Slow Progress

An analysis of implementation of policies and action on HIV/AIDS care and treatment in Nigeria

Edited by **Omololu Falobi & Olayide Akanni**

JAAIDS
JOURNALISTS AGAINST AIDS NIGERIA

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Journalists Against AIDS (JAAIDS) Nigeria is a media-based non-governmental, not-for-profit organization, with a mission to contribute to the prevention, care and control of HIV/AIDS in Nigeria by providing innovative communication interventions that will facilitate positive behavior change to reduce the spread of HIV/AIDS.

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Titles

ACRONYMS & ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
APIN	AIDS Prevention Initiative in Nigeria
ARV	Antiretroviral Therapy
CBHC	Community-based Healthcare
CDC	Centres for Disease Control
CiSNHAN	Civil Society Network on HIV/AIDS in Nigeria
HEAP	HIV/AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
JAAIDS	Journalists Against AIDS
LGA	Local Government Area(s)
MOU	Memorandum of Understanding
MTCT	Mother-to-Child Transmission of HIV
NACA	National Action Committee on AIDS
NASCP	National AIDS and STD Control Program
NGO	Non-Governmental Organization(s)
PLWH	People Living With HIV
PMTCT	Prevention of Mother - to - Child Transmission of HIV
VCCT	Voluntary Counseling and Confidential Testing
MCH/FP	Maternal Child Health/Family Planning
HBCP	Home-based Care Provider
STDs/STIs	Sexually Transmitted Diseases or Infections
RH	Reproductive Health
UCH	University College Hospital, Ibadan
LUTH	Lagos University Teaching Hospital
FMOH	Federal Ministry of Health

PREFACE

The policy framework for access to treatment and care for HIV/AIDS in Nigeria remains far from desirable. Many policy decisions affecting access to care and treatment are taken without the effective participation of people living with HIV and other important stakeholders.

Even when such decisions are taken, no effective mechanism exists for monitoring their implementation. Although some policy documents such as the HIV/AIDS Emergency Action Plan (HEAP) and the revised draft National Policy on HIV/AIDS articulate commitments and actions to be taken by different actors in ensuring the provision of care and treatment services and facilities, there is little or no effort to monitor the effective implementation of these commitments. Even where actions are taken, the processes for their implementation are often times not inclusive and lacking transparency.

These issues formed the focus of a Treatment Advocacy Project commenced in 2002 by Journalists Against AIDS (JAAIDS) Nigeria, with support from the Ford Foundation.

The treatment policy initiative project aimed at accelerating implementation of policy initiatives and promoting accountability in the context of access to HIV/AIDS care and treatment in Nigeria. Under the project, JAAIDS conducted policy analyses around treatment issues as well as map key policy documents, pronouncements and programmes on HIV/AIDS care and treatment in the country. The monitoring exercises addressed the content of policies relating to access to treatment, posing probing questions such as: Are the processes leading to such policies open and transparent? Are the promised deliverables evident? Are the issues addressed most appropriate or relevant to local needs? Are the financial resources committed to implementation of the policies and programmes justifiable? Do they address priority needs? Are the implementation activities sustainable? Will they build capacity of people and institutions?

The outputs from the mapping exercises were designed to serve as tools for a media and advocacy campaign to drive the quick implementation of policies. Deriving from the policy analysis component, the media and advocacy campaign were carried out on many fronts including convening of a quarterly Treatment Policy Roundtable - a forum for interaction

between policy implementing agencies and activists, and confronting decisions makers with scorecards of their polices and their (non) implementation. *Agenda for Action* - a quarterly bulletin detailing the main findings of the policy analyses and gaps to be addressed, served as an advocacy tool to mobilize public and media push towards implementation by relevant actors of the findings of the policy analyses. The publication complemented *Access Alert,* the bi-monthly newsletter on access to treatment in Nigeria published by JAAIDS since 2002.

In addition, JAAIDS used the popular email discussion listserv - the Nigeria-AIDS eForum to publicise the reports, potentially reaching over 3500 HIV/AIDS stakeholders in Nigeria and across the world. The reports were also placed on JAAIDS' website <www.nigeria-aids.org>.

In order to build a critical mass of advocates and supporters for the treatment policy initiative project, the project collaborated actively with major HIV/AIDS advocacy groups and networks in the country, including the Treatment Access Movement (TAM) and the Network of PLWHA in Nigeria (NEPWHAN).

Other components of the project included four treatment literacy workshops with PLWA, treatment advocates and care providers in the western, eastern, central and northern parts of the country. The workshops held in Ibadan and Abuja (October 2002), Enugu (2003) and Kano (2003).

We hope that this publication will contribute to efforts to achieve effective implementation of plans and commitments on treatment and care, and lead to the institutionalization of feedback forums and disclosure policies within national programmes on HIV/AIDS.

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Journalists Against AIDS (JAAIDS) Nigeria
December,2004

Chapter 1

Executive Summary

1.0 Background

HIV/AIDS is a leading health problem and development challenge in Nigeria. The prevalence of the infection has continued to increase progressively, from 1.8 percent in 1991 to 4.6 percent in 1996 and stands at 5.0 percent (2003). While primary prevention is the key to controlling the disease, treatment of HIV positive people is increasingly receiving attention for a number of reasons. On one hand, treatment has proven effective in mitigating disease progress, thus enabling the individual to enjoy a higher quality of life and contribute his or her quota to national development. On the other hand, treatment reduces viral load, and so contributes to decreased potentials for transmission of HIV infection. Availability of effective treatment options is also likely to contribute to more willingness on the part of the populace to participate in voluntary and confidential testing to determine their HIV status, and to reduce stigmatisation. Above all, access to treatment is a human rights issue and every individual has the right to benefit from progress and advancement in scientific and medical fields.

In March 2003, Journalists Against Aids (JAAIDS) commenced a Treatment Access Policy Initiative project, which aims at accelerating HIV/AIDS policy implementation, and ensuring accountability in the context of access to HIV/AIDS care and treatment in Nigeria. As part of the project implementation, JAAIDS awarded a research and policy analysis consultancy to analyse key policies, pronouncements and programmes on HIV/AIDS care and treatment in Nigeria; track the status and process of implementation of policies; identify key actors, major inputs and outputs, financial managerial processes and compliance to principles of openness, accountability and transparency.

Methodology

The assignment, which was carried out by three consultants involved two key elements: desk review and field-based key in-depth interviews.

Desk Review

The desk review involved the analysis of relevant policy documents, and documented policy pronouncements. With regards to the former, a number of existing national policies were examined, including: the current National Policy on HIV/AIDS, the HIV/AIDS Emergency Action Plan (HEAP), the Reproductive Health (RH) Policy, the National Health Policy, the National Policy on Women, National Youth Policy, the draft National Policy on HIV/AIDS & STIs, and the draft National Policy on HIV/AIDS in the Workplace. Other documents reviewed included National Curriculum on Sexuality Education, *Access Alert* bulletins, 31 Months Milestone Report by the former NACA Chairman (Prof. Ibironke Akinsete), copies of public lectures and statements made by relevant government officials, particularly the current NACA Chairman, Prof. Babatunde Osotimehin, and the head of the National AIDS & STD Control Programme of the Federal Ministry of Health, Dr. Nasir Sani-Gwarzo. National newspapers, dating back to January 2002, when Nigeria formally launched its HIV/AIDS treatment programme, were also reviewed.

Key In-depth Interviews

A number of officials who are key policy makers and programme implementers based in the federal capital were identified to be interviewed (key in-depth interview), and to comment on the process of development and status of implementation of various policies and programmes aimed at HIV/AIDS treatment and care in the country. These included NACA officials, officials of the Federal Ministry of Health, HIV/AIDS focal officers from other sectoral ministries, representatives of civil society organizations and key donor partners *(See Annex II)*

Limitations

The period provided in the consultancy for one consultant to visit Abuja was rather inadequate to conduct interviews with all the identified and relevant persons. On the one hand, the busy work schedule and field

nature of the assignments of several officials kept them away from their offices during the week of the visit. On the other hand, those who were available in Abuja still needed several visits and sometimes, long waiting periods before interviews that had been previously scheduled could be held. Others, especially the representatives of the major donor partners, could not be scheduled for an interview within the short time available to the visiting consultant.

Secondly, the fact that only key persons available in Abuja were interviewed is a limitation in terms of representativeness and the mix of responses, as provisions were made in the assignment for only a visit to Abuja and attempts to get some key non-Abuja based officials, such as the members of the National ARV Committee, on telephone proved abortive.

Chapter 2

Analysis of Policy Documents

INTRODUCTION

HIV/AIDS is a multi-sectoral development challenge. Thus, it would be expected that all sectoral policies would have provisions relating to HIV/AIDS. In this chapter, a review of selected Nigerian national policy documents and related documents, including draft policies, is presented, with a focus on their provisions in the area of access to treatment and care for people living with HIV/AIDS (PLWHA). The relevant portions of the policies are quoted as deemed necessary. Processes leading to the development of the documents, as obtained from the key informant interviews, and available documentary evidences are also discussed.

NATIONAL REPRODUCTIVE HEALTH (RH) POLICY (2001)

The National RH Policy has provisions related to HIV access to treatment under its stated (general) principles in a broad manner. The policy also has a goal directed to HIV/AIDS issues, with specific targets focusing on care of people living with HIV (PLWH). The issue of anti-retroviral drug was, however, not mentioned specifically. The principles, goals, and targets are linked in a very logical manner, and the target directly addressed the issue of PLWH (Table 1).

