Achieving The Millennium Development Goals Through Combating HIV/AIDS In Nigeria: Ethical Perspective

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Abstract

The need to make the world a better place triggered off the Millennium Development Goals. Thispaper addresses the issue of combating HIV/AIDS for Nigeria to achieve MDGs target of 2015 from ethical view point. Presently, Nigeria is one of the countries that are highest hit globally. In this study, the effort of Nigerian government and other nongovernmental organisations to combat HIV/AIDS were brought to lime light. But despite their efforts, HIV/AIDS remains unabated. It was observed that the unethical practices by some managers of the funds provided to control and reverse the trend of HIV/AIDS in the country is a contributory factor. In view of this, the study recommends, among others, that ethical issues of impunity, embezzlement of such funds by agency and commission officials etc in Nigeria should be addressed and offenders brought to book. While the government, donor agencies and faith-based organisations should increase their funding and involvement in the fight against HIV/AIDS in Nigeria.

KEY WORDS: Millennium Development Goals, HIV/AIDS, and Ethics.

Introduction

The world leaders at the Millennium Summit in September 2000 adopted the Millennium Declaration, committing their nations to reducing poverty; improving health; and promoting peace, human rights, and environmental sustainability. The Millennium Development Goals (MDGs) are a set of eight goals which member states of the United Nations are committed to achieve by the year 2015 and were unanimously accepted as the framework for measuring progress in development. Specifically, the MDGs are a global pact between developing and developed countries (Amina az-Zubair 2009). They represent a bold attempt at changing the current skewed and undesirable global development patterns and lead many developing

countries into the desirable level of equitable economic development (Richardson et al 2008). The eight MDGs are:

1. Eradicate Extreme Poverty and Hunger
2. Achieve Universal Primary Education
3. Promote Gender Equality and Empower Women
4. Reduce Child Mortality
5. Improve Maternal Health
6. Combat HIV, Malaria and Other Diseases
7. Ensure Environmental Sustainability
8. Develop a Global Partnership for Development (MDGs 2000).

Since after the 2000 summit, different nations of the world have adopted different strategies to meet the 2015 target. Nigeria for instance, has adopted among other things National Economic Empowerment and Development Strategy (NEEDS), Universal Basic Education (UBE) and also created the Office of the Senior Special Assistant to the President on MDGs (OSSAPMDGs). This office is primarily mandated to establish a virtual poverty fund (VPF) that will channel resources derived from the Debt Relief Gains (DRG) to MDGs related projects and programmes (Emenalo 2010). Nigeria has also been carrying out a lot of expenditure to meet the 2015 target. According to Hajiya Amina az-Zubair (2009) former Senior Special Assistant to the President on the MDGs, three hundred and twenty billion naira only (₦320 bn) was appropriated for the period 2006-2008 to scale-up investments in achieving the MDGs. This represented 16% of the cumulative Federal Capital Budget for that period.

However, despite this laudable effort of the government, Goal 6 of the MDGs, aimed at combating Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS) amongst other diseases such as malaria and tuberculosis is yet to be achieved to a reasonable extent as Nigeria still remains one of the countries that are highest hit by the scourge of HIV/AIDS pandemic. Consequently, the thrust of this paper lies in the fact that any effort towards achieving the MDGs mandate in 2015 in Nigeria without combating the HIV/AIDS scourge is constrained. It argues that to achieve the MDGs targets in Nigeria by 2015, the issue of HIV/AIDS amongst the Nigerian population must be taken seriously and addressed. Hence, the paper further argues that controlling the occurrence and

spread of HIV/AIDS is imperative in achieving the Millennium Development Goals in Nigeria.

HIV/AIDS in Nigeria: Trend and Situation

The emergence of HIV/AIDS has continued to constitute serious health and socio-economic challenges throughout the world since the disease was first discovered more than two decades ago. Human Immunodeficiency Virus (HIV) is a retrovirus that infects cells of the human immune system destroying or impairing their functions which results in infected persons becoming susceptible to other opportunistic infections (W.H.O 2009:n.p). HIV is the virus that causes the human disease known as the Acquired Immunodeficiency Syndrome (AIDS). Presently, HIV/AIDS is incurable, affecting all population groups and the pandemic has been devastating the world especially the developing countries (Onah 2010). Commenting on this, Kaiser Family Foundations (2009:n.p) stated that HIV/AIDS cases have been reported in all regions of the world, but "most people living with the disease reside in low and middle-income countries". HIV/AIDS is still holding firm as the worst communicable disease in history. AIDS is now the leading cause of death in Sub-Saharan Africa and the fourth biggest global killer (Bellamy 2004:n.p).

