policy brief | Volume 1, Issue 5

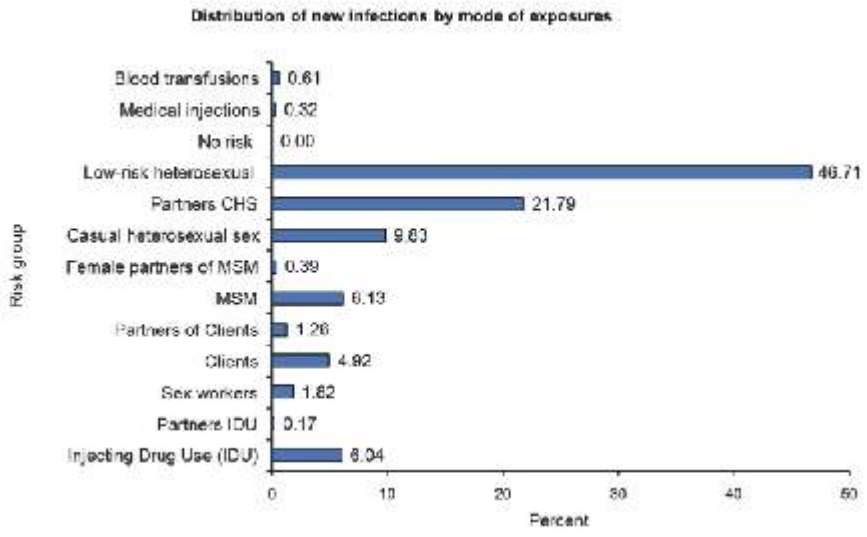
SAVING LIVES THROUGH THE SCALE-UP OF HIV & AIDS PREVENTION AND TREATMENT SERVICES

EXECUTIVE SUMMARY

One out of every ten persons in Nasarawa State is infected with HIV.[1] The HIV prevalence rate in Nasarawa State currently stands at 10%, the 2nd highest in the country as revealed by the 2008 Sentinel survey. In the state capital, the prevalence is as high as 19.5% which means that for every 100 persons, 20 are infected. Contrary to the earlier assumptions that HIV infections occur mostly among high risk groups (such as the commercial sex workers, transport workers, uniformed personnel etc), new research findings from the Modes of Transmission Study and Epidemiology Response and Policy 2009[2] revealed that 70% of new HIV infections will occur among cohabiting or married partners who are not engaging in "high risk" sexual behaviour. (if nothing drastic is done to prevent new infections). These studies were conducted in a bid to understand the epidemic and ensure that HIV prevention response in Nasarawa State in terms of the scope, relevance and comprehensiveness is based on evidence thus reaching all members of target populations with appropriate HIV prevention interventions.

The findings also reveal that preventing new infections require that women, men, girls and boys have easy access to comprehensive HIV Counseling and Testing (HCT) services. HCT is a crucial strategy not only as an entry point for people that are already infected but also for treatment, care and support. Unfortunately, HCT centres in the state are grossly inadequate. Test kits are not available and there are inadequate trained counsellors.

Other services such as Prevention of Mother to Child Transmission (PMTCT) still pose a huge challenge. The few facilities offering PMTCT services cannot cope with the high



[1]2008 ANC sero-prevalence survey by the Federal Ministry of Health
[2]Enhancing Nigeria's Response to HIV/AIDS and World Bank / NACA Survey

burden of infection in the state. Development partners offering PMTCT services identify deficiency in follow up mechanisms as a huge challenge in providing efficient PMTCT services. In addition, there is frequent transfer of trained staff and many women still deliver at home even after attending ante-natal clinic (ANC). According to 2008 ANC survey, the number of women requiring PMTCT services is 8,757 with only 2,202 benefitting as at April 2009.[3]

In addition, early infant diagnosis facilities are inadequate, male involvement and community participation in PMTCT is also poor. It is estimated that about 68,000 people are living with HIV/AIDS in Nasarawa State of which only 7,480 are currently on treatment with ARVs.[4]

This gap is as a result of inadequate health facilities providing HIV treatment services in the state. To further compound these problems, provision of HIV prevention and treatment services is mostly donor driven. With the exit of donor agencies, the provision of these services becomes the sole responsibility of the state as projects come to an end. Thus failure to own and lead the scale-up process of access to equitable HIV and AIDS prevention and treatment services will ultimately lead to increase in new infections, resistance to treatment, increase morbidity and mortality rate, reverse developmental gain and derail the state from achieving the MDGs as planned.

These gaps need to be bridged as it negates the principles of universal access to equitable HIV services, particularly in a democratic dispensation. **Therefore, adequately resourced scale-up of HIV prevention and treatment services becomes expedient to ensure even and equitable service delivery and the full realisation of democratic dividends.**

This policy brief discusses the actions needed to scale-up equitable HIV/AIDS prevention and treatment services among people in rural and urban areas of the state. . These actions, as recommended here are evidenced informed by the series of studies conducted by different development partners, and also in line with state commitments to the universal access to HIV prevention, treatment care and support by 2010, and the millennium development goals of halting and beginning to reverse the spread of HIV by 2015. (Sources: MOT, ENR, 2009; ERPS, UNAIDS, 2009.)

