

Reproductive Health of Humankind in Asia and Africa:

A GLOBAL PERSPECTIVE

Vol. 1

Edited by

Kuttan Mahadevan

GAO Ersheng

Yu Jing Yuan

R. Jayasree

A.K.M. Nurun Nabi

P. Rajaram

Frederic Bourdier

P.J. Reddy

V.K.R. Kumar

V.M. Sandeep

The logo for BR Publication, featuring the letters 'BR' in a stylized, cursive font with a small 'a' above the 'B', and the word 'Publication' written in a smaller, sans-serif font below it.

Distributed by:

BRPC (India) Ltd.

4222/1, Ansari Road, Darya Ganj

New Delhi-110 002.

Phones: 3259196, 3259648

Fax : 3201571

E-Mail: brpcltd@del2.vsnl.net.in

© 2000 Authors

ISBN 81-7646-097-4 (Set)

ISBN 81-7646-116-4 (Vol. 1)

All rights, including the right to translate or to reproduce this book or parts thereof except for brief quotations, are reserved.

Published by:

B.R. Publishing Corporation

[A Division of BRPC (India) Ltd.]

3779, 1st Floor,

Kanhaiya Nagar, Tri Nagar,

Delhi-110 035

Phone: 7152140

E-Mail: brpcltd@del2.vsnl.net.in

Rs. 1500 (Set of 2 Vols.)

Laser Typeset at:

River's Edge Graphics

New Delhi-110 018

Printed at:

PRAJA Offset

Delhi

PRINTED IN INDIA

Contents

Introduction

v

Vol. 1

Part - I: Reproductive Health of Humankind

1. Reproductive Health Affecting Variables of Humankind: A Conceptual Model 3
- K. Mahadevan, GAO Ersheng, Yu Jing Yuan, R. Jayasree, P. Rajaram, K.K. Sai Prasad, P.J. Reddy, V.K.R. Kumar & V.M. Sandeep
2. Reproductive Health of Mothers in China 57
- Wu Junqing & GAO Ersheng
3. Issues and Priorities of Reproductive Health in Bangladesh 75
- A. K. M. Nurun Nabi
4. Obstetric and Gynaecological Implications in Reproductive Health 93
- P. Rajaram
5. Reproductive Health of Lactating Mothers 113
- V.S. Toddywalla, K.T. Hazari, J. Neela & H. S. Juneja
6. Early Menopause and Its Determinants 123
- K. Mahadevan, M.S.R. Murthy, P.R. Reddy & Syamala Bhaskaran
7. Reproductive Health in Primary Health Care 133
- V. Kapali
8. Reproductive and Child Health Approach: Strategic Changes in Planning and Implementation 165
- K.A. Pisharoti

Part - II: HIV/AIDS Prevalence and Perspectives

- | | |
|---|-----|
| 9. Women's Matrimonial Practices and Social Vulnerability to the HIV/AIDS Epidemic
- <i>Frédéric Bourdier</i> | 185 |
| 10. STD and AIDS in China
- <i>Zhao Pengfei</i> | 233 |
| 11. Cultural Practices and The Spread of AIDS in Nigeria
- <i>Dominic Azuh</i> | 249 |
| 12. An Overview of Prevalence and Control Strategies of HIV/AIDS in Kenya
- <i>Simon K. Ruttoh</i> | 269 |
| 13. AIDS and Women's Health: Perspectives on Communication Policy
- <i>Kiran Ramachandran N.</i> | 291 |
| 14. Concept Formation on AIDS Comprehension among University Girl Students
- <i>D. Padmavathi & R. Vijayalakshmi Ramamohan</i> | 299 |
| 15. Sexual Behaviour of Commercial Sex-Workers and Risk for AIDS Epidemics
- <i>K. Mahadevan, M. Sumangala, K. Rajasekhar, V.B.K. Nair, S.P. Ramalingam, M.S.R. Murthy & M. Ubaidullah</i> | 313 |
| 16. Rehabilitation of HIV/AIDS Positive
- <i>Ramesh Babu Rayapu</i> | 331 |
| 17. HIV Infection and AIDS in Rayalaseema Region of South Central India
- <i>A. Gururaj Kumar, B.K. Reddy & P.J. Reddy</i> | 337 |
| 18. Condom Promotion in China
- <i>GAO Ersheng</i> | 343 |

Vol. 2

Part - III: Adolescent Mother's Health, Nutrition and Sexuality

19. Adolescent Girls and Health Issues 357
- *Kamala Chandrasekhar*
20. Reproductive Health of Unmarried Youth in China 365
- *GAO Ersheng*
21. Adolescent Sexuality 383
- *D. Narayana Reddy*
22. Nutrition and Health Status of Adolescents: A Study 395
- *P.M. Sandhya Rani & Usha S. Nayar*
23. Dysmenorrhea amongst Adolescent Girls: Strategies for Remedy 415
- *A. Jyothi & K. Chandralekha*