Ensure access of the public to scientifically proven preventive and curative reproductive health conditions including HIV/AIDS and protect them from unproven claims
- National RH Policy, Principle 2.2.2.8

Table 1: Provisions of the National RH Policy Relevant to Care and Treatment of PLWHA

Principles	Goal	Targets
■ Ensure compliance by all tiers of government and individuals with all relevant treaties, policies and laws supporting the attainment of the highest level of reproductive health irrespective of age, sex, ethnicity, religion and socio-economic status (Provision 2.2.2.4) ■ Ensure access of the public to scientifically proven preventive and curative reproductive health conditions including HIV/AIDS and protect them from unproven claims (Provision 2.2.2.8) ■ Provide comprehensive (including referral), client-oriented reproductive health services that are of good quality, equitably accessible, affordable and appropriate to the needs of individual men and women, families and communities, especially under-served groups such as adolescents and youths, persons with disability, underprivileged populations and people living with HIV/AIDS (PLWHA) (Provision 2.2.2.16) Provide adequate funding of reproductive health programmes through increased and timely financial contributions, judicious and transparent use of funds available to the programmes (2.2.2.27)	To reduce the incidence and prevalence of sexually transmitted infections including the transmission of HIV infection (Section 3.2.4)	*The following targets were set for between 2001 and 2006:* · Train at least 60% of health care providers to care adequately for and protect the rights of people living with HIV/AIDS (PLWH/A) and people with other STIs; · Protect the public from wilful/deliberate transmission of HIV/AIDS by HIV patients through adequate education and provision of condoms; · Establish at least one voluntary counseling and confidential testing center in every state of the Federation for HIV/AAIDS

NATIONAL YOUTH POLICY AND STRATEGIC PLAN OF ACTION

The policy has a section on health care, with the main objective stated as: *"to enhance youth accessibility to basic hygiene, healthcare and health education. This is aimed at providing information, education and safe-guards against preventable and communicable diseases such as sexually transmitted diseases (STDs), HIV and AIDS to which youths are most vulnerable".*

While the policy has provisions for HIV/AIDS prevention such as *"establishment of HIV/AIDS Awareness Clubs"* and *"promotion of public enlightenment programmes which provide knowledge and awareness about the dangers of STDs and HIV/AIDS"*, no mention was made whatsoever about young people that may be living with HIV or those otherwise affected by it.

NATIONAL POLICY ON WOMEN

The National Policy on Women focuses on health as one of its key areas, and mentioned HIV/AIDS as one of the important health problems. It advocateds an integrated multi-sectoral approach for effective service delivery for women. While the policy does not exactly focus on HIV care or ARV specifically, the policy nevertheless has a broad reference to the issue as it declares one of its aims as being to *"ensure provision of accessible, affordable, well staffed and equipped health facilities at all levels for the use of women and other vulnerable groups".* Under its key targets, the policy declared that by 2004 "special attention should be given to HIV/AIDS"

"Strengthen the national response to HIV/AIDS to rapidly control the spread of the epidemic and mitigate its social and economic impacts".

- National Population Policy, objective 14.

NATIONAL POLICY ON POPULATION FOR SUSTAINABLE DEVELOPMENT

This policy recognises HIV/AIDS as a major threat to health status and socio-economic development of the nation (section 5.1), and makes several pronouncements on HIV/AIDS control and care as part of its overall goal stated as ***"the improvement of the quality of life and the standards of living of the people of Nigeria"*** (section 6.1).

The policy specifically addresses the need for enhanced national response to HIV/AIDS and recognises access to care and treatment as a critical part of this effort, with specific provisions on anti-retroviral drugs. In addition, provisions on ensuring the protection of rights of PLWHA and encouragement of non-discriminatory practices and community support are positively complementary to the provisions on treatment and care.

Target and strategies

One of the policy targets is to achieve a ***"25 per cent reduction in HIV adult prevalence every five years from the launch of the policy"*** (target 10, section 6.3). Section 7.14 of the policy specifically identifies a number of strategies which include provision of ARV, and responsibility of government, non-governmental groups and private sector to provide care and support to PLWH. Importantly, the provision on ARV duly incorporates treatment of related infections, and emphasises need for financial affordability of such treatment. The policy provisions are well linked.

The policy provision concerning HIV/AIDS in the population policy represents a strategic and positive change in population policy formulation in the country, and an improvement over the existing policy launched in 1988. The provisions in the area of HIV/AIDS also represent an adherence to the spirit of the proclamation of the International Conference on Population and Development (ICPD) which is the current international framework in the population field.

Government shall initiate efforts to improve the access of PLWH to anti-retroviral drugs and related medications at affordable prices

- National Population Policy: Section 7.14, Strategy 14

Table 2: Provisions of the National Population Policy relevant to care and reatment of PLWH

Principle	Aims	Implementation Strategies
"Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. All tiers of government in Nigeria shall take appropriate measures to ensure, on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health care programmes shall provide the widest range of services without any form of coercion or discrimination. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so" (Principle 3)	*Goal:* Acceleration of a strong and immediate response to the HIV/AIDS epidemic and other related infectious diseases (Goal 5, Section 6.1) *Aim:* Strengthen the national response to HIV/AIDS to rapidly control the spread of the epidemic and mitigate its social and economic impacts (Objective 14, Section 6.2). *Target:* Achieve a 25 per cent reduction in HIV adult prevalence every five years (Target 10, Section 6.3).	● The government shall mobilise and commit resources sufficient to respond to the magnitude of the HIV/AIDS epidemic and implement national action plans (Strategy 1, Section 7.14). ● Programmes for voluntary and confidential counselling and testing for HIV, and early detection and treatment of other sexually transmitted infections shall be strengthened (Strategy 4). ● Government at all levels shall encourage public, private and non-governmental organisations and communities to develop supportive, non-discriminatory HIV/AIDS related policies and practices that protect the rights of people living with HIV/AIDS (PLWHA) and people affected by HIV/AIDS (PABA) (Strategy 8). Legislation shall be enacted to protect the rights of ● PLWHA and PABA (Strategy 9). Government, NGOs, the private sector and ● communities shall provide care and social support for persons living with HIV/AIDS and for those otherwise affected by the epidemics such as orphans and other relations (Strategy 13). Government shall initiate efforts to improve the ● access of PLWHA to anti-retroviral drugs and related medications at affordable prices (strategy 14).

NATIONAL POLICY ON HIV/AIDS

It would be expected that a national policy on HIV/AIDS would be the cornerstone for HIV control programmes and actions in the country. The revised HIV policy Launched in 2003 was developed to provide a more comprehensive, appropriate and responsive framework than the earlier policy drafted in 1998

The overall goal of the HIV/AIDS policy is ***"to control the spread of HIV/AIDS in Nigeria, and to mitigate its impact to the point where it is no longer of public health, social and economic concern, such that all Nigerians will be able to achieve socially and economically productive lives free of the disease and its effects"***. Conceptually, the policy is built on ***"the principles of human rights, social justice and equity"***, and such would be expected to address the issue of treatment and care to PLWHA which falls into these contexts. The following paragraphs present an analysis of the provisions of the policy with this background.

The policy articulates the commitment of the Federal Government of Nigeria to HIV prevention and control, and three of its provisions in this respect are particularly relevant to care and treatment for PLWH:

- ***Improve national understanding and acceptance of the principle that all persons must accept responsibility for prevention of HIV transmission and the provision of care and support for those infected and affected;***
  Provide cost-effective care and support for those infected;
- ***Protect the rights of those infected and affected by HIV/AIDS as guaranteed under the constitution and laws of the country.***
-

"The main strategies that will be used to achieve the overall goal will include ... Care and Support for those infected or affected by HIV/AIDS; including the provision of clinical management of diseases and access to care for all PLWHA; provision of home-based-care; treatment of opportunistic Infections (OI); provision of access to anti-retroviral therapy; care of orphan and vulnerable children; Support for the Infected; Support for the People affected by HIV/AIDS; and the Certification of Traditional Healers and Other Health Practitioners"

- National HIV Policy (Draft): Culled from the Executive Summary

(B) Aims

Objectives

Specific objectives indicated in the policy and which are relevant to the issue of access to care and treatment are as follow:

- *Improve national understanding and acceptance of the principle that all persons must accept responsibility for prevention of HIV transmission and the provision of care and support for those infected and affected; (Part II; Objectives no 16)*
- *Provide cost-effective care and support for those infected;*
- *Protect the rights of those infected and affected by HIV/AIDS as guaranteed under the constitution and laws of the Republic;*
- *Remove all possible barriers to HIV/AIDS prevention and control.*
- *Empower people infected and affected by HIV/AIDS through training, counselling, and education to cope with their circumstances.*
- *Develop standards and guidelines that lead to the institutionalisation of best practices to mitigate the impact of AIDS.*

Targets

- *Ensure that at least 20% of all local government areas will be able to offer home based care services to the people living with HIV/AIDS in their communities by 2010;*
- *Ensure that by 2010, 50% of health institutions will be able to offer effective quality care and management for HIV/AIDS;*
- *Ensure that by 2005 10% - and by 2010, 20% - of communities affected by HIV/AIDS will have programmes designed to provide social safety nets for persons infected with HIV.*

In addition, the policy specifically has a section on care and support and on clinical management of AIDS.