UNAIDS and WHO (2008) stated that at the end of 2007, about 33.2 million persons were estimated to be infected with HIV globally. Out of these, 22.5 million were in Sub-Sahara Africa and about 3 million in Nigeria (Melaugha 2010). In its own report, the National Agency for the Control of AIDS (NACA 2009a:1) stated that "with an estimated 2.95 million people living with HIV in Nigeria in 2008, Nigeria ranks as one of the countries with the highest burden of the virus in the world, next only to India and South Africa". The report further stated that within the population of people living with HIV in Nigeria, females constitute almost three fifth (58.3%); as about 1.72 million women and girls are infected with HIV. Even more alarming is the fact that the highest prevalence rate of 5.6% occurs among the age group of 25-29 years; thus young people are disproportionately infected with HIV in Nigeria. The report equally observed that the April 2009 HIV/AIDS update indicated that an estimated 2.99 million people, consisting of 1.38 million males and 1.61 million females have so far died from HIV-related causes in Nigeria. In addition, according to the Federal Ministry of Women Affairs and Social Development report (2006-2010), 1.8 million children were orphaned by HIV/AIDS in 2003 alone; while the Federal Ministry of Health (2008)

estimated that 2.23 million children were orphaned by HIVAIDS in 2008. NACA (2009a) further observed that HIV/AIDS constitutes a leading developmental challenge and a major threat to the general advancement of the nation as well as her capacity to achieve the Millennium Development Goals.

The Nigerian epidemic is characterized by fluctuations in HIV Sero-prevalence as obtained through sentinel surveys of antenatal care attendees. The prevalence (Figure 1) shows an increase from 1.9% in 1991 to 5.8% in 2001 down to 5% in 2003 and 4.4% in 2005 followed by a recent rise to 4.6% in 2008. In Nigeria the prevalence also varies among the geopolitical Zones and States. For instance, the prevalence ranges from as high as 10% in Benue State (North Central Zone), 8% in Akwa Ibom State (South South Zone), 6.5% in Enugu State (South East Zone), 6.1% in Taraba State (North East Zone) to as low as 1.8% in Jigawa State (North West Zone) and 1.6% in Ekiti State (South West Zone)(FMOH 2005). However, the 2008 national survey showed the HIV sero-prevalence to be 1.0 % in Ekiti State (South West geo-political zone) and 10.6% in Benue State (North Central geo-political zone). Seventeen states and the Federal Capital Territory (FCT) recorded sero-prevalence of 7% or higher; four of these were from South-South (Akwa Ibom, Bayelsa, Cross River and Rivers) while two are from the North Central (Benue and Nassarawa States) and one from the North West (Kaduna) geo-political zones of the country. Also in most States, higher prevalence rates were recorded in the urban than in the rural populations (NACA 2009b).

The leading route of HIV transmission in the country is via heterosexual sex, which accounts for over 80% of infections. Mother-to-Child transmission, and transfusion of infected and blood products rank next, each accounting for almost ten percent of infections. Other modes of transmission particularly intravenous drug use (IDU) and same-sex intercourse are slowly growing in importance (NACA 2009a).