Part - IV: Nutrition and Empowerment of Women

24. Social and Cultural Constraints in Attaining Optimal Nutrition in Women 433
- *Philomena R. Reddy*
25. Women's Empowering with Nutrition and Health 441
- *Usha Chandrasekhar*
26. Appropriate Technologies for Promoting Nutritional Well-being of Rural Women and Children 483
- *Mehtab S. Bamji, P.V.V.S. Murthy & K.V.L. Lakshmi*

Part - V: Gender Perspectives

27. Women's Health through Comprehensive Rural Services: Experiences of Christian Medical College (RUHSA) 505
- *Rajaratnam Abel*
28. Participation of Women in Panchayati Raj: Perception of Women's Leadership at Grass Roots Level 521
- *R. Varalakshmi*
29. Autonomy of Women and Contraceptive Behaviour 535
- *M. Lalitha Kameshwari*
30. Women's Empowerment and Demographic Behaviour: Perspectives on Rural and Urban Women 549
- *M.S.R. Murthy & N. Dhanalakshmi*
31. Dowry and Status of Women in India 561
- *Sushma Pandey & Babban Mishra*

Part - VI: A Successful AIDS Awareness Project

32. AIDS Awareness by Arogya Agam (NGO): A Replicable Case Study 585
- *Kuttan Mahadevan, M. Sumangala, K. Rajasekhar, V.B.K. Nair & V.M. Sandeep*

Cultural Practices and The Spread of AIDS in Nigeria

Dominic Azuh

Background and Objective

AIDS is an acronym for Acquired Immuno-Deficiency Syndrome and HIV stands for Human Immuno-Deficiency Virus. AIDS is a form of biological warfare being staged by the microbial world (Viruses), which have eluded medical solution up to date—neither is there any cure nor vaccine to prevent its onslaught. AIDS, without referring to the virus that causes it, symbolizes total breakdown of the body's resistance to infection and makes it easier for opportunistic infections to aggravate an infection that would normally not be problematic. There is no other ailment at the moment that is causing greater concern to every- one than HIV/AIDS.

In Majority of places, it is receiving attention in order to safeguard the health of the masses. Today, no country on earth can claim ignorance or escape from its consequences. The unprecedented speed and vigour at which it spreads is highly unimaginable. It is now a global tragedy. The amount of money, time and effort put in to educate the public by concerned UN agencies, Non-Governmental Organisations (NGOs) and dedicated governments are worth commendable. There is government apathy and lack of political will to tackle the pandemic disease and mass ignorance among the populace in Nigeria. This paper seeks to highlight several cultural ways which facilitate the spread of the deadly virus, throw more light on the HIV/AIDS situation in Nigeria and the need for

government to take decisive action towards HIV/AIDS control & prevention among its citizenry

The Global Picture

HIV/AIDS infection has dawn on people for more than 2 decades since it first emerged. In spite of increasing global efforts aimed at eliminating or reducing AIDS scourge, the disease still ravages the world. Today, over 30 million people are believed to be suffering from AIDS according to a joint report by the United Nations programmes on AIDS and the World Health Organization. The report further states that 5.8 million people acquired HIV infection in 1997. This makes it equivalent to nearly 16,000 new infections everyday of the year including children infected at birth or through breast-feeding. With the current trends unbroken, it is estimated that more than 40 million people will be living with HIV in the year 2000. What a high potency for those who will contract the AIDS. And an estimated 2.3 million people died of AIDS in 1997. These deaths represent a fifth of the total 11.7 million AIDS deaths since the beginning of the epidemic in the late 1970s. Of the people who died of AIDS in 1997, 46 per cent, were women and 4,60,000 were children (UNAIDS,1997) (See Table 1). This does not only show the magnitude of AIDS havoc as years progress in the world, but equally the need to stop the AIDS menace in its track of ravaging humanity.

The African Overview

The relentless spread and the human toll of the HIV/AIDS pandemic is more evident in the developing countries. Africa continues to be the continent most affected by HIV/AIDS. The fear is that in Africa, for instance, where poverty is rife and health facilities are grossly inadequate, the chances of many AIDS victims appear bleak.

Sub Saharan Africa is the region with the fastest moving epidemic, now thought to have fully two-thirds of the total world number of people living with HIV. Sub-Saharan Africa as a whole has reached the unprecedented level of 7.4 per cent (Adult prevalence Rate) of all those aged 15-49 infected with

HIV. (See Table 1). Unprotected sex between men and women accounted for most of the 3-4 million new HIV infections estimated among adults in sub-Saharan Africa in 1997. In addition, high fertility combined with poor access to information and services resulted in 5,30,000 infected children being born to mothers with HIV, around 90 percent of the world total.