Policies and Strategies

The policy identified a number of strategic approaches to achieve the desired objectives which specifically include care and support for PLWH as well as affected people. In clear terms, the policy indicates government's recognition of its responsibility in the area of care and

support and specifieS objectives for this purpose as follows:

"Nigeria recognizes its responsibility to provide access to health care for all its citizens. Given that no effective curative therapy exists presently for AIDS, effective management of the condition must include an emphasis on compassion and support for the persons infected and affected by HIV/AIDS. The effects of the HIV/AIDS epidemic go beyond health, and affect the ability of persons infected and affected to live productively; therefore support is needed".

The objectives for the strategies for care and support are "to provide accessible, affordable and sustainable quality care for those infected by HIV/AIDS, and also to provide them and those affected by HIV/AIDS with the ability to live positively in spite of their condition" (Part II, paragraph 1 of "care and support" section).

The policy also makes provisions for the following specific implementation sub-strategies in the areas of care and support: clinical management, home-based care, management of opportunistic infections, and anti-retroviral treatment, certification of traditional healers and other health practitioners, support for the infected, support for the people affected by HIV/AIDS (care for orphans and other vulnerable children). Thus, the policy attempts to provide a broad and comprehensive coverage on the issues of care and support and appropriately link the sub-components.

Anti-retroviral Therapy

The provisions under the subsection on anti-retroviral therapy, with regards to policy objectives and strategies, are as quoted below.

Policy Statement:
The government will work towards ensuring that all persons in the country shall have access to the quality of health care that can adequately treat or manage their conditions, including the provision of antiretroviral medication (ARV).
Strategies:

- *Cost-effective and affordable care shall be made accessible to all people with HIV-related illnesses, including access to anti-retroviral therapy;*
- *The use of ARV shall be under medical supervision and shall be governed by established effective guidelines. These will be updated regularly with the results of research.*
- *A cost-effective drug list for the management of HIV/AIDS shall be developed and incorporated into Nigeria's essential drug list;*
- *Sale of ARVs shall be provided solely under strict medical supervision*

The government will work towards ensuring that all persons in the country shall have access to the quality of health care that can adequately treat or manage their conditions, including the provision of antiretroviral medication (ARV)

N*ational Policy on HIV/AIDS: Part III (Policies and Strategies), sub-section G under Care and Support- policy statement on anti-retroviral therapy*

Table 3: Provisions of the National HIV/AIDS Policy relevant to care and treatment of PLWH

Principle	Aims	Implementation Strategies
. The Policy shall be based on the principles of human rights, social justice and equity; . The various governments of the federation acknowledge their responsibility to provide Nigerians with adequate information to take responsibility for, and safeguard their health and well-being. . The various governments of Nigeria acknowledge their responsibility to provide for the health and well being of the people, which shall be fulfilled by the provision of adequate health and social services. . The nation will adopt strategies that are cost effective, practical, socially acceptable, and scientifically sound to ensure that the HIV/AIDS epidemic is brought under control. Improve national understanding and acceptance of the principle that all persons must accept responsibility for prevention of HIV transmission and the provision of care and support for those infected and affected	Policy Objective on Care and Support The objectives for the strategies for care and support are to provide accessible, affordable and sustainable quality care for those infected by HIV/AIDS and also to provide them and those affected by HIV/AIDS with the ability to live positively in spite of their condition. Policy Objective On Antiretroviral Therapy The government will work towards ensuring that all persons in the country shall have access to the quality of health care that can adequately treat or manage their conditions, including the provision of antiretroviral medication (ARV)	● Cost-effective and affordable care shall be made accessible to all people with HIV-related illnesses, including access to anti-retroviral therapy; ● . The use of ARV shall be under medical supervision and shall be governed by established effective guidelines. These will be updated regularly with the results of research. ● A cost-effective drug list for the management of HIV/AIDS shall be developed and incorporated into Nigeria's essential drug list; ● Sale of ARVs shall be provided solely under strict medical supervision

NATIONAL POLICY ON HIV/AIDS IN THE WORKPLACE

Key Principles

Under its key principles, the National Policy on HIV/AIDS in the Workplace recognises care and support as important entities and states as follows: "*Solidarity, care and support should guide the response to HIV/AIDS in the work place. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependants in access to and receipt of benefits from statutory social security programmes and occupational schemes".*

In the spirit of decent work and respect for human rights and dignity of persons infected or affected by HIV, the policy recognizes that there should be no discrimination against workers on the basis of real or perceived HIV status., and that discrimination and stigmatization of people living with HIV inhibits efforts aimed at promoting HIV prevention. The policy obligates the Federal Ministry of Labour and Productivity in collaboration with representatives of employers and workers' organizations to ensure that HIV.

Specific Provisions on access to treatment and care for PLWH

The policy provides for a package of care for PLWH, which includes access to HIV screening tests and ARV at *no cost* to the PLWH who is in the employment of the organisation. In this regard, this policy is different from others in that it advocates a specific step to financial access to services (i.e. "free" or at "no pay"). The second point to note about the specific provisions relating to HIV care and support is that the provisions specified cover virtually the entire spectrum of care for the infected person VCCT, pre- and post-test counseling, access to ARV, management of opportunistic infections, and protection from discrimination and stigmatization.

Care and Support
The following paragraphs quote specific provisions of the policy which are relevant to access of care and treatment in HIV:

As part of the comprehensive Care Support and Solidarity with

- *employees infected and affected by HIV/AIDS, voluntary counseling shall be provided at no cost to the employee and shall include pre-test, post-test, nutritional, ARV, and other relevant forms of counseling (section 13.1).*
- *Counseling shall be confidential and shall aim at providing psychosocial support including stress and anxiety reduction, promoting positive living and assisting persons infected or affected by HIV make informed decisions about HIV transmission. Counseling shall also address antiretroviral and other treatment available and terminal care concerns where necessary. (section 13.2)*
- *Voluntary anonymous testing with pretest and post-test counseling shall be made available to all employees and their families. (section 14.1)*

Strength and Limitations of the Policy Documents

The strength and weaknesses of the policy documents reviewed are presented in Table 4 below. However, it should be noted that these issues are not always within the strict framework of the specific issue of access to treatment on HIV/AIDS, but that of a larger policy context.

The review of the various policies shows that they are generally complimentary to one another in terms of pronouncements and provisions. However, the targets specified in the different documents were not in total harmony. The implication is that a less-than-ideal situation exists such that assessment or evaluation could only be expected to be carried out realistically by using selected indicators from a particular or limited number of policies, with each individual or group being at liberty to select the policy basis that best suit their purpose.

Table 4: Strength and Limitations of Reviewed Policies (with relation to access to HIV/AIDS treatment)

Criteria	Health Policy	RH Policy	Women Policy	Population Policy	HIV Workplace Policy
Adequacy of data base & situational analysis	Good situation analysis, but poor with regards to HIV/AIDS issues specifically	Good situation analysis of HIV/AIDS, but very inadequate with regards to treatment issues	Poor generally, and none relating to HIV/AIDS in general	Defined for HIV/ AIDS, but with little or no attention to HIV treatment situation	Excellent analysis of HIV/AIDS situation and impact, and fair treatment of treatment and care issues
Strategic consideration /treatment of key elements of drug and related logistics issues	Key approach to improving drug availability and management considered	Addressed in a broad fashion	None	No attention drug issues for PLWH	Strategically highlighted the issue of drugs and related treatment
Availability and appropriateness of targets	Not available	Specific targets included availability of VCCT centre and access to trained provider, but none on access to ARV specifically	No specific targets, but some broad objectives covered	No specific target availble for HIV/AIDS control, and for access to HIV treatment	Specific and fairly realistic targets set for treatment and care issues, including access to VCCT, facility- and home-based management of HIV/AIDS, ARV, and reduction of MTCT

Table 4: Strength and Limitations of Reviewed Policies (with relation to access to HIV/AIDS treatment)

Criteria	Health Policy	RH Policy	Women Policy	Population Policy	HIV Workplace Policy
Specification of implementation strategies	No specific strategy on HIV treatment issue	Broad strategies to addressing RH issues, including HIV/AIDS specified	No specific strategy on HIV treatment issue	HIV/AIDS issues, including treatment issues, well identified	Appropriate policy strategies identified
Institutional framework & Allocation of responsibilities	Roles and functions at different level well defined	Roles and responsibilities for both government (different levels) and non-goverment sectors specific	Partially addressed under the “general proposal for action”	Clear and broad institutional framework exists for programme implementation, with roles for different level of government and sectors of the economy	Specified with a broad participatory focus, including government and non-government sectors.

Table 4: Strength and Limitations of Reviewed Policies (with relation to access to HIV/AIDS treatment)

Criteria	Health Policy	RH Policy	Women Policy	Population Policy	HIV Workplace Policy
Consideration of resource mobilization and management issues	Health care financial issues addressed	Mentioned as part of roles and responsibilities of different groups	Non-specific	Broadly addressed	Clear consideration of resource mobilization and management issues
Provisions for monitoring, evaluation & review	Specially addressed	Explicit, with roles identified for governments and non-governmental groups	Poor	Specified as part of implementation strategies	Specified as part of strategies that will promote and enhance programme management and development
Overall consistency of policy provisions with technically expertise & best practice on HIV/AIDS treatment and focal development field	Not applicable (no attention to HIV treatment issues)	Broad policies and overall technical approach consistent with best RH practices, but not specific to HIV/ AIDS treatment	Not applicable (no attention to HIV treatment issues)	Overall consistency with new population and development paradigm, including focus on HIV/AIDS	Provisions are consistent with know technical knowledge and practice in HIV/AIDS-related fields.

