



Towards Promoting an African Medical System

A critique of government responses to claims of a cure for HIV/AIDS in Nigeria,
1986-2007

S. B. Amusa

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Abstract

The HIV/AIDS epidemic has been described as the greatest health challenge of our era. Aside from Highly Active Antiretroviral Treatment (HAART), the virus has defied any other form of permanent cure or disease control. The continents of Africa and Asia are the worst-hit areas by the scourge of the pandemic. Yet in Africa, there have been claims of HIV/AIDS being cured by African indigenous medical practitioners. Our paper examines the official responses of the Federal Government of Nigeria to such claims. We will examine the emergence and national responses to the epidemic in Nigeria and assess the government's contempt for the efforts of indigenous medical practitioners in the quest for a viable cure. We conclude by asserting that until African governments realize, recognize and appropriate indigenous medical achievements into mainstream health strategy and policy, Africa will not only remain at the periphery of global health systems but will also continue to be ravaged by HIV/AIDS.

Keywords: *Africa; AIDS; Colonialism; cure; HIV/AIDS; Westernization*

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1. Introduction

The African continent is historically rich in cultural, social and political diversity (Falola and Heaton, 2008: 1). Diversity, present in all aspects of African life, is often unacknowledged and under-exploited for the overall promotion of African development. This can be partly explained by the historically lengthy Colonial experience and partly a result of the greater influence of Westernization (Ndege, 2002: 250-253). The African health sector at present (and possibly more than any other culturally infused and socio-economically determined official milieu) reflects the diverse tapestry of African society. In contemporary Africa, a traditional medical system thrives and lives on, alongside modern scientific Western medicine – this, the parallel of the ancient and modern yet to be recognized by the governing authorities¹.

The contemporary era of Africa has been marked by the emergence of the HIV/AIDS epidemic and where the impact suffered has simultaneously exposed both the reality of medical diversity and the lack of acknowledgement by African governmental regimes. Until now, there has been no known cure for the scourge and there is yet to appear from the world's laboratories a medical vaccine against the virus (Adler, 2001: 1). The most adequate and viable form of biomedical management has been with us since the mid 1990s – that is, Highly Active Antiretroviral Therapy (HAART). Since the emergence of HAART in 1996, the AIDS mortality rate has been drastically reduced in the dominant economies of North America and Western Europe (Irwin, Millen and Dorothy, 2003: xxvii). Yet the scenario of developing nations, particularly sub-Saharan Africa, is where the world's HIV/AIDS burden is more heavily concentrated with more than 90% of HIV+ persons (PLWHA) without access to antiretroviral therapy. This is due, not only to high level of poverty but also to the weaknesses and systematic discrepancies within the health care structures of many African countries (Irwin, Millen and Dorothy, 2003: xxvii).

Since antiretroviral drugs are sooner a management than a cure for HIV/AIDS, and given that there is a stark insufficiency of disease control programs in Africa, the search for a permanent cure for HIV/AIDS, particularly through alternative means, has continued to evolve in various parts of the world (Soyinka, 2000: 13). On the African context, traditional medical practitioners emerged within the different composing countries, and at different times, to lay claim to the knowledge and practices of indigenous medicines that could cure those people living with HIV/AIDS. What's more, it has been even said (albeit unofficially) that indigenous medical knowledge can harness a vaccine capable of immunizing against the virus. Such efforts and claims have been met with diverse responses from the governments of most African states ranging from official condemnation and proscription to the outright illegalization of any such practices.

¹ Indeed, where a good number of Africans prefer traditional medical attention to modern Western medicine, others are sooner contented to mix both indigenous and modern Western therapies for ailments.

It is against this background that our paper examines some of the indigenous HIV/AIDS vaccines and curative drug claims in Nigeria since 1986 and the nature of official responses to such claims by the Nigerian government. The study adopts a historical approach by analyzing and interpreting primary and secondary sources of historical data such as newspapers, journal articles and books. The paper is a scholarly contribution to the current debate on the relevance of African indigenous medicine in modern health care provision, which continues to be dominated by orthodox western medicine.

A European incursion, Colonialism and the Westernization of Nigerian health care

With the dawn of the 20th century, Nigeria had come under the colonial tutelage of the British government. The “Nigerian Project” was officially formalized in 1914 (Olaniyan, 2003). British colonial rule in Nigeria between 1900 and 1960 had socio-economic and political impacts upon the various peoples, regionally and nationally, who constitute the national picture of a modern Nigeria. One of the major impacts of British rule upon the social ways of life of the Yoruba peoples for example, was the introduction of Western medicine. This came by way of early Christian missionaries who had sought to primarily provide healthcare for the European missionaries dying of tropical diseases en masse. Later, access to health became synonymous with a strategy of modern religious conversion, where the Nigerian peoples who were adherents to African Traditional Religions turned to Christianity at the same time as to elementary health provision (Ayandele, 1966; Ajayi, 1965).