Southern Africa continues to be the part of the continent worst affected by HIV. By early 1997, the government of South Africa estimated that 2.4 million South Africans were living with HIV, up by more than a third over 1996. In Botswana, the proportion of the adult population living with HIV has doubled over the last five years. Zimbabwe's infection was estimated at one in five adults in 1996. In Harare, which is the capital, 32 per cent of pregnant women were already infected in 1995. And in Beit Bridge, another major city, the proportion shot up from 32 per cent in 1995 to 59 per cent in 1996. Although levels in cities were slightly higher than in rural areas, the difference was not great. This may be due to the close ties between urban workers and their families in the rural homes and the contemporary migratory life-style occasioned by economic necessity. The rate of HIV positive patients in Zambia is very high especially among men and women of ages between 20 and 45 years. This has prompted civil servants to distribute free condoms to villagers against the dreaded disease with the assistance of Western Partners, not minding the feelings of some religious groups. In a recent survey, HIV infection was identified in 13-24 per cent of pregnant women, 18-23 per cent of healthy blood donors and 36-54 of persons with sexually transmitted diseases. According to Kaluwa (1997) about 1 million people may be carrying the HIV virus and close to 2,00,000 may have died of AIDS.

East Africa was one of the first areas to suffer a massive regional epidemic, countries like Kenya (56,523), Uganda (46,120) and Tanzania (45,968) reported very high number of AIDS cases than other places. Data from 1994 Kenyan National AIDS and STD control programme indicate increase in the national HIV prevalence among adults and by the year 2000 it is projected that one adult Kenyan in ten will be infected with

HIV. The situation has changed for now. For instance, with open and concerted efforts Uganda has been able to make a significant drop on the proportion of Ugandan adults infected with HIV.

West Africa though has its rate of infection stabilized at much lower levels than their counterparts in East and Southern Africa, some populous countries are the exception to this rule. For example, the National AIDS programme estimated that 2.2 million people are currently living with HIV in Nigeria, a country with no commitment towards prevention and/or control of the silent killer (UNAIDS, 1997). HIV infection rates in Cote d'voire are the highest in West Africa. WHO estimated that 6.8 per cent of the adult population, 3,90,000 people were HIV positive at the end of 1994. In Abidjan, AIDS is now the main cause of death among adult men and the second most important cause of death among adult women. The first cases of AIDS in Ghana were reported in 1986. A decade later at the end of 1995, 17,564 cases of AIDS had been officially registered by the Ministry of Health. This figure is thought to represent about 40 per cent of the actual cases, estimated at between 30,000 and 40,000 (AIDS Analysis, Africa, 1996) Thus regional differences are stark and in Africa the epidemic is particularly advanced.

Genesis of AIDS

It is on record that the AIDS virus was first noticed in 1981, over one and half decades ago among homosexuals in the U.S.A. Not too long after that heterosexuals and bisexuals became infected alike. Since then medical technologists have unravelled the intricacies of the impact and consequent breakdown of the body immune system by HIV, the disease that gives AIDS. The origin of AIDS virus has become a matter of intense international debates and controversies. Since then many theories and hypotheses have been advanced, trying to discover the origin of this "mysterious and ravaging plague". Despite all efforts in this direction, no one seems to want to admit the origin of the HIV virus which remains unknown to the present day scientists who may in fact have formed it.

The nature of this first entry into humans is the object of great interest and speculation. It is likely that there was no one instance of a single human infection from which the current epidemic originated. Western Scientists place the origin of the current epidemic in Central Africa because of the discovery that the AIDS virus is similar to the virus found in African green monkeys. Perhaps it may be ambitious to state that the linking of AIDS origin to Africa by the West has been a mere racist speculation or propaganda by the West to denigrate Africans.

The AIDS epidemic in Africa, largely invisible and insidious as it began, became visible in what first appeared in an unlikely place, Rakai in Uganda. And soon the transmission has occurred all over Africa.

Nigeria's Situation

The first HIV case in Nigeria was reported in 1986. From this time to early 90s, one really found or heard about people with HIV positive or AIDS even in cosmopolitan city like Lagos. But nowadays the dire demon marches on and extending its tentacles across numerous victims like a vampire gone berserk. Some have died already, others are dying and many are just walking in the shadow of death. Nigeria is now at a threshold and within a shortest possible time a widespread manifestation and probable decimation of the populace will occur. But saddened enough Nigerians and their leaders are yet to wake-up from their deep slumber to realise the need to face squarely the unfettered reign of a monster in the country.