OTHER POLICY DOCUMENTS

In addition to specific national policies, Nigeria has a number of other policy documents. Two of these are particularly important from the perspective of HIV/AIDS infection and shall be presented in this chapter: the HIV/AIDS Emergency Action Plan (HEAP) and the National Curriculum on Sexuality Education.

HIV/AIDS EMERGENCY ACTION PLAN (HEAP)

The HEAP is a multidisciplinary and multi-sectoral short-term strategic response to the HIV/AIDS epidemic in Nigeria developed by a broad range of developmental partners, under the leadership of the National Action Committee on AIDS (NACA). It identifies over 200 activities which the Federal Government intends to pursue over the period 2001 to 2004. HEAP broadly encompasses three types of actions:

* *Urgent interventions that can be quickly expanded or initiated:* These include core health sector activities, targeted prevention measures, behavior change communication, and essential care and mitigation measures. These will begin by building on existing programs;
* *Measures to stimulate a broader and more decentralized respons*e: These include the development of HIV/AIDS plans by participating line ministries, and the mobilization and funding of states, communities and NGOs.
* *Measures to provide the institutional groundwork for more effective implementation of HIV/AIDS control programmes over the long term:* These include the development of a multi-sectoral coordinating framework, standards for best practice in prevention and care, and a strong surveillance, monitoring and evaluation system.

(**Guiding Principles**

The guiding principles of HEAP virtually consider the issues of prevention, care and support as being a continuum as well as view communities' role as integral to the process. These two elements represent important strategic and conceptual linkages which would contribute to increased impact. The policy also stated that a proactive approach will be adopted towards gender issues within the context of HIV infection. This is a positive developmental approach that was neglected by most of other national policies.

Governing Principles

A total of 16 governing principles are listed in the HEAP, which include the following that have relevance to the issue of care and support .

Principle 5: To promote a national understanding and acceptance of the

principle that all communities and all persons must accept responsibility for providing care and support for those infected and affected by HIV/AIDS;

Principle 10: To develop standards and guidelines leading to the institutionalization of best practices in care giving and support to people infected by HIV/AIDS

Principle 12: To mitigate the impact of AIDS by

* Providing affordable and accessible drugs
* Encouraging counseling to those infected and affected by AIDS
* Providing financial assistance to AIDS orphans; and
* Providing micro-credit facilities to people infected and affected with HIV/AIDS

These principles highlight the recognition of the need to programmatically address the issue of care in a holistic manner, and the specific issue of access to drugs (even though the issue of anti-retroviral drugs was not mentioned specifically, the broad reference to drugs should suffice under programmatic "principles").

Strategic Components

The HEAP is built around two strategic components:

* Creation of an enabling environment
* Specific interventions against HIV/AIDS (which comprise of preventive interventions, and care and support programmes).

Strategies

Eight main strategies are identified in the HEAP with regards to specific interventions, with Strategy 7 specifically addressing the issue of "care and support for persons infected by HIV/AIDS".

* ***Strategy 7: "Care and Support for Persons Infected by HIV/AIDS"*** Under this strategy, NACA and its programme implementers "***will address the numerous problematic issues associated with persons infected by HIV/AIDS. Accordingly, this strategy focuses on the development of guidelines on such issues as appropriate and effective care for PLWHA infected with TB, development of guidelines for training health workers and PLWHA themselves, and establishing parameters on home-based care".***

The strategy has the objectives to: build capacity of health care providers on care and support of PLWH; provide care for PLWH at the local level through community home based care approach (CHBC) and identify community level support and solidarity mechanism of families of PLWH; promote operational research to stimulate innovative care mechanism for PLWH; improve skills and knowledge on the diagnosis and management of TB and other opportunistic infections; achieve access to integrated

diagnosis and treatment in all states by 2004; establish integrated care on HIV/AIDS and TB in all PHC centres.

The specified outcome indicators for this strategy include: improved quality of management of AIDS cases; enhanced capacity of health personnel to provide care and support to PLWHA; increased capacity for home-based care; improved counseling for PLWHA; and increased access to drugs. In general, the objectives and output and outcome indicators are noble in themselves, but an examination of the activities in terms of their depth, quantity and coverage showed technical inadequacies and deficient strategic linkages which may make them impossible to lead to the achievement of the desired outcomes.

For example, one of the activities specified is to "organize 3-day training workshop for 50 health care providers in the areas of patient management and counseling in 18 states (zonal level)": the duration of this training is clearly inadequate technically to ensure provision of quality care either in clinical management or in counselling support for PLWH is that while an objective of achieving "access to integrated diagnosis and treatment in all states by 2004" is specified, no provision is made for relevant and critical supplies and logistics support (including drugs and test kits) to support the health workers who will be trained from both public and private sector facilities to be able to provide quality services (but provision of supplies were made under sub-strategy 5.4).

On the other hand, while HEAP gives significant attention to CBHC with a plan to train 4,500 home-based care providers and provide drugs and equipments and materials supplied, the plan failed to provide for the strategic linkage between capacity building for facility-based healthcare workers and the community-based activities, which will be critical to the overall success of the CBHC. The plan (HEAP) does not also pay attention to the need to conduct relevant baseline and needs assessments (of focal communities, health personnel and facilities on ground), as a basis for initiation of context-specific programmatic actions.

* ***Other Strategies***

A number of other relevant strategies exist in the HEAP document, which have relevance for care and treatment of PLWHA. These include the following: *sub-strategy 5.4* (Prevention of infection through MTCT) and *sub-strategy 5.7* (workplace policies and programmes related to HIV/AIDS) of Strategy 5 (preventive interventions targeted to high risk population); *Strategy 6* (preventive interventions for the general population) whose focus include "ensuring structures and systems for

providing affordable VCCT services are developed"; and *Strategy 8* (care and support for person affected by HIV/AIDS).

Sub-strategy 5.4, with the objective of preventing mother to child transmission of HIV in Nigeria, has the integration of ARV into antenatal clinics in 18 states and the creation of an ARV revolving scheme in selected ANC clinics for sustainability of HIV/AIDS programme as part of its key activities. These activities, interestingly, have been scheduled to start in the same month (month 4) as that of the training of health workers stated under strategy 7 (discussed above), but earlier than the training of counselors (under strategy 6), with the training of trainers in VCCT scheduled for months 4 and 5, and lower level training from month 5 onwards. This objective, while focusing on prevention of transmission to the baby, fails to recognize the inter-related need of the mother for ARV to improve her health and prolong her life.

The objectives of sub-strategy 5.7 include: "to prevent HIV infection and provide care and support for workers infected and affected through the initiation of workplace policies and programs" (5.7.1) but none of the 8 activities described under the sub-strategy has to do specifically with treatment, and none of the outcome and output indicators focuses on improving access of infected workers to treatment. Strategy 6 (relating to VCCT) would be expected, if well developed, to provide counselling support to people with HIV infections as part of an overall care and treatment plan. Strategy 8, on the other hand, aims at addressing the numerous problematic issues associated with persons affected by HIV/AIDS.

On the whole, the HEAP attempts to mainstream treatment, care and support agenda into the HIV/AIDS prevention and control programme in the country, and specifies some relevant activities towards this end. Conceptually, the activities indicated in the HEAP are generally short-term in nature, and potentially of high impact: the implementation of these interventions is expected to form the base for a medium term strategic plan for HIV/AIDS control in Nigeria. While HEAP has a broad range of activities, concrete implementation steps are rather wooly with very little depth, and technical and strategic foci and linkages in the document are somewhat weak. HEAP also shows little sense of priority, which makes the document in some ways seem like a "wish list" rather than an action plan.

NATIONAL CURRICULUM ON SEXUALITY EDUCATION

The National Curriculum on Sexuality Education was developed by the Nigerian Educational Research and Development Council (NERDC), a parastatal under the Federal Ministry of Education (FME), in collaboration with Action Health Incorporated (AHI)

The curriculum highlights sexual health as a distinct theme. The issue of access to treatment and care in HIV infected people is specifically addressed under the topic of sexually transmitted diseases and HIV/AIDS in the senior secondary curriculum (Table 5), and not in the lower ones (primary or junior secondary). Targeting upper senior secondary school students alone within the school system leaves the majority of school children without exposure to knowledge of the issue of treatment and care.

Table 5: Provisions of the National Curriculum on Sexuality Education related to HIV Care and Treatment

Performance Obejectives	Contents (Core)	Activities
11. Explain the advice to the infected person	Advice to the infected. - Most STDs can be cured with proper medical care- There is no cure for HIV infection, AIDS and genital herpes, although medications are now available which lessen symptoms and slow the development of the diseases - Persons infected with HIV should encourage their partners to seek medical care - Some persons infected with STD and HIV can live satisfying and productive lives.	Students to develop more statements. Teacher to divide students into small groups of 5-6. Have the groups be assigned either one of the two tasks. Once the group has worked on the task they can have one member of the group present their ideas to the rest of the class. The one task is for the assigned groups to make a list of all the ways people can prevent STD and HIV/AIDS. The other groups will brainstorm and present advice to those who have been infected with a STD or HIV. The teacher can provide groups with more information or give them pamphlets that may help them with gathering this information.
Enumerate places to go for counseling for STDs, HIV Explain the need for community care and support for HIV infected person	12 Places for STDs and HIV counseling and medical care: - Public STD, HIV/AIDS clinics - Private doctors - Family planning clinics and - Hospitals Community care and support: - Explore having support groups for HIV-infected persons, persons with HIV - Reduces stigma associated with HIV - Prolongs the lives of people living with AIDS.	12, 13 14 Class guided discussion on the care and support for people living with STD, HIV/AIDS. They should suggest places that people can go for counseling and treatment, and explain why they should. They also need to talk about how to help family members living with HIV/AIDS. People living with these diseases need care and support.