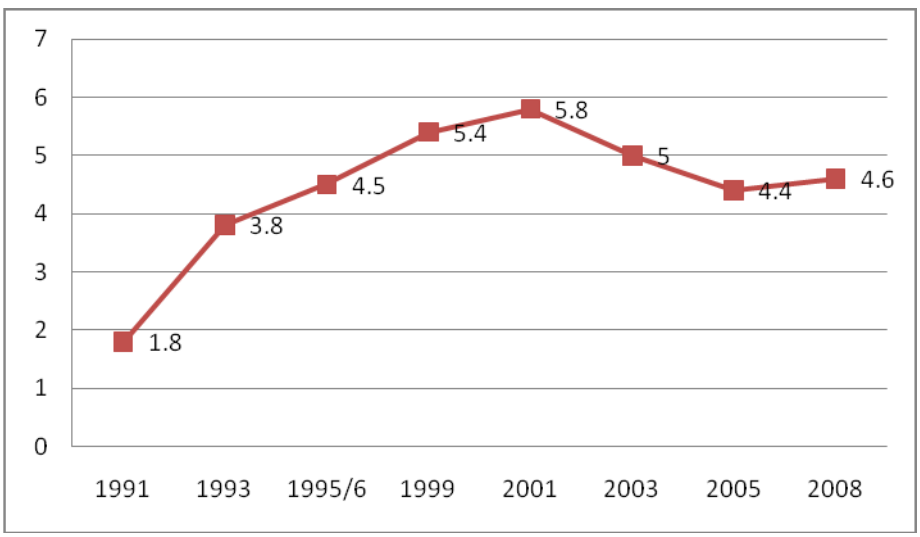
In Nigeria, the key drivers of the epidemic include: low risk perception, multiple concurrent partners, informal transactional and inter-generational sex, ineffective and inefficient services for sexually transmitted infections (STIs), and inadequate access to and poor quality of health services. Entrenched gender inequalities and inequities, chronic and debilitating poverty, and stubborn persistence of HIV/AIDS-related stigma and discrimination also significantly contribute to the continuing spread of the disease. The most-at-risk populations (MARPs) for HIV infection include female sex workers (FSWs),

intravenous drug users (IDUs), men who have sex with men (MSM), long-distance drivers, young people, and members of the uniformed services (NACA 2010a:11).

However, Nigeria has been responding through multi-sectoral comprehensive intervention programs. This notwithstanding, there is yet a continued persistence of the disease in Nigeria. Consequently, HIV/AIDS remains an ominous public health and developmental problem in the country, which could make the mandate of achieving the MDGs unattainable.

Figure 1

Trend in National HIV Sero-Prevalence Rate, Nigeria, 1991-2008



Source: NACA 2009b

National response to HIV/AIDS epidemic: The journey so far

The first case of AIDS in Nigeria was recorded in 1986. But the Nigerian government was slow to respond to the increasing rates of HIV transmission. The initial reaction was to vehemently deny it. As a result of this, the virus gradually spread across all the population of the nation affecting all the social strata of the society. The first sign of serious response to the epidemic was carried out by President Obasanjo who constituted a Presidential Committee

on AIDS (PCA) with him as the chair and Cabinet Ministers as members. He also established the National Action Committee on AIDS, (NACA), presently known as the National Agency for the Control of AIDS (NACA) in 2000, whose mandate was to co-ordinate the multi-sectored and multi-level response to the AIDS challenge. NACA therefore coordinates the various activities of HIV/AIDS in the country. NACA set up committees at State and Local Government levels (SACA and LACA) to spearhead both the State and Local government multi-sectoral response to HIV/AIDS (UNDP Nigeria, 2004). In 2001, the government set up a three-year HIV/AIDS Emergency Action Plan (HEAP). In the same year, Obasanjo hosted the Organisation of African Unity's first African Summit on HIV/AIDS, Tuberculosis and other related infectious diseases (Kanki and Adeyi 2006:.8). But before the development of HEAP, a National policy on AIDS was developed as part of the national response and backed up with the development of HEAP. HEAP was later replaced by the National Strategic Framework (NSF) in 2005. Nigeria National Response Information Management System (NNRIMS) has also been developed under the multi-sectoral response. These developments had enabled the country's national response to operate under the framework of the "Three Ones" principle, one coordinating agency (National Agency for the Control of AIDS) [NACA], one strategic plan (National Strategic Framework) [NSF 2005-9], and one monitoring and evaluation framework (Nigeria National Response Information Management System) [NNRIMS] (NACA 2009b:4).

In 2007 NACA later transformed into full agency known as National Agency for the Control of AIDS. While NACA leadership reports to the President, SACA and LACA report to the State Governors and Local Government Chairmen respectively. With the establishment of NACA, many nongovernmental organisations (NGOs) registered with it as health providers especially on HIV/AIDS.