The tempo of HIV infection spread is highly unimaginable. For instance, from an initial sero prevalence rate of 0.66 per cent in 1991 the figure has risen to 3.8 per cent or about 5 million are now HIV positive. The number is very much soaring and government's effort at combating it is most abysmally inadequate. It is very ridiculous to know that in some states there is no allocation while at the federal level, it is less than N3,00,000 (<\$4,000.00) for AIDS control programme. This assertion was given by one former Health Minister, Professor Olikoye Ransome Kuti, at a press briefing at which he announced that his brother, the Afro Beat Music Maestro died from complications arising from AIDS.

The president of the Nigeria Medical Association (NMA), Boniface Oye Adeniran, has declared that "we are right now in the position where our East African brothers were five years ago. Government has not shown political will, rather we are in a state of self denial. Government officials are behaving as if there is no problem. There is a problem "Many prominent Nigerians both in the medical field and outside have echoed similar sentiments on the existence of AIDS in Nigeria. The author is very convinced that the "Rod of Misery" has fallen on Nigerians and to be candid HIV/AIDS has taken a firm root. And this requires urgent step by both the three tiers of government and the public.

But the level of public awareness of HIV/AIDS seems to be a national malaise in the implementation of the National AIDS and Sexually Transmitted Diseases Control Programme (NASCP). For example, the programme has been managed by six national coordinators in its 10 years of existence with a resultant absence of sustainability of programme ideas. Other factors implicated in the failure of the programme include the breakdown of more than half of its screening facilities, lack of funds as well as the shelving of the National Blood Transfusion Service. Experts blame government for demonstrating no political will and commitment to HIV/AIDS pandemic. Such issues bedevil the National Tuberculosis and Leprosy Control Programme. Eka Esu Williams, the resident adviser of the AIDS control and prevention project, asserts "we lack the political will and everything has been subsumed in the fight against anti-government forces and maintenance of internal security."

The report of 1995-96 HIV sentinel sero prevalence in Nigeria by the NASCP not only concurs to all the above information but throws more light on the current situation in our nation. In the bid to determine the accuracy of current data on HIV infection and to further confirm the presence of HIV in Nigeria, NASCP carried out a survey on the prevalence of HIV positive among different categories of the population. To this end, blood samples were collected from these categories of people under investigation. These categories are: Antenatal Clinic Attendees (ANC), Patients with Tuberculosis (TB), Patients Attending STD Clinics and Commercial Sex Workers (CSWs). The report

confirms the spread of HIV in Nigeria and more worrisome is the decline capacity to carry out prevention and control activities principally due to lack of adequate funding which is a reflection of poor commitment on the part of the government. The HIV prevalence were high for Commercial Sex Workers (34.2%), Patients Attending STD Clinic followed (15.0%) then Tuberculosis Patients (13.0%) and the least among pregnant women (4.5%). When compared with data from national surveillance studies in 1991-92 and 1993-94; a substantial increase in HIV infection was observed, and more so in similar pattern. (See Table 3 and Chart A). This shows a growing problem of HIV infection in Nigeria. Consequentially it suggests the presence of a rural HIV epidemic too. The main source of transmission being unprotected sexual intercourse between men and women. (See Tables 2 and 3). It further shows the high level of promiscuity, growing incidence of untreated sexually transmitted diseases and risky sexual practices among people in Nigeria. Reports from other sources have it that 80 per cent HIV infection in Nigeria is through heterosexual practices and remaining 20 per cent are from blood transfusion, mother to child (during birth) among others (The Guardian 1997). The joint UNAIDS and WHO (1996) also report that between 75 and 85 of every 100 HIV infections in adults have been transmitted through unprotected sexual intercourse. In Africa, a high prevalence rate of HIV infection among commercial sex workers is not uncommon. It is as high as 80 per cent in Nairobi (Kenya) 55 per cent in Abidjan (Cote d'Ivoire) and 55 per cent in Djibouti. A similar trend is found in Asia and other developing countries. For instance, in Bombay (India), HIV prevalence has reached 55 per cent in sex workers, 36 per cent in STD patients and very low among woman attending clinics for antenatal care (AIDS Analysis Africa, 1997).

Transmission through blood has diminished in most developing countries, it is still a major route of transmission in Nigeria. The study by eleven researchers on the sero prevalence of HIV in Nigeria reported 7.7 per cent of HIV prevalence in blood donor. Another researcher (Takane Harry) while decrying the transfusion of unscreened blood in the country pointed out that of the 20 per cent cases of HIV in the university of Maiduguri

Teaching Hospital in February, 5 per cent were caused through the transfusion of HIV infected blood (*The Guardian*, 1997).