PROCESS OF DEVELOPMENT OF THE POLICIES

Generally, policy development in Nigeria is usually in response to sectoral developmental challenges on national scenes or increased government attention to global challenges with local significances. For example, it was the seriousness of the HIV/AIDS epidemic in the country, characterized by a steady rise in sero-prevalence from 1.4% in 1991 to 5.8 in 1999, and the need to develop pro-active, short-term high impact interventions that formed the basis for a medium-term strategic plan such as the HEAP. On the other hand, the paradigm shift from MCH/FP to Reproductive Health, following adoption of the new concept of RH by the global community at the 1994 International Conference on Population and Development, was a major contributory factor to the development of the National Reproductive Health policy.

Steps taken in the formulation stages generally involves processes of broad consultations at several levels and with major relevant stakeholders, including national and international professionals, public and private sector organisations, civil society groups including faith-based organisations, and PLWH.Information obtained during the interview of key persons and documentary evidences indicated that this approach was used for national policies/documents such as the HEAP, the National RH policy, the Revised National Policy on HIV/AIDS and STIs, the Policy on HIV/AIDS at the Workplace, the National Policy on Population & Development and the National Policy on Women. Thus, virtually all the policies witnessed a fair degree of broad-based participation, involvement of civil society groups and transparency. However, the degree to which such broad based participation occurred differ for different national policies and documents.

In general, the process includes the production of several drafts that are widely debated and discussed by all identified stakeholders at different stages. Civil society groups are usually also involved in the process of reviewing final versions of the policy documents. Typically, the review of draft policy framework and documents involves the public sector (line ministries) at different levels of government; the private sector; Non-governmental Organisations (NGOs) and community-based organizations (CBOs); donor agencies; the academia, and religious,

traditional, women's and youth organisations.

As an illustration of civil society involvement, the Network of People Living with HIV/AIDS (NEPWHAN) and the Civil Society Network on HIV/AIDS in Nigeria (CiSNHAN) were involved in the development of the National HIV/AIDS Policy. NGOs such as Planned Parenthood Federation of Nigeria, Society of Gynaecologists and Obstetricians of Nigeria (SOGON) and Adolescent Health Information Project (AHIP), Kano were involved in the development of the RH Policy; and Inter-Gender, Jos, and Centre for Gender and Policy Studies of the Obafemi Awolowo University were involved in the development of the National Policy on Women. The involvement of civil society organisations, represent far more than tokenism as they have the privilege of full participant status and given the same rights as other groups involved in the process. The degree of representativeness of the civil society that participated in the process also varies widely with respect to geographical spread and influence.

The best example till date in terms of openness of the development process, and involvement of the civil society, including a high and even degree of geographical spread of such organizations, is the process of development of the National Population Policy. A meeting of civil society players was organized in various parts of the country where the draft policy, in its earlier form, was presented and considered virtually sentence by sentence. A national review took place after that with representatives of the civil society in each region featuring and presenting the perspective of their group. Financially, though, this highly involving process proved very expensive. On the other hand, the National RH Policy in its earlier form, which was developed by a wide group of stakeholders, was forwarded to all State Ministries of Health (specifically with a copy to each of the following: the Commissioners; Permanent Secretaries; Directors of Primary Health Care; Heads of HIV/AIDS Control Unit; and, RH/MCH/FP Coordinators). The draft was also sent to each tertiary institution departments of community/public health, nursing, sociology, and demography for their critique and inputs.

In terms of documented evidences of the development process, HEAP is one of the very few HIV/AIDS policy-related documents that made

reference to its development process, and it bears credence to the broad and participatory approach process earlier described. The development process is described as follows: “In defining the breadth and depth of the HEAP's framework for implementation, NACA, supported by the Government of Nigeria and its development partners, facilitated an extensive consultation process of programme formulation whose elements included a situation analysis, extensive consultation with national and international professionals in both the public and private sectors …”

Chapter 3

Analysis of Programme Implementation

The stage for the take-off of Nigeria's initiative in the area of access to anti-retroviral (ARV) was set by the announcement by President Olusegun Obasanjo at the Summit of African Leaders on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, which was held in Abuja in April 2001. The announcement stated that the Nigerian government would soon commence 'Africa's largest antiretroviral (ARV) treatment programme'. Consequently, pronouncements by other high ranking government's officials in charge of HIV/AIDS control effort including the health minister, the chairman of the National Action Committee on AIDS (NACA) and the head of the National AIDS and STD Control Programme (NASCP) gave greater details about the programme, including its starting date, approach and coverage (Table 5 shows the chronology of reported events in the initiation of the programme).

Although the government did not meet its initial declared start-off dates of September 2001, and later 1st December 2001, for what was described as “logistics reasons”, the programme took off in January 2002. The goal of the programme is to treat about 10,000 adults and 5,000 children in the first year, and a cocktail of three drugs are provided under the programme, namely ***lamivudine*** (also know as 3TC), ***nevirapine*** and ***stavudine.***

The Nigerian ARV programme is being conducted in phases. The first phase was that of “clinical trial”, which involved 25 centres each of which was expected to recruit 25 clients. The first phase was designed to end in three months: thus, each centre was expected to meet the quota of patients before the end of March 2002. At the trial phase, the government was expected to be responsible for all the costs for laboratory investigations as well as the drugs. In the words of one of the foremost managers of the programme, the first phase was “a learning experience”.

The first phase was to “give the medical practitioners and health care workers an idea of how clients would respond to treatment”, and would also afford the implementing government agencies time to compile data and produce preliminary reports which would be submitted to the National Agency for Food and Drugs Administration and Control (NAFDAC) for the registration of the drugs being used in the programme.

The next phases sought to build on the initial phase, as each centre was expected to increase clients' uptake to between 200 and 250, with a corresponding increase in the number of health facilities involved. A uniform slot of 200 patients was allocated, for example, under phase 2, and further increase in slots was dependent on the capacity of each facility, based on assessment of performance in the first phase. Government has also stated its desire to increase the number of ARV-providing facilities from 25 to 100. The facilities involved in the programme were expected to move directly to the phase 2 at the end of phase 1.

Unlike in the clinical trial phase, the services are not being given free of charge in phase . Rather, the government would be subsidizing 80 per cent of the cost of the drugs, and patients would also pay a sum of N1,000 per drug supply for the month. Clients are also required to pay for preliminary tests before being included on the trial as well as pay for their on-going investigations. Pronouncements by lead programme managers of the ARV initiative, as recorded in various media reports, indicate that the number of centres was to be increased from 25 centres to 100 within the first year. However, reports from the media and in-depth interview of key players showe that the government saw a need to review this stated programme approach, and decided to concentrate on the use of hospitals so as to derive “multiple advantages” in terms of technical personnel, manpower development for the level as well as for programme implementation at lower levels, coordination, and research, among others.

Analysis of Programme Implementation and Achievements

A review of the comments in the media and in-depth interviews of

stakeholders revealed concerns in a number of programme implementation areas, with the following as the major ones: issues of quality of programme operation; limited availability of information; inadequate involvement of stakeholders; high cost of treatment of infection; training and human resources; and logistics of supplies.

Quality of Programme Operation

Many stakeholders in the civil society were of the opinion that the pace of programme implementation lagged between government's declared “timetable”. As an example, some stakeholders were dismayed that some of the centres involved in phase 1 activities were not able to fulfill their 25 patients' slot by March 2002. A key reason for this, as the programme managers explained, was the industrial strike that took place in some of the centres.

“It is unbelievable that the centers had not yet filled the initial 25-person quota in a country with many people living with AIDS. One in 17, or 5.8 percent of Nigerians between the ages of 15 and 49 are estimated to be HIV-positive.
- Ebenezer Durojaye, an HIV/AIDS counselor at the Center for the Right to Health (culled from Access Alert)

Table 5: Highlights of Policy Pronouncements on the ARV Programme

Date	Pronouncement/Event	Key Elements
April 2001	President Olusegun Obasanjo formally announced his government's determination to commence ARV treatment initiative as part of HIV/AIDS control efforts	* Large scale initiative that would be 'Africa's largest antiretroviral (ARV) treatment programme' * Substantial government's contribution
September 2001	Prof. Alphonsus Nwosu, the Health Minister, announced that the country was ready to begin the clinical trials as he stated *"we have completed the training for the health workers. We have the drugs. We have designated the centers and we have set up the monitoring mechanisms. We are ready"*.	* Annual cost of programme is N500 million. * More than 60 health centers had already been trained to administer the trial treatment to 15,000 PLWHA. * Generic drugs would be purchased from two India pharmaceutical firms, Cipla and Ranbaxy
January 2002,	Administration of ARV drugs on a limited basis at 25 sites across the country "quietly commenced"	* Three drugs involved: lamivudine (also know as 3TC), nevirapine and stavudine. * Drugs and medical investigations were at no cost to the clients during the first 3-month Phase 1 activities (clinical trials)
3 June 2002	Permanent Secretary of the Federal Ministry of Health, Alhaji Shehu Suleiman, explained the approach in the second phase of the ARV programme	* Clients would pay N1,000 per month for ARV, and be responsible for costs of medical investigations
June 2002	Prevention of mother-to-child transmission of HIV/AIDS (PMTCT) takes off	* Eight pilot project centers involved * Nevirapine is used * Conceived to be linked with the ARV initiative

There were concerns by prominent PLWHA groups that many of their members were being left out of the programme. In the wider dimension, there were concerns that perhaps the programme was not reaching the persons that need it most: those that could not afford the cost of the drugs in the open market.