But this was by no means a reasonable “turn” for the better: European Christian missionaries attacked and condemned the use of indigenous medicine, equating it with magic, sorcery and idol worship, and thus in complete contradiction to the reigning principles of Christianity and the dictates of the Church (Babalola, 2003: 273-274). The result, was that converts to Christianity during this period embraced Western medicine in the name of modernity, which necessitated the moral rejection of indigenous medicine. Christian missionaries had thus little resistance when commanding new converts to publicly and openly burn charms, symbolic objects and medicines which had otherwise formed the cultural tapestry of traditional identity and practices (Babalola, 2003: 273-274). It is true to say that early converts still held faith to their indigenous medical practitioners, yet with the Christian missionary bodies building a number of modern hospitals along with their churches in all parts of Nigeria, the common choice was sooner a Christian and scientific rather than traditionally indigenous (Omotoye, 2010: 118).

The colonial regimes in Africa pursued a policy of Westernization of African health services on the premise that African health and healing traditions were insignificant when compared to the power of science and Rationalism, and that it could neither reinforce nor replicate the objectivity of scientific medicine and its methods (Ndege, 2002: 249-262): the “Westernization” of health subsequently instilled itself as the only viable route to social betterment for Africans.

The colonial government of Nigeria pursued a policy which would severely limit indigenous cultural values among the peoples, including medicine, which was illegalized along with its practitioners. This had a negative impact on the status indigenous African medicine among the people as those who had embraced Christianity began to look down on indigenous medical practices as nothing other than a mere fetishistic system of occultism (Babalola, 2003: 273-274). A point of historical distinction is that whilst the colonial government had not demonstrated interest in establishing hospitals during its fledgling years, it nevertheless supported the Christian missionaries both in their efforts to implant Western medicine onto the cultural landscape of Nigeria and other African countries and also in their bid to limit, if not stamp out, Nigerian indigenous medicine.²

² For details on how colonial powers restricted and reduced African traditional medicine during the colonial period in Tanzania for example, see Merdith, T. (1977). “The Impact of Colonialism on Health and Health Services in Tanzania” *International Journal of Health Services*, Vol. 7, No. 1. This said, Western medicine did not gain wide acceptance among the peoples of Nigeria during the colonial period in spite of its imposition and illegalization of

Yet despite the supported opposition of Christian missionaries and to the tradition and practice of indigenous medicine, the latter has remained resilient and relevant in the healthcare system of the Nigerian peoples. In contemporary Nigerian societies, for example, recourse is still made to aspects of indigenous medicine irrespective of the particular religious convictions of the health seeker – be they Islamic, Christian or ATRs (Lambo, 1990: 9). It must also be noted that in the event of an ailment defying the analytical optic of orthodox medicine, indigenous medical practitioners become a commonly sought recourse which on several occasions has borne solution.³

II. The HIV/AIDS Epidemic in Nigeria: A History of its Emergence and Factors of its Spread

Historically, the first global cases of HIV/AIDS were first reported in May 1981 by Dr. Michael Gottlieb of the University of Los Angeles, Medical School (Gallo and Montagnier, 1988: 10). The first victims were reported to be five Homosexual men who were suffering from an unusual pneumonia technically known as *pneumocystis carinii pneumonia* (PCP) as well as a rare type of cancer known as *Kaposi's Sarcoma* (Ks). When Dr. Gottlieb reported these unusually rare cases, the Centre for Disease Control (CDC) in Atlanta, Georgia, put together a small working group baptized as the Task Force on Kaposi's Sarcoma and Opportunistic Infections (KS/OI). The groups were led by Dr. Harold Jaffe, and by the summer of 1981, after a series of medical investigations, an epidemic had been confirmed (Gallo and Montagnier, 1988: 11).