Mother to Child (vertical) transmission is very low in Nigeria. The study report confirms this state from women who attended Antenatal Clinic (4.5%). According to Akinsete 4 out of every 100 antenatal patients in the country have HIV which they pass to their children (*The Guardian*, 1997). No doubt it accounts for the main route of infections in infants in the country. To date, over 85 per cent of all children infected through mother to child transmission have been in sub-Saharan Africa. And during 1995 approximately 5,00,000 children were born with HIV infection (about 1,400 per day). Of these children, 62 per cent were in sub-Saharan Africa, 30 per cent in South-East Asia, 2 per cent in Latin America and 1 per cent in the Caribbean. As of July 1996, about 1 million children are living with HIV/AIDS, of whom 65 per cent are in sub-Saharan Africa (UNAIDS, 1996).

Unsterilised skin piercing instruments used for circumcision, tattooing, cutting of umbilical cord and tribal marks used by "Native Doctors" and unqualified Birth Attendants may result in the spread of HIV infection in the country. This is a cultural dimension and a potential research area if there is realistic commitment and fund from the federal government.

Socio-Cultural Practices which Accelerate the Pace or Spread of HIV/AIDS in Nigeria

There is no doubt that HIV/AIDS is one of the major epidemics of this century and that the consequences are a disaster. Adverse socio-cultural practices add insult to the injury and hence call for urgent need to shake off all those aged tenets which aid AIDS. In addition to the sexual behaviour, there are certain cultural practices that favour the spread of AIDS in Nigeria. Some of these practices may also have the same impact in many other places where they exist.

A. Female Genital Mutilation (FGM)

Female circumcision apart from other consequences, has the risk of HIV transmission if the same equipment is used for several individuals. The gruesome procedure leads to much bleeding, requiring blood transfusion which increases the chances of HIV infection.

B. Male Dominance

Here in Nigeria, some cultural norms give the men folk freedom to be more sexually active while restricting their female counterparts. Needless to say that only men have multiple sexual partners; the crux of the matter is that men have greater decision-making power regarding sex and reproductive health matters. For instance, if a man gets STD and goes for treatment he may inform his wife to do the same. But a woman has no power to force her husband to be examined and seek treatment. Due to cultural influence women never take assertive approach to sex, rather gender role and traditional expectation of woman is that of subordination. In some communities in Nigeria, it is taken for granted that men need to have sex regularly whether married or not, deciding when, how and with whom they will have sex. Whereas women are expected to remain faithful and not to question their partners' behaviour. This male dominance and gender discrimination may reduce the ability to engage in protective sexual behaviour.

C. Customary Laws

In some other communities, customary laws permit a man to inherit or marry his brother's widow. If the woman has become a widow because her husband died of AIDS, she may be HIV positive and transmit the virus to her brother-in-law or vice versa. The rituals around widow inheritance though diminished in extent may be a real vehicle in HIV spread.

The socio-cultural dimension is multifaceted and revolves around sexual habits. The study carried out by the Society for Family Health (SFH), a United States funded family planning and HIV prevention products provider, show an alarming sex explosion among adolescents aged 12-19 years and among youths between the age bracket of 12-30 years. Also in a joint study conducted by Chevron, an oil company operating in Nigeria and Nigerian National Petroleum Corporation in few States confirms the existence of high pre- and extra-marital sex in rural areas among their peers and neighbours. Siblings were known to be having cross-marital sex and young men, married or not, frequently slept with their brother's wives. The study

disrespect to those infected, denying them educational opportunities, health care in hospitals and social support necessary for living. Imagine a situation where families and relatives isolate their own persons having HIV/AIDS causing more distress and hopelessness.

The fear of condemnation and ostracism make people with HIV positive reluctant to come forward for counselling. This is more serious in a place like Nigeria where government is not seriously committed on this pandemic, talk more of its citizenry who present complacency over the hard fact that HIV/AIDS scourge is spreading fast and killing many people. The stigmatization and discrimination causes further suffering for HIV/AIDS individuals who may face termination from job or may be forced to go underground. People with HIV live normal lives with the help of the society and their loved ones providing love and passionate care. Talking to them rejuvenates their will to live. The entire feeling of an AIDS patient is encapsulated in the words of one AIDS patient who gave press interview to the guardian newspaper, "I decided to go into hiding because I feared I might be stoned to death if those around found out. At first my family members wanted to throw me out into the streets when they became suspicious of my condition. I cannot do without thinking about it now and then and the thought of the whole thing has been very traumatizing for me. I always feel weak, it's terrible".