Among other purposes, NACA's mandates are to:

1. Coordinate and sustain advocacy by all sectors and at all levels for HIV/AIDS/STDs Expanded Responses in Nigeria;
2. Develop the framework for collaboration and support from all stakeholders for a multi-sectoral and multi-disciplinary response to HIV/AIDS in Nigeria;
3. Develop and present to the Presidential Council on AIDS, PCA, all plans on HIV/AIDS in Nigeria for policy decisions;

4. Develop and articulate a strategic plan for an Expanded National Response to HIV/AIDS in Nigeria;
5. Coordinate, monitor and evaluate the implementation of the Strategic National Plan for the control of HIV/AIDS/STDs in Nigeria and all other approved policies;
6. Coordinate and facilitate the mobilization of resources for an effective and sustainable response to HIV/AIDS/STDs in Nigeria, and
7. Undertake any other duties as assigned by the PCA from time to time (NACA 2010b).

Thus, NACA spearheads the overall multi-sectoral coordination of the response to the HIV/AIDS epidemic in the country. The Federal Ministry of Health provides leadership to the health sector response and also provides national leadership in implementing antiretroviral therapy programmes, including developing treatment policies and guidelines, allocating resources and providing technical support to states and implementers. Furthermore, it is responsible for the overall monitoring and evaluation of programmes and for operational research. The National AIDS and STI Control Programme in the Ministry of Health coordinates the health sector response (W.H.O 2005). W.H.O. further observed federal government's effort to combat HIV/AIDS epidemic thus:

> The overall national response to HIV/AIDS is decentralized and multi-sectoral and has focused on increasing awareness about the epidemic, promoting behaviour change, providing care and support for people living with HIV/AIDS and establishing an effective surveillance system. Until recently, the health sector response to HIV/AIDS was integrated in the multi-sectoral response to HIV/AIDS, implemented within the framework of the HIV Emergency Action Plan 2000–2004. The government recently finalized the Health Sector Strategic Plan on HIV/AIDS 2006–2010. In addition, a new HIV Emergency Action Plan is also being developed to guide the multi-sectoral response. The government programme to provide antiretroviral therapy began in 2002 with the purchase of drugs and test kits for 10,000 people. The National Antiretroviral Scale-up Plan was launched in December 2004. Health facilities are being prepared to provide antiretroviral therapy services. The Health Sector Strategic Plan on HIV/AIDS 2006–2010 has been endorsed. The Nigeria National Response Information Management System is being rolled out in many states. Nigeria has a vast network of health facilities in the public sector at the federal, state and local levels (W.H.O. 2005:2).

In 2002, the Nigerian government started anti-retroviral (ARV) treatment programme which was regarded as Africa's largest anti-retroviral treatment programme. The programme aimed at supplying 10,000 adults and 5,000 children with anti-retroviral drugs within one year. An initial three and half million US dollars (US $3.5 million) worth of ARVs were to be imported from India and delivered at a subsidized monthly cost of $7 per person (Odutolu, Ahonsi, Gboun, Jolayemi, 2006 cited in Avert n.d). However, in 2004 the programme suffered a major setback, because there were too many HIV positive people with limited drugs to carter for them such that many people did not receive treatment for about three months. Eventually, another US $3.8 million worth of drugs were later ordered and the programme resumed (Avert n.d). Reuters Limited (2006) however, observed that ARVs were being administered in only 25 treatment centres across the country which was not adequate for the estimated 550,000 people requiring anti-retroviral therapy. In 2006 Nigeria opened up 41 new AIDS treatment centres and started handing out free ARVs to those who needed them. Between 2006 and 2007 treatment scale-up rose from 81,000 people (15% of those in need) to 198,000 (26%) by the end of 2007 (Avert n.d). Makinde (2010) also observed that between 2005 and 2006 alone, a total of ₦14.7 billion was budgeted to fight HIV/AIDS from the federal allocation.

In the year, 2010 NACA launched its comprehensive National Strategic Framework to cover 2010 to 2015 which requires an estimated N756 billion to implement (AllAfrica 2010, 30th March). The broad aim of the comprehensive National Strategic Framework 2010-15 include Behaviour Change and prevention of new infections while sustaining the momentum in HIV/AIDS treatment, care and support for adults and children infected and affected by the epidemic. Some of the main aims included in the framework are to reach at least 80 percent of sexually active adults and at least 80 percent of most at-risk populations with HIV counselling and testing by 2015; ensure that at least 80 percent of eligible adults and at least 80 percent of eligible children are receiving ART by 2015; at least 80 percent of HIV positive pregnant women access to more efficacious ARV prophylaxis by 2015 and to improve access to Positive Health, Dignity and Prevention interventions to at least 8o percent of people living with HIV by 2015 (NACA 2010).