The Human Immunodeficiency Virus (HIV) was first isolated in 1983 from patients with the AIDS-related complex and was initially called Human T-lymphotropic Virus type III (HTLV-III) in the U.S. In France, the complex had been termed the Lymphadenopathy Associated Virus (LAV). Later, in 1986, the AIDS virus was renamed HIV when both the viruses discovered by Robert Gallo in the U.S. (HTLV-III) and Luc Montagnier in France (LAV) were found to be genetically indistinguishable. HIV/AIDS was questionably known in the early years of research as the disease of the *Four Hs* – Homosexuals, Heterosexuals, Heroine pushers and Haitians who were believed to have contacted the virus from the Central African region (Cohen, Sande and Volberding, 1994; Kaslow and Francis, 1989; Stine, 2000).

On the African continent, the first case of HIV/AIDS in Africa was reported in 1982 in Uganda, East Africa, and before the end of the 1980s, widespread occurrences had been reported in most sub-Saharan African countries (Odubona, 1988: 12). Today, sub-Saharan Africa is central to the debate of the origin of HIV as Eurocentric writers have retroactively traced its origin to Africa. What's more, sub-Saharan Africa remains the worst-hit region in its having the highest number of PLWHA, AIDS deaths and AIDS orphans. The contemporary sub-Saharan health landscape can be thus defined by a major health and development challenge, one which impacts upon the African continent in its entirety, even though the virus no longer poses a serious threat to the economically

traditional medicine during the period. This was partly due to the resilience of African culture and partly to the fact that Western medicine was unavailable to the majority of Africans (Falola, 2003). The former factor appears more plausible given the fact that even in our contemporary when modern Western medicine is firmly established among the people of Africa, indigenous medicine still thrives tremendously in Africa.

³ It is equally important to emphasize that the contemporary patronage of indigenous Yoruba medicine is constituted by people of all social categories, backgrounds and religions.

developed countries of the world where access to antiretrovirals is guaranteed and the rate of new infections drastically minimized (Irwin, Millen and Fallows: 2003: 59).

First reports of HIV/AIDS in Nigeria emerged in 1985 and consequently reported at an international conference in 1986. Available evidence suggests that Lagos, the then Federal Capital of Nigeria, and Enugu, the then Capital City of Anambra recorded the first two occurrences (Adeyi, 2006: 20). According to the then Minister of Health, these included a 13 year-old sexually active girl and a female commercial sex worker from a neighboring West African country. Indeed, the youth and women of Nigeria have been at the centre of the HIV/AIDS phenomenon since the outset of concerted enquiry. The disease continued to spread throughout Nigeria and by 2005, the country ranked third, globally, among those with the highest number of people living with HIV/AIDS (Federal Ministry of Health, 2005: 15).

Three major phases to the evolution of HIV/AIDS in Nigeria have been identified: (1) the era of absolute official and personal denial of presence or of any possible discovery of the virus within Nigeria itself (1981-1986); (2) the era of AIDS skepticism, indifference and misconceptions (1986-1997) during which people were skeptical and indifferent to the presence of HIV/AIDS in Nigeria. AIDS was also jocularly referred to as an “American Invention” and as a measure for “discouraging sex”. As one bar-tender in Lagos expressed in 1986:

I have African blood in me. I was raised from the womb by African herbs and traditional medicines. AIDS is an “Oyinbo” disease, so it cannot attack me. I “no dey [dare]” meet Oyinbo woman (Oluduro: 1986: 3; Ajayi, 1988: 11).

The third era is where (3) the reality and awareness of the virus (1997-) increases, spurred by the death of Fela Anikulapo Kuti, one of Nigeria’s finest musicians, from AIDS-related complications (Okon-Ekong, 1997: 19).

Since 1986 in Nigeria there have been patterns of spread. In terms of its geographical dissemination pattern, HIV/AIDS is believed to have spread from the Southern part of the country to the Northern. The reason for this is not far-fetched. The first two cases of HIV/AIDS in Nigeria were discovered in the two Southern cities of Lagos and Enugu. However, as the disease began to gain root in the country during the 1990s, the Northern cities, particularly in the North Central Zone of Nigeria, began to record greater incidents of HIV/AIDS (Federal Ministry of Health, 2003). There have, however, been variations to the prevalence since the 1990s when the government started to conduct its National HIV Sentinel Survey. Data evidenced that while Plateau State in the North-Central Zone of Nigeria had the highest HIV/AIDS prevalence by State in 1991/1992; 1993/1994 and 1995/1996 with 6.2%, 8.2% and 11.0% respectively, Benue State (also in the North-Central Zone) had the highest prevalence of HIV/AIDS in 1999 and 2007 with 16.8% and 13.5% respectively. However, in the 2003 Setinel Survey, Cross River State in the South-South Zone had the highest HIV prevalence in the country with 12.8% (The Guardian, 2004: 29). This meant that Benue State topped the 2005 prevalence percentage.

