Democrat-Newark, New Jersey). Don is very active on the Black Caucus in Congress and has agreed to help promote polio eradication among African Americans in the United States as a way to help Africa. Don is also familiar with Charles Taylor and has indicated he would be willing to assist polio eradication any way he can.

For more detailed information on Sierra Leone, please contact Dr. Dennis King, CDC at 404 639-8252. He is currently in Atlanta.

- 2) President Jerry Rawlings of Ghana will not be running for re-election in December 2000. He may be able to provide additional leadership in Africa for polio eradication, especially with the encouragement of President Clinton. He has been extremely supportive of polio eradication efforts in Ghana. Rotary has very strong Rotary Clubs in Ghana.

Please let me know if you need any additional information. I can be reached at (847) 866-3304 or by fax at (847)869-6987 or e-mail at diamondm@rotaryintl.org

Yours sincerely,



Michael Diamond
Manager
PolioPlus Division

NIGERIA POLIOPLUS PROJECT

Quick Reference Document

Approximate population: 107 million (1998 data)

Approximate under five population: 18 million (1998 data)

Annual number of reported polio cases:

Year	# of cases	Surveillance rate*
1993	1,083	
1994	502	
1995	439	
1996	942	0.00
1997	383	0.01
1998	312	0.40
1999	981	0.50

**Cases of non-polio AFP (acute flaccid paralysis) per 100,000 children – rate of at least 1.0 indicates sensitive surveillance.*

Percent of children under one fully immunized against polio: 22% (1995-1998)

History of PolioPlus grants to Nigeria:

Month/Year	Trustee Decision
Feb. 85	Rotary Foundation approves grant of US\$ 2,810,000 for OPV and social mobilization.
Dec. 87	Rotary Foundation approves grant of US\$ 85,000 for social mobilization.
Jul. 87	USAID grant of US\$ 960,429 is awarded for social mobilization.
Apr. 89	Rotary Foundation approves grant of US\$ 5,057,300 for OPV and cold chain.
Oct. 92	USAID grant of US\$ 1,251,300 for social mobilization
Jun. 96	Rotary Foundation approves grant of US\$ 100,000 for social mobilization.
June 97	The Trustees approve a grant of US\$10,000 for operational cost during 1997 NID's.
Nov. 97	US\$ 12,450 was approved for administrative and social mobilization purposes.
Apr. 98	US\$16,000 was approved for administrative and social mobilization purposes.
Oct. 98	US\$19,000 administrative grant.
Oct. 99	US\$19,960 administrative grant.
Jun. 00	US\$97,650 grant for WHO personnel costs in Nigeria.
Jun. 00	US\$210,000 grant for operational support through UNICEF.
Jun. 00	US\$19,950 administrative grant.
	(US\$2,049,135) Grant adjustments.

Total adjusted grants: US\$ 8,619,904

Nigeria also benefited from a portion of the 1996-2000 block grants totaling more than US\$63,800,000 awarded to the World Health Organization for the African Region.

NIGERIA NATIONAL POLIOPLUS COMMITTEE

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PolioPlus Partners Information

Nigeria

2000 National Immunization Day Project

Total Funds Requested: US\$971,744

Total Funds Received: US\$336,843.58

Through PolioPlus Partners, Nigeria has received US\$224,775 for previous years' NID projects. This year, the National PolioPlus Committee requested items such as cold boxes, solar vaccine refrigerators, megaphones, Armbands, banners, aprons, caps, press advertisements, press releases, TV advertisements and radio advertisements to aid in their social mobilization campaign. Due to the reason that this year Nigeria was a big project, PolioPlus Partners has been only able to partially fund it, but eventually it will be totally funded because that project is still in the funding process.