How far care, love and understanding could go in boosting the will of AIDS patients to live on is equally highlighted in another interview granted to STOPAIDS organization, an NGO in the country by an HIV positive person "Although my father's tender heart was easily placable, the question on the minds of other family members left them uneasy. Disenchantment seemed to be written all over their faces. The results of this apparent disillusionment made living at home rather unsalutary for my emotions. But for the friends at STOPAIDS organisation whose understanding, care and counselling paid off, I was to have gone into some form of psychological reclusion."

The psychological consequences for the Nigerian children range from the effects of rejection to gossip at school and neighbourhood when their sero status gets known by people.

Children who are not themselves infected are often withdrawn from school to tend to their parents who are infected. When the parents who are infected die, they become deprived orphans who are either looked after in a withering extended family "safety net" or by aged grandparents. Many of these adolescent children now look after themselves and siblings, living on streets without a roof over their heads and most of them end up in prostitution for females and banditry for the males.

The suffering of AIDS patients in Nigeria is multifarious, with government low level commitment both politically and financially has made provision of better services to persons with HIV a distant dream.

Nigerian Government Efforts in War against HIV/AIDS

AIDS is spreading at an alarming rate throughout the world and Nigeria is inclusive. It has become a public health problem that threatens social and economic development because most of its victims are young men and women who are needed for social, political and economic development. The demographic implication of this is highly imperative. During the early 80s (early days of the AIDS epidemic), many governments denied the presence of AIDS in their countries and refused to take the threats of AIDS seriously. Today, this trend has changed towards widespread recognition of the consequences and governments are mobilizing resources to prevent spread of AIDS.

The Nigerian government is among the exception. The absence of political will, policy and non-provision of funds towards the control and prevention action plan says it all. All these reflected on the lip service that has been paid to the control programme. When the war against AIDS was relaunched in 1991, General Ibrahim Babangida, then Head of State pledged N20 million each year to the programme and directed the government controlled broadcast media to air AIDS related information free of charge. He also directed States and Local Government Authorities to respectively earmark N1 million and N0.5 million each to AIDS control.

To date most of those promises have remained largely unfulfilled, with so little money available to run the programme. The NASCP has by the admission of its many Co-ordinators

and Acting Co-ordinators from 1986 to day been unable to do or cause to be done a good deal of what it has had in its masterplan (STOPAIDS, 1997). The starvation of funds has been manifested in the breakdown of more than half of its screening facilities as well as the shelving of the National Blood Transfusion Service (NBTS), non-training and re-training of personnel, hiring of skilled personnel and equipments needed for public enlightenment and so on. A plan to introduce HIV/AIDS education into secondary school curriculum and that of making condoms available in hotels dating back to 1990 are yet to materialise. And what is unacceptable is that each successive Head of State turns his eyes away from HIV/AIDS control programme file. In addition to the earlier revelation by a former Health Minister, Prof. Olikoye Ransome Kuti, some of the officials with the NASCP confided with the author of this paper that sometimes nothing was given to the programme.

International Programme and Role of Non-Government Organisations (NGOs) on HIV/AIDS Control

Despite the soaring figure of AIDS cases, Nigerians regard the campaign against the spread of the infection with disdain. But the terrific thing about HIV/AIDS is that as the rate of HIV infection soars, its effects are being compounded by other infections.

But for the International Agencies and Local NGOs, the situation would have been more hopeless than it is. The HIV/AIDS scenario on Nigeria puts no smile on a rational person's face. Most of the international agencies are in funding agreements with NASCP and some work through their NGO affiliates which they fund and provide material and logistic support. Sometimes, both the International Agencies and Local NGOs collaborate with related government departments to carry out studies on HIV/AIDS prevention.

The benefits of these bodies towards HIV/AIDS control and prevention programme is better imagined than expressed. This is even more in a country like ours where the government has no substantial inputs vis-a-vis the much needed political commitment. Since the relaunch of the War Against AIDS in 1991, government's slogans are yet to be translated into action.

Our Government seems to be relying more on donor agencies to fight AIDS, even among our people. This is very ridiculous and exposes the malaise that has characterised our way of life. Some of these International Donors Agencies are: The Ford Foundation, the Asian Centre for Population and Community Development, The Canada Fund, WHO/GPA-CEDPA, British Council/ODA, UNICEF etc.

NGOs fill the yawning gap between most governmental development plans and implementation for the development through intervention projects. NGOs have been able to achieve results where government bureaucracy had often ensured the failure of its own programmes. In other words, it would have been stagnation but for the indispensable "Missionary" NGOs.