Moreover, the national response to HIV/AIDS scourge has been enhanced by outside financial support. The Nigerian government has been getting financial assistance from

external sources. Such organizations that make significant contributions to Nigeria's response to HIV/AIDS include Global Fund, Department for International Development DFID, World Bank, President's Emergency Plan for AIDS Relief (PEPFAR), United Nations (NASA 2010:10) among others. It has been receiving help from bilateral and multilateral partners, nongovernmental organizations and other international agencies. Funds received from such organizations have gone a long way in helping Nigeria fight the HIV/AIDS scourge. The federal government actually recognizes the importance of International partners in the fight against HIV/AIDS when it stated in the National policy on HIV/AIDS that:

> Nigeria recognizes the importance of international technical and financial support in combating the HIV/AIDS epidemic. It also appreciates the need for cooperation between countries to prevent the further spread of the epidemic within and between countries; and the successful mitigation of the impact of the epidemic; especially within and between the developing world (Federal Government of Nigeria 2003:28).

NASA (2010:59) report shows that the expenditure on implementing HIV and AIDS services in Nigeria was US $300 million in 2007, of which the majority US $255,392,257.00 (85.3%) was from International funds, with bilateral contributions totalling US $197,219,367.00 (65.9%), multilateral agencies US $58,140,411.00 (19.43%) and the rest were from International not-for-profit organizations and foundations amounting to US $32,479 (0.01%). The same trend continued in 2008 with International funds contributing 92.3% of the US $364,581,432.00 of the total expenditure. US $319,040,525.00, (80.8%), US $45,477,907.00, (11.5%), and US $63,000.00 (0.0%) were respectively contributed by the direct bilateral contributions, multilateral agencies and International not-for profit organizations and foundations funds.

However, it has been observed that such funds are not being effectively managed. Commenting on this Mbah (2007:171) observed that People living with HIV/AIDS in Nigeria held a protest march on Monday 5th of December, 2005 at the International Conference to protest the dearth of anti-retroviral drugs for treatment of infected people in most parts of the country. He noted that one major reason for the failure of government in providing enough anti-retroviral drugs is the magnitude and ferocity of corruption, lack of accountability and transparency in the nation. He further made reference to the case of

embezzlement levelled against NACA by Global Fund. Citing News watch (2005:15) he stated that how NACA spent a whooping sum of ₦2.772 billion (US $201 million) on HIV/AIDS is subject of an investigation by Global Fund.

According to the Global Fund, which is the largest donor agency in Nigeria on HIV/AIDS, Nigeria has attracted approximately US $200m over five years to fight HIV/AIDS. This figure, the body said, is outside the yearly budgetary allocations to the agency from government and grants from other donor agencies. The principal recipient of most funding for HIV/AIDS remains the National Agency for the Control of AIDS (NACA). In 2006, the Global Fund cancelled a grant to Nigeria for reasons that bordered on non-performance. To the Global Fund, "funds should not just be spent simply for its own sake, just as a process, or disappear into deep private pockets, but to achieve concrete outcomes in prevention, treatment and lives saved by the interventions funded" (Makinde 2010). Commenting further on this, HIV/AIDS activist, Fredick Adegboye who is living with HIV said the efforts of the stakeholders are being channelled in the wrong direction, adding that most of the funds are being spent on irrelevant logistics that has nothing to do with the anti-AIDS fight. "We have more people in the rural areas. A lot of people are living with the virus in the rural areas and little or nothing is being done for them (Makinde 2010). Nwanyanwu (2010:26) in her own remark noted that HIV/AIDS control policies in the country are limited by a lot of challenges such as lack of sophisticated managerial capacity and technological equipment, shortage of professional volunteers, funds for project implementation, divers traditions, believes, customs and practices among others.

A critical reflection on this situation reveals that the political will of the government to fight HIV/AIDS is faced with challenges. This situation captures the import of reflecting on ways to combating HIV/AIDS for the attainment of the MDGs target of 2015.

Achieving the Millennium Development Goals through Combating HIV/AIDS in Nigeria:

Ethical perspective

It is said that a healthy nation is a wealthy nation. Less than five years into the target year of achieving the MDGs, Nigeria is still battling with how to halt and reverse the spread of HIV/AIDS epidemic. More so, instead of declining the prevalence has rather increased recently. This is a worrisome situation and urgent drastic measures are needed. In this

regard some suggestions are hereby made on better ways of combating HIV/AIDS for achieving the MDGs by 2015.