> **…."rich PLWH who could afford to purchase the drugs at market prices are depriving poor PLWHA whose only hope is the subsidized treatment programme".**
>
> *- Dr. Pat Matemilola, Coordinator, NEPWHAN*

Another concern relating to the programme implementation is the issue of monitoring of programmes. This includes monitoring the on-the-field activities of the programme (in various facilities), tracking of the drugs to ensure that it does not find its way to the open market.

Limited availability of information on the Programme

Many people living with HIV complained of lack of information about the treatment sites and programme details. Many stakeholders also raised the issue that such lack of information may be responsible for low number of people enrolled in the phase 1 treatment. Programme managers, however, indicated that the considering the limited spaces of patients' slot available in the programme, there was no need for wide publicity which would have raised expectations unnecessarily and bring undue pressures on the facilities.

Involvement of Stakeholders in Programme Implementation

There was considerable outcry in the media by prominent PLWH groups, including the Network of People Living with HIV (NEPWHAN) and the AIDS Alliance in Nigeria, that their members were not actively involved in the ARV treatment programme, and only a small number was enrolled on it. However, interactions with programme managers indicated that about one-third of the slots during the phase 1 were allocated to PLWH groups. What seems obvious is that greater dimension of interactions and understanding is needed to facilitate improved collaboration between government officials and the civil society.

On the other hand, the treatment programme is essentially federal government's baby, with only few states, indicating interests in carrying out such programme in their area of jurisdiction.

> **…"There were several questions begging for answers: were these drugs completely free or merely subsidized? How much were patients to pay for accompanying laboratory investigations? Would the programme be accessible to only HIV-positive people who had openly declared their status?"**
> *- Access Alert*

Cost of Care

While there had been little or no complaint about the cost of the ARV (N1,000 per month), a number of stakeholders complained that the cost of the series of preliminary screening tests, which PLWH have to undergo before being included in the initiative and during periodic assessment while on the drug, is a big barrier to adequate access to drugs even where available.

> **In LUTH, patients are required to spend a minimum estimated sum of 6,400 naira on these tests every three months.**
> **-** *Access Alert*

Many patients manage to do the initial tests prior to commencement of therapy, but only very few repeat the tests as at when due. Reports in the mass media showed that many health workers working with PLWH were worried about the eventualities of clients not complying with investigation schedules. As a health worker in one of the ARV facilities stated: "All they (the PLWH) seem concerned about is paying N1000 for the drugs. They are aware that these tests are necessary and we keep encouraging them to do these tests, but complain that they simply cannot afford them."

> **"All they (ARV Clients) seem concerned about is paying N1000 for the drugs. They are aware that these tests are necessary and we keep encouraging them to do these tests, but complain that they simply cannot afford them."**
> *- Dr. Sulaiman Akanmu, consultant heamatologist at LUTH and a member of the ARV team*

In the opinion of the leading programme managers of the Federal Ministry of Health, there are no reasons for clients to spend as much as the amount that have been reported, if facilities followed the national directives as to regularity and desirability of specific tests, and adhere to cost stipulation of some of the materials supplied to the facilities under the HIV/AIDS revolving funds. If

this is strictly correct, the implications are that most health institutions are either carrying out more investigations than desirable, or at more regular intervals, than the national programme recommended.

We recommended that no hospital should use Western Blot but ELISA which is cheaper, and should not cost more than N300. CD 4 should be at N2,00 per assessment. Liver function tests are also to be done, but no facility is expected to carry out viral load measurement except the national research institutes. So how are clients spending up to N6000?

- Dr. Nasir Sani-Gwarzo during an in-depth interview

This, on one hand, reveals a performance gap in the monitoring of the programme, and on the other hand, a need for closer interactions between players at the central level and those at the facility level. The existing framework of partners' meetings, though have potentials, have not shown effectiveness. More importantly, efforts to make the "HIV agent revolving fund" more effective is necessary for to reduce the high burden of treatment costs.

Training

Many stakeholders expressed concern over the quality of the training the Federal Ministry of Health provided to the health workers who are involved in the programme and the degree to which it prepared the health workers to be able to meet the need of the clients. An example was the case of the 1-day counselling training conducted by the ministry, whereas standard counselling training on takes at least ten (10) days. While the ministry officials explained that the people trained were not just coming into the counselling arena, but have either previously been trained under other health initiatives or by other institutions, the argument of professionals for more in-depth and skilled-based training is technically sound. It appears that the ministry had also realized the need for improved skill building

activities as programme managers indicated that the training programmes are being reviewed. A number of training manuals are also in the process of being developed.

Drug Supply

Concerns about regularity of drug supply to clients, ordinarily, should be of little concern to the initiative in its first year as drugs for the anticipated number of clients were ordered before the commencement of the programme. However, industrial strike actions by health workers had been severally reported to have disrupted the regularity of supply to patients.

"PLWH undergoing the ARV therapy have lately been unable to replenish their supply of drugs after exhausting the last batches. This is despite the importance of strict adherence to the regimen of ARV drugs by patients living with HIV/AIDS. There have been no provisions for taking care of the present emergency as regards the case of PLWHA undergoing ARV (at this facility)".

Both the clients and health workers agreed that there is need to make arrangements to continue to offer services to PLWHA on retroviral drug. Professor David Olaleye, head of virology at the UCH, for example, explained that ***"when the industrial strike went beyond two weeks, the people manning the ARV program made arrangements to provide some level of service to beneficiaries of the program. They continued to provide services: those on treatment continued to receive their medications; those who were not on medication were referred to virology. The only snag was that because the laboratory was closed, people were referred to reputable laboratories outside***

the health facility for their monitoring and tests. People still did their CD4 count with us. They continued to enroll on the ARV program"

One of the lessons learnt from the 'industrial action of health workers' episode is that managers of the ARV programme must put in place contingency plans to guard against such disruptions in future.
- Professor David Olaleye, Head, Virology unit, UCH, Ibadan

The fact that the facilities had not been able to increase their number of patients' slots means, essentially, that they could only continue to manage the old patients enrolled on the programme. This also has implications for linkage between the ARV programme and the PMTCT initiative as women and children weaned from the PMTCT cannot transfer to the ARV programme without increase in drug allocation and supply. So far, the paediatric dimension of the ARV programme has not even taken off, despite government's stated target of covering 5,000 children in the first year of the programme.

A further dimension to the question of drugs is the lack of drugs option for clients who may have a need for other types of combination (a switch-over option). One stakeholder, for example, stated: ***"As a result of drug misuse, resistant strains of HIV are likely to emerge. This would portend a great problem for the country as these strains could easily be transmitted across borders. How does resistance develop? Why are only three types of drugs being imported? What is the basis of the reactions of the drugs used in the combination therapy? If resistance develops, what should we do? These are the questions that the review committee monitoring the trials has to answer if the programme is to go full scale".***

Dr. Nasir Sani-Gwarzo indicated, in response to the questions on the issue, that the ministry was not aware of the importance of having switch options, but that since the clients are "ARV naïve" individuals, immunologically, and going by the nature of the drug combinations

selected, the Ministry does not expect any significant problem in terms of drug reactions. In addition, the ministry had planned to broaden the drug options in the second year of the operation of the programme.

Clinic operations and clients' waiting time

Long waiting time is becoming a critical issue affecting clients' satisfaction with the programme and resulting in significant level of frustration in mant facilities.

Reports from some facilities indicated that there is a high case load of patients in the ARV treatment clinic, and insufficient personnel to handle the clients. In the Lagos University Teaching Hospital (LUTH) for instance, lack of sufficient personnel to handle the high number of clients participating the ARV programme is a major source of worry. As the newsletter *"Access Alert"* stated, ***"ARV clinic days at the LUTH, which take place every Tuesday, are always a beehive of activities. Patients arrive as early as 7 a.m. in order to receive consultation early, and sometimes do not leave until about 4 p.m. Many of the clients stand for hours on end before they get a chance to see the doctor or even pay for their drugs, a situation which was alleviated only recently when the hospital provided more chairs for patients to sit."***

"The long wait is physically exhausting, both for me and my sister. The situation is bad enough to deter others who might want to join the programme. There are often too many delays, in record taking, consulting and even waiting to receive the drugs from the pharmacy. There is only one person handling the records, issuing cards and attending to the crowd that gathers here every Tuesday."
- Fadelis Amanze who has been bringing his sister for treatment at the LUTH ARV clinic since September 2002 "Access Alert" Jan/Feb. 2003).

The following words from a PLWHA care giver also illustrate the challenge in the quality of clinic operations: ***"The pharmacists often take a while to audit the drugs. They want to know the number of***

times an individual has collected drugs, the quantity of drugs used and amount left. These records are important, but the process wastes a lot of time. Every clinic day a client should be prepared to spend an average of five hours before being attended to. This can discourage a client who is already registered on the programme from returning on subsequent clinic days", he stated.