Notwithstanding the plethora of NGOs scattered around the country, very few are engaged in active and direct assault on HIV/AIDS, others could be said to be associates. Most are engaged in awareness campaign to prevent the spread of the virus, media sensitization workshops, rallies, education of commercial sex workers, providing information that will promote HIV/AIDS sufferers, HIV product providers and others are into provision of supportive services to the victims. Some of these Local NGOs include Society for Women and AIDS in Africa, Nigeria (SWAAN), Nigerian Association of Women Journalists, STOP-AIDS Organisation, Nigeria media Network, Nigerian Youth AIDS Programme (NYAP) and Global Association for war Against AIDS (GAWAA). Infact their works have been very encouraging in spite of all odds and worthy of commendation.

Looking Ahead—Attitudinal Change in Perspective

Developing countries should not ignore to assault the HIV/AIDS epidemic which has extended its tentacles to all nooks and corners, urban and rural alike. Each day thousands of infected patients are being added to the already frightening proportion of victims. Developing countries are the worst hit and contribute about 90 per cent of the global incidence. AIDS has the power to tear asunder families, cause people to turn on one another and perpetuate acts of indignity and inhumanity, exacerbates poverty and renders the rich poor. It's pain silences.

The experience of its impact and fearful vision of the future create the tone of concern and the sense of urgency regarding its assault.

But sadly enough, Nigeria the giant of the black race, has ignored this pandemic which is ravaging the entire universe. The government of Nigeria is non-committal to this noble and acclaimed course, without even a policy guideline to date on the control of the infection which has no chemotherapeutic cure as of now. Absence of the policy makes initiatives very unimplementable.

The paper is based mainly on the report of National AIDS/STD Control Programme. NASCP (a government department which is concerned with HIV/AIDS control and prevention) should offer persuasive evidence that active government commitment is the need of the hour in the country to avert the suffering and death of millions of potential lives. The paper also envisages to add that government facilitates the operations of Local and International NGOs which are strong force in the fight against the epidemic. This can be through collaboration and minimising procedural tendencies which militate against securing funds from donor agencies abroad.

To forestall an onslaught of HIV/AIDS cases in spite of several catalogues of constraints and problems militating against control programme, there is the need for a sound policy on HIV/AIDS, guaranteed government involvement, provision of funds regularly and utilisation of the state machinery to mobilise the population.

Commercial sex workers and their clients hold important keys to successful HIV prevention effort. Hence, special programmes should be developed to rehabilitate girls and women who have adopted prostitution as a way of life and those predisposed to enter commercial sex industry.

Economic-cum-income generating activities should be developed for families, girls and women who are at an economically disadvantageous state. In Nigeria, severe socio-economic pressures have eroded cultural values and parental controls that normally would have a positive effect on the HIV prevention. Several parents are bitten by the harsh economic

hardships and rely only on their daughters' sexuality to support the family.

HIV transmission in Nigeria is mainly through heterosexual practices. And since there is no chemotherapy, grassroots public enlightenment campaign becomes imperative in eradication of ignorance and needed behavioural change. More so the propensity of young people to engage in risky sexual behaviour is exacerbated by the absence of constructive sex education at home and in school. Behavioural change ensures usage of condoms (practice of safe sex), reduces number of sexual partners, delays the age at first sexual intercourse which will lower the rate of teenage pregnancy and STD, orients against adverse religious and cultural tenets, ushers in favourable community response and modifies male attitudes about sexual behaviour.

The HIV/AIDS campaign should be made a year-round activity with increased out-reach among schools, high transmission areas like long distance truck drivers' garages, hotels and brothels where premarital and commercial sex activity takes place. Promotion, distribution and use of condoms should also be included in this awareness campaign.

Government should refurbish screening facilities at both designated university teaching hospitals and centres to improve the safety of blood transfusion, which is also a major mode of transmission in Nigeria; train and re-train personnel, revitalise the information system and public enlightenment unit of NASCP and creation of research, monitoring and evaluation unit. The village approach should be evolved since HIV/AIDS is perceived as a societal problem. Involving communities can help to incorporate local knowledge and commitment which are vital ingredients of successful intervention measures. Village participatory approach lowers stigmatization and decrimination against HIV/AIDS victims, making infected patients to have sense of place in the society. The syndormic approach to STD treatment should be pursued aggressively.

Since HIV/AIDS is a disease of shame, government should strengthen the Home Base care and counselling practice being carried out by some of the Local NGOs. Home visiting and care bring families together, minimise stress and isolation apart from

helping victims to plan for their family welfare before they finally die.

Companies should be made to take active role in the creation of awareness. Manufacturer's Association of Nigeria (MAN) which interacts with all the manufacturing companies should be integrated fully into the campaign against HIV/AIDS control programmes and prevention activities. Both employers and employees of companies should be educated to protect themselves against the dreaded disease.