1. To say that Nigeria is blessed with human and natural resources is to restate the obvious, but ironically about 70% of her citizens lives below poverty level. Poverty is one of the key drivers of HIV/AIDS in Nigeria. The Government should deal with the issue of poverty. It is an obligation on the part of the government to alleviate poverty among the masses. Due to poverty, some people living with HIV/AIDS are unable to go to the hospital to receive treatment. Poverty is equally identified as part of the reason for engaging in prostitution which makes women vulnerable to HIV/AIDS.
2. Corruption, lack of accountability and transparency are identified as setbacks in fighting HIV/AIDS in Nigeria. Funds provided for HIV/AIDS control should not only be accounted for properly but should be seen to have been judiciously deployed with measurable results in the fight against and control of the scourge. It is unethical and morally wrong to embezzle, misuse or misappropriate monies meant to be used in combating HIV/AIDS and help people living with HIV/AIDS and other vulnerable groups. Culprits should be made to face the full wrath of the law.
3. Many people living in the rural areas cannot be reached because of lack of accessible roads. Therefore good roads are necessary to reach such people in dire need of medical attention. Other infrastructure such as hospitals, electricity, and clean water are also very important. Water scarcity poses a big challenge for someone suffering from AIDS. Clean water is needed in food preparation and for drinking to avoid infection and diarrhoea which PLWHA are vulnerable to. Where this is lacking both the infected and the caregivers become vulnerable to infections of different sought.
4. Government should increase and closely supervise her expenditure on HIV/AIDS control in all sectors. Enough funds should be provided to SACA and LACA coordinators to enable them reach the grassroots.
5. Many hospitals in Nigeria are not properly equipped. They are characterized by poor infrastructure, insufficient numbers of service providers, and lack of drugs

including ARVs. The government needs to beef up the current status of health care delivery system in the country to meet up with the current situational demands.

6. Research centres should be built to carry out relevant research on HIV/AIDS and their result utilized for the control of the disease.
7. With regard to peoples believe and practices, there should be a re-orientation of different communities about those cultural practices that put people at risk of contracting HIV/AIDS.
8. More help is needed from non-governmental organizations such as faith-based organizations in the fight against HIV/AIDS. Help such as sponsoring research on HIV/AIDS and reaching out to more people infected and affected with HIV/AIDS are of necessity.
9. The general populace should make the fight against HIV/AIDS and the achievement of MDGs a reality through portraying non-discriminatory attitude to those living with HIV/AIDS, submitting one's self to free HIV test and making ones status known if HIV positive.

Conclusion

The need to make the world a better place triggered off the Millennium Development Goals. The MDGs are dedicated to eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability and developing a global partnership for development with a target year of 2015. This paper addressed the ethical perspective of combating the HIV/AIDS scourge as a *sine qua non* for achieving the millennium development goals in Nigeria. It recognised that the nation transited from a position of denial to that of acceptance, which came rather lately and when the virus and disease had taken a firm foothold in the population. This was followed by a coordinated action to address and tackle the scourge by the Obasanjo administration. This resulted in the establishment of NACA and other agencies with defined mandates and funded by the government and several external donor agencies. These provided funds running into billions of naira but unfortunately, for over ten years and just a few years to MDGs achievement target year of 2015, the HIV/AIDS scourge in Nigeria does not seem to be abating. However, it has been observed that such funds are not being

properly managed. There has been accusations of unethical practices by managers of the funds in the various agencies such that the funds sometimes end up in deep private pockets and the ARV drugs, counselling and behavioural change advocacy end up not being properly provided to people living with HIV/AIDS and the most vulnerable and at-risk populations both in the rural and urban areas of the country. It is concluded that combating the HIV/AIDS epidemic is imperative in achieving the millennium development goals mandate in Nigeria and that it is essential for the government, donor agencies and faith-based organisations to increase their funding and involvement in the fight. However, such increase in funding will not yield the desired results unless the ethical issues of impunity, embezzlement of public funds by agency and commission officials etc in Nigeria are addressed and commensurate legal punishments meted as a deterrent to others.

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