Thus, the ARV programme itself is a challenge to the poor human resource situation of many Nigerian health facilities. However, hospitals need to explore various ways to reduce clients' waiting time so as not to jeopardize the programme. Luckily, in response to the problems of the patients' case load, there are evidence that many hospital administrators are increasingly making efforts to improve the situation. These include increasing the number of seats and the number of doctors available to attend to clients in the ARV programme.

Patient Monitoring

Health professionals involved in the programme are worried that adequate monitoring of emerging resistance to drugs may be difficult in the absence of facilities for monitoring viral load and determining resistance. For instance, a member of the ARV team in one of the ARV facilities were reported to have stated as follows: ***"because the number of patients taking ARVs are enormous, the use of the drugs has a pressure effect on dictating resistance. We cannot conduct viral load tests or even do resistance tests at the moment. The Federal Government needs to develop these laboratory facilities and we cannot compromise on that with the number of ARV drugs in use, facilities need to be put in place to measure drug resistance variants. We may be consuming drugs without touching the virus.***

Facilities need to be put in place to measure drug resistance variants. We may be consuming drugs without touching the virus
- Dr. Sulaiman Akanmu, reported in Access Alert

"We need to develop our laboratories and train our personnel. Without this, the very good efforts of the ARV programme can become counter productive, if there are no laboratories. Manpower development is crucial and centers like this needs to be equipped to conduct these tests. If there are support groups who can meet, associate with and encourage the clients to continue their drugs, it will reduce the chances of defaulting"

Continuity support and integration of care

Facility-based care of the patients had not been adequately complemented by creation of effective support groups, and the community dimension to the ARV care is very poor. The complementarity of home-based care does not exist also with respect to most facilities. Experiences from Uganda and other countries where care and support programme had been successful highlight the lesson that a strong community orientation is important for overall success.

Many of the programmes targeted at care and treatment of HIV/AIDS in Nigeria, and contained in various policy documents have taken off, albeit

Chapter 4

Gaps and Successes

at different stages of implementation, and with varying degrees of successes. These include the treatment of PLWH with anti-retroviral drugs (ARV) introduction of voluntary counseling and testing (VCT) centers all over the country, prevention of mother-to-child transmission of HIV/AIDS (PMTCT), treatment of opportunistic infections among PLWH support of the establishment of care and support groups for PLWH to access care and support services.

While targets have not been met in most instances, and several obstacles still stand in the paths of various programmes there are a number of success stories worth mentioning.

- There has been a more-proactive involvement of civil society and PLWH in advocacy and implementation of care and support services in the country through a reorganization of the Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) into a very dynamic body, and one that has a secretariat. As at the time of this report there were over 50 support groups affiliated to NEPWHAN scattered all over the country, and funding partners and the donor community are showing more interests in the activities of NEPWHAN.

- Stigma and discrimination is receiving increasing attention in various sectors of our national life and this is impacting positively on care and support activities. Also, with the formulation of National Workplace Policy on HIV/AIDS , the rights of PLWH at the workplace are being upheld.

- A national protocol on the management of AIDS for health workers in the country has been developed by the FMOH and would soon be made available to health care facilities. This will prove invaluable in standardizing care and treatment services all over the country.

- The commencement of such treatment programmes as the ARV drug therapy and PMTCT (even at the modest levels of coverage) has started to reverse the fatalistic outlook of the HIV/AIDS epidemic in the country. There have been reports of patients who had become too sick to work or even function in their civil roles, but who had improved so much on commencement of ARV therapy to be able to return to work. Such instances bring hope to other patients, help to increase the proportion of Nigerians who are willing to undergo voluntary counseling and testing, and thereby reduce stigma and discrimination

- At the individual and family level, many PLWHA are enjoying improved quality of life, health and well-being through participation in the ARV programme and activities of support groups.

At present, several of the policies/programmes targeted at HIV/AIDS care and treatment in the country are not being implemented as planned, and targets are not being met. Some of the shortcomings that have been identified by various stakeholders are highlighted in this section.

Voluntary Testing and Counselling (VCT)

Presently, there are a number of VCT sites scattered all over the country. Some of these are health facility based, while others are stand-alone sites. A number of partner agencies and civil society groups are collaborating with the government in the establishment and operations of these sites. However, as identified by the National RH Policy, the HEAP and the revised National Policy on HIV/AIDS , there is a need to establish HIV voluntary counseling and testing centers in every state, and possibly every LGA in the country. This objective is yet to be realized.

Access to ARV drug therapy

The target of the Federal Government, as indicated earlier, is to make ARV drugs available to 10,000 adults and 5,000 children at the end of the first year of the programme. While the need for a modest beginning is appreciated for technical and logistic reasons, it must be noted that the targeted figures constitute a very low proportion (less than 0.5 %) of the 3.5 million Nigerians who are living with HIV. Even the 25 centers established by government for ARV treatment are themselves not functioning at optimal capacity due to limited supply of ARV drugs *vis a vis* the potential number of clients that could be enrolled. While a large number of clients continue to request to be enrolled on the programme, which has gone into its second year in almost health facilities the number of patients slot had remained at the same level.

At the National Hospital, Abuja for example, 570 patients had been recruited unto the ARV programme since its take off in February 2002, but since January 2003, no new recruitments have been made despite the almost daily request from clients who have had VCT and tested positive for HIV, due to shortage in supply of ARV drugs. Such category of patients who can afford to purchase ARV drugs at unsubsidized rates do so from the open pharmacy, while those who cannot afford it are left with no option. In the Lagos University Teaching Hospital (LUTH), it was reported that an average of 30 to 40 new clients are registered every week. The facility had enrolled up to 596 patients as at the time of this report, yet there are more cases presenting on regular basis requesting for enrollment on the programme.

The paediatric ARV programme is yet to take off despite numerous children who need the regimen. Moreover, there are still no switch-over drug options for patients who either develop resistance to the present drug regimen, or who cannot continue with the regimen for reasons of side effects.

Prevention of mother-to-child transmission (PMTCT)

Not only is the scale of operation of this programme too small (12 centers

country wide: 6 supported by the federal government, 2 supported by APIN and 4 supported by the CDC) to meet the needs of the country, the programme is still very inefficient in its operation. At the National Hospital, Abuja, pregnant women who are positive for HIV are only commenced on a single drug therapy (Nevirapine) during labour and immediately after delivery for the purpose of PMTCT. Such women cannot even convert to the regular ARV progamme post delivery due to shortage of drug supply, except the patient is ready to buy her drugs at unsubsidized rates (10,000 Naira per month) from the pharmacy. Not only is the duration of therapy too short, the single drug therapy also leaves room for development of resistance. For the newly delivered baby, his or her HIV sero-status cannot even be determined until 15-18 months after delivery due to unavailability of necessary examination equipment/test kits for HIV diagnosis. So, the anxious mother who has volunteered for counseling and testing, and then undergone the PMTCT regimen has to wait for this long before knowing the fate of the baby. If at the end of 15 months, the baby happens to be HIV positive, there is yet no paediatric ARV programme to commence such a child on

Treatment of opportunistic infections

This is the greatest challenge facing PLWHA in the country today. It has been observed that an HIV positive individual who has access to prompt management of inter-current and opportunistic infections might be stable and live positively with HIV, even without ARV drugs. However, nowhere in the country today is the treatment of such infections made free, despite the impoverishing nature of HIV/AIDS.

Non-decentralization of activities

This is a problem that cuts across various policies and programmes. An objective of HEAP, for example, is to foster the development of a dialogue with states and local communities so that, within HEAP's first 4 quarters of approval by the Government of the federation, 18 of Nigeria's states (those currently assumed to be facing the most dire impact of the epidemic) will have developed a state-specific action plan for

implementation of HEAP during the second year following HEAP's approval. Only Plateau State had developed and submitted such an action plan to NACA for possible commencement of implementation. Also, NACA has not been able to sufficiently decentralize its activities and care and support programmes in the country.

This is not unconnected with the fact that NACA is yet to fully address its own need for organizational and capacity development by recruiting the right mix of staff with relevant skills and experience, as well as that of SACAs and LACAs. Till date, NACA's status is still that of a committee with responsibility to the presidency. To ensure efficiency in its operation, and be able to decentralize activities as appropriate, NACA's mandate has to expand beyond the level of a committee to that of an independent agency, backed by relevant enactments and legislations.

Even at the ARV treatment sites, the implementers of the programme are of the opinion that the programme and other related ones are very sensitive, and should accordingly be given some level of autonomy from all the bureaucratic processes that govern the day to day running of public hospital services in order to enhance efficiency. This will remove such programmes from such obstacles as the out-of-stock syndrome that characterize several aspects of hospital services, including the supply of essential drugs and laboratory consumables. In effect, there will be better programme management in terms of availability of ARV drugs and medicines for treatment of opportunistic infections, availability of laboratory test kits and consumables, day-to-day decision making and funding.

Multi-Sectoral Involvement in Policy/Programme Implementation

One of HEAP's two key strategic components is the creation of an enabling environment for the management and mitigation of HIV/AIDS in Nigeria. In order to achieve this, the need to involve all segments of the society and all organizations in the country in the implementation of programmes and the

fight against AIDS was recognized by the HEAP. The document provides for various institutions to identify specific components, strategies, objectives and activities which best lend themselves to support, based on each organization's comparative advantage. Since the beginning of the unified National Response to HIV/AIDS, there has been a sustained willingness on the part of civil society groups and organizations to respond in relevant ways in combating the epidemic.