It is an equally significant fact that Nigeria between, 1986 and 2007, evidenced an urban-to-rural pattern as well as a higher prevalence in urban centers. Significantly, the first two cases of HIV/AIDS were identified in two urban cities of Lagos and Enugu in 1986. However, it must be emphasized that HIV/AIDS has penetrated deep into rural centres of the country where most studies on HIV prevalence were not always conducted. The 2005 HIV sentinel survey conducted by the Federal Ministry of Health showed that the virus was sooner a concentrated occurrence in urban centers than in rural areas (Federal Ministry of Health, 2005).. Thus the Nigerian Minister of Health asserted in 2000 that the national picture of the virus incorporated by rural and urban landscapes: “HIV/AIDS is as much a city problem as it is a problem for small towns and villages. Indeed no part of Nigeria is unaffected” (Lawal and Akinmoladun, 2008).

Age-group prevalence between 1986 and 2007 in Nigeria showed that the virus affected 25-29 year olds. In terms of sexual distributions, females evidenced preponderance of HIV in both urban and rural areas of Nigeria. Several factors accounted for this higher prevalence of women than men: women were exposed to procedures that incurring a break in skin or vaginal continuity while healthy or ill. Apart from these biological disadvantages, other factors that made women more vulnerable to HIV/AIDS included high levels of poverty, a lack of proper education, traditional beliefs and other contributing factors such as sex trade; sexual abuse; anogenital sex and intravenous drug addiction (Yalwa, 2005: 36-37).

Tantamount to these trends of occurrence, are the contributory factors of: sexual transmission (heterosexuality, homosexuality, anal sex and oral sex), mother-child transmission and blood transfusion/blood products; the use of contaminated sharp objects; medical procedures and surgical operations; obstetric and dental procedures; circumcision; the dressing of wounds; vaginal and rectal examinations and cultural practices such as tattooing; tribal marking; female genital mutilation (FGM); blood rituals and circumcision. To this list of factors can also be added thorn pricks; needle stick injuries; blade cuts; clipper cuts and bites as well as diseases such as skin ulcers; genital ulcers; eczema; anal tear; peptic ulcers; bruises; cracked/sore nipples, and mouth ulcers. Intravenous Drug Use (IDU) was another factor contributing to the trend of HIV transmission in Nigeria over the years (Federal Ministry of Health, 2005: 24).

More specifically, it is the prevalence of untreated STDs; tuberculosis and the lack of male circumcision among some Nigerian groups which reportedly enable the spread of the virus. On the socio-cultural front, cultural practices relating to skin cuttings such as tribal markings; body scarification; blood-letting and blood oathing, coupled with child marriage, polygamy, and partner exchange likewise contributed to the rapid spread of HIV/AIDS in Nigeria. There was also an erroneous belief among some Nigerians that intercourse with a female virgin could cure sexually transmitted infections (STIs) and HIV. This resulted in rape and assaults, with an upsurge in HIV/AIDS infections as consequence. Socio-economic and political factors too, such as high levels of poverty; unemployment; economic insecurity; years of official lack-lustre attitudes to HIV/AIDS and the general lack of government commitment also did not help to quell the spread of the virus (Poku, 2005: 75-87).

Towards a History of National Responses to HIV/AIDS in Nigeria, 1986-2007

National HIV/AIDS interventions can be divided into two eras defined by different strategies. These are (1) the era of health sectoral interventions and, (2) the era of multi-sectoral interventions. The Nigerian health sector led by the Federal Ministry of Health (FMOH) was the first to initiate and coordinate national responses to the epidemic. When HIV/AIDS was officially reported, and its presence acknowledged in 1986, the Nigerian Federal Ministry of Health responded by rolling out programmes and measures aimed at curtailing the disease. Some of the highlights of the Health sector's responses to the epidemic included the constitution of an 18-Member National Experts Advisory Committee on AIDS (NEACA) under the chairmanship of Professor Etim Essien in February 1986 by the then Minister of Health. In 1988, the FMOH under the Honourable Minister of Health, Professor Olikoye Ransome Kuti, formally established the National AIDS Control Programme (NACP) to succeed NEACA which was ad-hoc in nature (Oshevire and Orere, 1988: 7).