The sooner we slow the tide of the pandemic the more manageable the situation becomes. Governments should act now or never, as our future is in jeopardy.

Table 1. Global Summary of The HIV/AIDS Epidemic, December 1997

People newly infected with HIV in 1997	Total	5.8 Million
	Adults	5.2 Million
	Women	2.1 Million
	Children below 15 years	5,90,000
No. of People living with HIV/AIDS	Total	30.6 Million
	Adults	29.5 Million
	Woman	12.1 Million
	Children below 15 years	1.1 Million
AIDS deaths in 1997	Total	2.3 Million
	Adults	1.8 Million
	Women	8,20,000
	Children less 15 years	4,60,000
Total No. of AIDS orphans since the beginning of the epidemic		8.2 million
	REGION	
	Sub-Saharan Africa	
No. of People living with HIV/AIDS	Adults & Children	20.8 Million
Adult prevalence Rate		7.4%
Cumulative No. of orphans		7.8%
Per cent of HIV-Positive adults who are women		50%

Courtesy UNAIDS

Table 2. The Prevalence Rates of HIV Positive among the Sentinel Groups for 1995/96

<i>Sentinel Group</i>	<i>Total No. Tested</i>	<i>No. HIV Positive</i>	<i>% HIV Positive</i>
Commercial Sex Workers (CSWs)	2,055	703	34.2
Antenatal Clinic Attendees (ANC)	6,033	713	4.5
Patients Attending STD Clinic (STD)	2,444	356	15.0
Patients with Tuberculosis (TB)	2,869	361	13.0

Courtesy NASCP

Table 3. Comparison of 91/92, 93/94 and 95/96 HIV Sentinel Surveillance Results

<i>Sentinel Group</i>	<i>1991/92</i>			<i>1993/94</i>			<i>1995/96</i>		
	<i>Total No.</i>	<i>No. HIV</i>	<i>% HIV</i>	<i>Total No.</i>	<i>No. HIV</i>	<i>% HIV</i>	<i>Total No.</i>	<i>No. HIV</i>	<i>% HIV</i>
	<i>Tested</i>	<i>Positive</i>	<i>Positive</i>	<i>Tested</i>	<i>Positive</i>	<i>Positive</i>	<i>Tested</i>	<i>Positive</i>	<i>Positive</i>
CSW	1,339	234	17.5	2,061	463	22.5	2,055	703	34.2
ANC	4,517	61	1.4	15,666	599	3.8	16,033	713	4.5
STD	1,359	63	4.6	2,627	235	8.9	2,444	356	15.0
TB	944	21	2.2	2,220	173	7.9	2,869	361	13.0

Courtesy NASCP

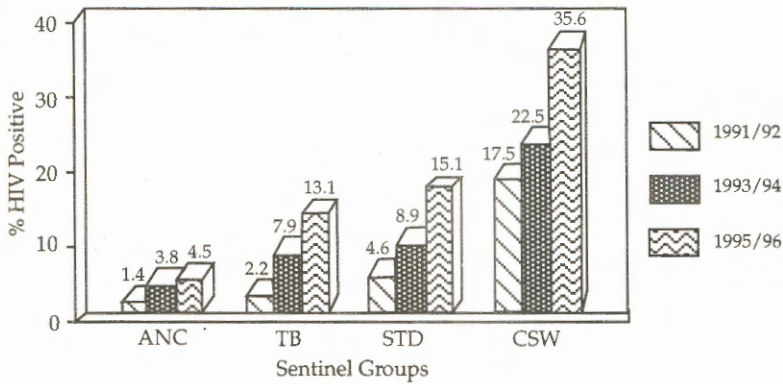


Fig. 1: Infection Prevalence Among Sentinel Groups (1991-1996)

Courtesy NASCP.

References

- AIDS Analysis Africa*, 1996 October.
AIDS Analysis Africa, 1997 Vol. 7 (2) April.
AIDS Analysis Africa, 1997 Vol. 7 (6) December.
 Azuh, Dominic 1994, *Child Survival Under Threat*. B.R. Publishing Corporation, Delhi, India.
 Kaluwa O.L. 1997, The National AIDS Control Programme Estimates, (Malawi) In *AIDS Analysis Africa*, Vol. 7, No. 6, December.
 National AIDS and STD Control Programme 1997, Report of 1995/96 HIV sentinel Sero-surveillance in Nigeria, May.
 STOP AIDS. 1997, *STOPAIDS News*, Vol. 1 No. 4, September.
The Guardian, 1997, August 7.
The Guardian, 1997, April 25.
 UNAIDS, 1996, Fact Sheet HIV/AIDS. Global and Regional Epidemic.
 UNAIDS 1997, Report on the Global HIV/AIDS Epidemic, December.