Over 700 civil society organizations working in the area of HIV/AIDS are operating in the country, and they are addressing different aspects of the National response. These include NGOs, CBOs, religious organizations private sector organizations and youth groups. While several are concerned with HIV/AIDS prevention, others are into providing care and support for PLWHA, HIV/AIDS research and human rights.

The major impediment to the success of the activities of the civil society groups is funding. While the Federal Government has recognized its role in ensuring that all entities responsible for the implementation of specific activities receive the financial and organizational support required to undertake such tasks, building the capacity of States and LGAs, and also formulated a strategy for catalyzing community responses in order to create an enabling environment for HIV/AIDS management in the country, it has given very little funding to civil society organizations.

Government at various levels (Federal, State and LGA) has financial responsibilities for the success of the policies/programmes targeted at the control of HIV/AIDS in the country, including treatment and care, as the citizenry has the rights of access to appropriate health care. However, apart from the federal government which had committed itself increasingly to financially support the access to treatment and care programme, very little action had been seen at the state and local government levels.

Nigeria received a $90.3 million credit facility from the World Bank in

June 2001 to implement her HIV/AIDS development project. As at the time of this report, very little of that money had been spent due to a number of logistic and technical reasons. The country had also received substantial grants from the Global Fund for HIV/AIDS activities, including treatment and care. There have been substantial financial input into the Nigerian HIV/AIDS control programme by other international agencies in terms of project, but very few of that had focused precisely on the issue of access to ARV as the specific mandate of many of the organizations do not deal with this aspect of HIV control. On the whole, an increasing amount of international aid has been given to Nigeria in the recent years to tackle the issue of HIV/AIDS.

The next logical question is, how well are these funds being spent? To answer this question correctly will involve a close review of financial outlays and reports, programme periodic reports, and specific project outputs and outcomes.

Sustainability

The issue of sustainability is definitely the greatest challenge in the context of the HIV/AIDS treatment programme. While the answer remains unknown it is clear that the political will and commitment of President Olusegun Obasanjo and his government will ensure significant support for the HIV/AIDS treatment agenda till 2007 when the government vacates office. Thus, while the future remains unknown, the prerogatives of the present must be to build a solid foundation for sustainable future that could reasonably withstand the uncertainties that had characterized the policy environment of Nigeria. The current efforts could be mostly regarded as immediate and short to-medium term measures. The current programmes will contribute to future sustainability if well managed and effectively implemented with a sense of accountability and technical efficiency.

Chapter 5

Conclusions and Recommendations

Nigeria has a number of policies that provide appropriate framework and strategic directions for effective actions in the area of HIV/AIDS control. The focus on HIV/AIDS treatment is stronger in the more recent policies, reflecting an increasing trend of national recognition that issues of care and treatment in HIV/AIDS are important. While there is room for improvement the problems in moving HIV/AIDS agenda forward in the country is essentially not one of policy formulation but that of policy/programme implementation.

The ARV initiative is a bold statement about the government's commitment to providing access to affordable drugs for people living with HIV. Despite the low proportion of PLWH that the programme targeted in its first year, and the many challenges that have confronted it, the programme has remained on course and holds hope of greater achievement in the future. It is the obvious that the programme managers are learning from their experiences, and are making efforts to respond to them appropriately.

The commitment of the present government to the issue of HIV/AIDS control provides an opportunity to build a solid foundation and an enduring platform for future HIV/AIDS treatment and care programmes. While efforts to increase the coverage of the present ARV treatment programme in terms of number of clients, facilities, geographical spread, and drug mix are laudable, significant efforts should also be directed to the issue of sustainability.

The major aim of the ARV programme to ensure its sustainability, in the sea of Nigeria's uncertain policy environment, should be to bring the country to a situation where the costs of ARV would be brought down to the lowest level to make it affordable to the common citizen. Options to be considered include in-country production of drugs, and use of internationally

recognised frameworks of compulsory licensing and parallel importation. For greater success and sustainability, HIV/AIDS control activities must continue to be multi-sectoral and aimed at reaching people in every part of the country. The role of the civil society is crucial to the success of the programme, as they can effectively serve as watchdog of government's actions and policies, and advocate for best practices. A strengthened relationship, coalition-building and partnership between various groups of stakeholders is important for success. Finally, a stronger commitment, funding support and effective programme management are critical to success.

Based on the above, we make the following recommendations:

- A review of the National ARV programme in order to learn from the experience, and apply this to future programme actions in the area of HIV care and treatment

- Production of relevant protocols in treatment and care and wide distribution of the protocols to inform appropriate decisions and support the practice of quality of HIV care and treatment

- Commencement of the process of revision of the HEAP and other core HIV policies to appropriately reflect strategic national approaches to treatment issue. Representatives of the HIV/AIDS programme units and organizations (both public and private) should be involved in future national policy revision or development processes to ensure that HIV treatment and care issues receive adequate attention.

- An overall strategic plan for HIV treatment and care, which is realistic in nature and fitting into the Nigerian context, consistent with best practices in the HIV/AIDS field, and has the aim of ensuring access to treatment for all PLWHA and prevention of MTCT on a sustainable basis should be jointly defined by stakeholders. The plan should be within an overall HIV/AIDS control agenda, with holistic focus on the various levels

of control: primary prevention; treatment of infected people (for both opportunistic and HIV infections); and care for affected people. Options for sustainability including possible local drug production, parallel importing, and compulsory licensing need to be carefully considered within such a plan. Such plan should be vigorously implemented with government on the driving seat, and critically monitored by other stakeholders, with civil society particularly playing an active role in the monitoring and as pressure group.

Appendix 1

National Policies and Strategy Documents Reviewed

- National Health Policy and Strategy
- National Reproductive Health Policy
- National Youth Policy
- National Policy on Population for Sustainable Development
- National Policy on Women
- National Policy on HIV/AIDS & STIs
- National Policy on HIV/AIDS in the Workplace
- HIV/AIDS Emergency Action Plan (HEAP)
- National Curriculum on Sexuality Education
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Appendix II

List of Persons Contacted

NAME	ORGANISATION	ADDRESS
Mr. Shodehinde	Deputy Director, National AIDS Action Committee (NACA)	Abuja
Mr. Sam Archipong	Communication Consultant, National AIDS Action Committee (NACA)	Abuja
Dr. Nasir Sani-Gwarzo	Deputy Director and Head, National AIDS and STD Control Programme (NASCP), Federal Ministry of Health, Abuja	Abuja
Mr. Paul Okwulehie	Coordinator, HIV/AIDS Programme, Federal Ministry of Labour	Abuja
Dr. Pat Matemilola	Coordinator, Network of People Living with HIV/AIDS (NEPWHAN)	Abuja
Dr. Jerome Mafeni	Country Representative, The Policy Project	Abuja
Dr. Oluwole Daini	Former Programme Officer, Civil Society Network on HIV/AIDS in Nigeria (CiSNHAN)	Abuja
Dr. K.C. Iregbu,	Coordinator of the ARV Programme, National Hospital, Abuja	Abuja
Mrs. Binta Hassan	Programme Officer, Ministry of Women Affairs	Abuja
Dr. Alti Zwandor	National Programme Officer, Joint United Nations Programme on HIV/AIDS (UNAIDS)	Abuja

List of Persons Contacted

NAME	ORGANISATION	ADDRESS
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Oba Oladapo	Positive Life Association of Nigeria (PLAN)	Block C3, suites 1 & 2, Trade fair complex Sango, Ibadan.
Mrs Nnabugwu Otesanya	Family Health International (FHI)	18, Temple road Ikoyi Lagos.
Dr. Onwujekwe	Nigerian Institute of Medical Research (NIMR)	Yaba, Lagos.
Mrs Bola Omotosho	Family Health and Population Action Committee (FAHPAC)	FAHPAC complex, Onyere, Orita Aperin, Ibadan.
Dr. (Mrs) Akingbola	Dept of Haematology College of Medicine	University College Hospital (UCH) Ibadan.
Dr. Akanmu	Department of Haematology College of Medicine	Lagos University Teaching Hospital, Idi Araba, Lagos.
Dr. Adetifa	Department of Paediatrics College of Medicine	Lagos University Teaching Hoispital, Idi Araba, Lagos.
Dr. Ogundiran	HIV/AIDS Unit, World Health Organisation (WHO)	World Health Organisation Lagos office, Yaba, Lagos.
Mrs A. U. Aina	Lagos Mainland Local Government, Dept of Health.	Yaba, Lagos.
Dr. Ogboye	Lagos State AIDS control Agency (LASACA)	General Hospital, Broad street Lagos.
Mr. O Falana	SMARTWORK Nigeria	Ladegbuwa plaza, No 6, Alhaja Ashabi Cole road, Agidingbi, Ikeja, Lagos.
Mr. Bede Eziefule	Center for the Right to Health (CRH)	3, Obanle Aro Avenue, Ilupeju Lagos.
Lt. Ekpe	AIDS Alliance of Nigeria (AAN)	26, Igbosere street Lagos.
Mr. Joseph Abende	Medicines Sans Frontiers	20, Alexandra Avenue, Ikoyi Lagos.
Mr. Kalu I. Kalu	Positive Life Organisation	C/o NIMR, Yaba, Lagos
Lt. Ojukoro	Armed Forces Program on AIDS Control (AFPAC)	Moloney street, Lagos.