CONTEXT AND IMPORTANCE OF THE PROBLEM

Nasarawa State has a high burden of HIV infection. It is located between the country's capital and Benue state which has the highest burden of HIV/AIDS in the country. The state has consistently recorded Ante-Natal Care HIV sero prevalence rate greater than the zonal [north central] and National averages. The trend shows a value of 10.8% in 1999, 8.1% in 2001, 6.5% I 2003, 6.7% in 2005 and 10% in 2008.

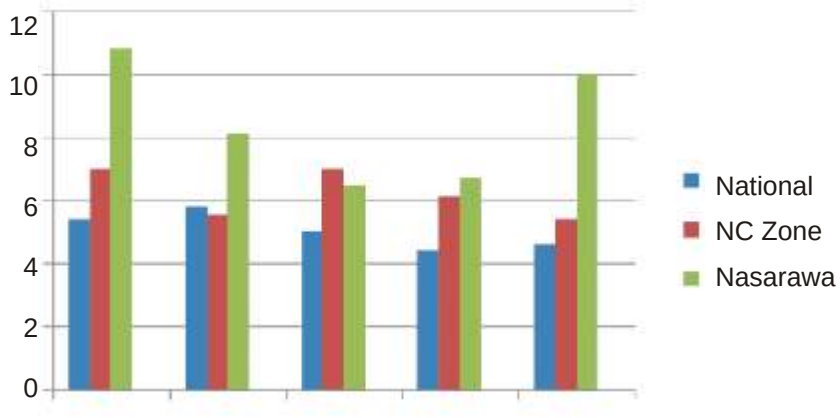
As of 2008, there was an estimated 68,570 HIV infected people, 16,092 of these are youth (15-24 yrs) 5,917 are pregnant women and 15,063 requiring anti-retroviral drugs. The state cumulative death due to HIV/AIDS is 78,000 with 51,000 AIDS Orphans accounting for 37.4% of the total orphans in the state by 2008.

Currently, there are 8 sites providing ART services in

[3]2008 ANC Sero-prevalence survey

[4]NARHS Survey, MOT survey and ERPS Study

the state, 22 PMTCT (including comprehensive sites) and 64 HCT centers in the state which are grossly inadequate to meet the increasing demand of PLWH and the general population in the state. The present sites providing these services are largely donor driven and presently overstretched. Majority of these development partners are winding up operations because they are time-bound and have reached their targets which will eventually affect those requiring these services.



The factors fuelling HIV/AIDS situation in the state which has necessitated the scale-up of ART, PMTCT and HCT services among others include the proximity of the state to Abuja, the federal capital, which has resulted in the influx of migrant populations into the state, harmful cultural practices like wife inheritance, unhealthy circumcision and scarification, lack of mutual fidelity within polygamous marriages, myths and misconceptions about HIV/AIDS, increase stigma and discrimination against PLWHA and gender based violence.

The scale-up of these sites will ensure accessibility to the rural populace which will lead to increased uptake of HCT services, reduction in the death rate among PLWHA, reduced stigma and discrimination, reduction in gender based violence and reduce the burden on existing sites. This will also ensure that the goal of full coverage will be achieved, since all those in need of the services will now be reached.

POLICY IMPLICATIONS OF THE ISSUE

If the ART, HCT and PMTCT sites in the state are not scaled up, the following implications are inevitable:

- High mortality rate among PLWHIV which will negates attainment of the the MDG goals
- Increase in maternal death as most pregnant women especially those infected are unable to access or may not access adequate treatment and safe delivery services.
- Increase in the number of children born with HIV at birth
- Increase in the number of Orphans and Vulnerable Children (OVC) which may lead to increase in crime and other social vices, as well as increase in the burden of social care.
- Low awareness and knowledge on the modes of HIV transmission and prevention by the general population leading to more risky behaviours resulting to more new HIV infection
- The age group mostly affected is 15-45 years who are the productive work force of the state and if

nothing urgent is done to address the issue; the man-power is threatened meaning that in the next 10 to 15 years, there will be less hands to work on the farm lands. Thus, the economic status of the state will be threatened. This will impact negatively on food security as well as on the socio-economic well-being of the state.

- If our leaders fail to take urgent steps now, there may be devastating effects as everybody will be at risk of being infected with HIV, prevalence rates will continue to increase, new infections will rise and cases of resistant strains of the virus will also increase.

Posterity will certainly judge our actions and or inactions.

POLICY RECOMMENDATIONS

This brief recommends that government scale up the provision of basic HIV prevention and treatment services to ensure that all persons have access to services on need basis, and that services are accessible, affordable and efficient. The following actions are hereby recommended:

- Increase the number of HCT sites from the present 84 to 135, particularly in the rural communities until every ward in each LGA has access to HCT services.
- Establish additional 5 HIV comprehensive treatment sites to be spread across and cover all the 13 Local Government Areas.
- Increase the existing PMTCT centres from the present 25 to 45 which will be spread across the 29 Local Government/ Development Areas for effective coverage,
- Recruit and train qualified and adequate staff for the sites

The process of scale up by the state government, will bring about ownership and better sustainability of the services, and also reduces cost of treatment in the long run.

The scale up of HIV and AIDS services will require increased and adequate state funding, and the prompt and timely release of allocated funds to the State AIDS Control Agency (NASACA) as well as the Local Action Committees on AIDS and the Line Ministries. It will also require building the capacity of the NASACA and the state level partners to enable them ensure universal access to prevention and treatment services in the state.

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