In 1992, following the launch of the National War Against AIDS (NWAA) by the Federal Military Government (under President Ibrahim Babangida) the Sexually Transmitted Infection Control Programme (STICP) of the FMOH merged with NACP – this leading to the creation of the National AIDS and STI Control Programme (NASCP) (Oshevire and Orere, 1988: 7).⁴ In the area of prevention, a major feature of the early prevention strategy of HIV/AIDS in Nigeria and other countries was the use of scare tactics. During this period, AIDS was presented to the public as a disease to be greatly feared, without cure and that HIV positive people faced a future of a mere few

⁴ At the state and local government levels, there is the AIDS and STI Control Programme (SASCP)

years. In fact, crosses and skulls and human skeletal images were common symbols of the anti-HIV/AIDS campaign in Nigeria and other parts of the world in the 1980s, and it was only in 1991 that the Red Ribbon became the international symbol of HIV/AIDS awareness and campaigning.⁵

As a result of the failed scare tactics, HIV/AIDS awareness creation through AIDS education and enlightenment was adopted by the Nigeria's health sector. An appreciable and considerable level of success was achieved in this regard as some Nigerians began to engage in safe sex through one, two or the three ABC model of safe sex – Abstinence (A); Faithfulness /Fidelity (B) and Condom use (C) (Jegade, 1993: 23). The health sector-led AIDS interventions spanned from 1986 to 2001, only succeeded by what is now termed as HIV/AIDS multi-sectoral interventions. The need for a multi-sectoral intervention was prompted by the realisation that HIV/AIDS was not a mere health challenge to be left to the health works alone but a global socio-economic and development challenge requiring the attention and energies of all classes – the ruler and the ruled; the rich and the poor, the young and the old, man and woman, and so on.

The National Council on Health (NCH) formally endorsed a multi-sectoral approach in 1997 which involved all sectors of the national life in the struggle against HIV/AIDS. As a consequence, the Federal Government established the Presidential Council on AIDS (PCA) in 2000 followed in 2001 by the establishment of the National Action Committee on AIDS (NACA) under the chairmanship of Professor (Mrs.) Ibronke Akinsete to oversee the national multi-sectoral responses to HIV/AIDS. The mandate of NACA was the overall coordination and direction of HIV/AIDS expanded responses for all sectors and at all levels in Nigeria including collaboration with international bodies/organizations.⁶

The key government partners of NACA in the national multi-sectoral response to HIV/AIDS during the period under review were the Federal Ministries of Finance; Internal Affairs; the National Planning Commission (NPC); the Ministry of Education and Information; Women's Affairs, the Ministr of Culture and Tourism, and of course, the Federal Ministry of Health. NACA also partnered with the Civil Society Network for HIV/AIDS in Nigeria Network (CISNHAN); the Network of People Living with HIV/AIDS in Nigeria (NEPWHAN); the Nigeria Faith-Based Coalition on HIV/AIDS (NFACA); the Nigerian Business Coalition Against AIDS (NIBUCM) and the National Youth Network on HIV/AIDS (NYNETHA) (Udoiong, 2008).

NACA's multi-sectoral intervention since 2001 has included the formulation and publication of the first long-term strategic plan for HIV/AIDS interventions in Nigeria demmed the HIV/AIDS Emergency Action Plan (HEAP) covering 2001-2004. This plan was jointly executed by government and non-governmental partners of NACA. In 2005, the second multi-sectoral plan for HIV/AIDS control was developed entitled the National Strategic Framework (NSF), covering 2005 to 2009. Under the coordination of NACA, the Federal Government of Nigeria (FGN) came up with the formulation and publication of the National Policy on HIV/AIDS for the first time in 2003. This document is a comprehensive and revised HIV/AIDS policy with a great improvement on the national policy on HIV/AIDS and STIs adopted by the Federal Republic of Nigeria through the Federal Ministry of Health in 1997 (Federal Ministry of Health, 2005: 43). The National HIV/AIDS policy has remained the regulatory framework for national multi-sectoral responses to HIV/AIDS.

⁵ This took place when *Visual AIDS, Broadway Cares, Equity Fight AIDS* and other organizations in New York, United States, adopted the wearing of a red ribbon as way of signifying support for people living with HIV/AIDS. See "History of AIDS from 1987 to 1992" available at http://www.avert.org/his87_92.htm (Accessed on 12/11/2008)

⁶ At the state level there is what is called State Action Committees on AIDS (SACA) while at the local council, level there are Local Action Committees on AIDS (LACA) as replicas of NACA. Significantly, NACA transformed from a mere action committee to a full-fledged federal government agency in 2007 and became known as the National Agency for the Control of AIDS (NACA)

In order to create an environment conducive for a successful AIDS control, NACA established the National Ethics Board in 2001. This led to the formulation and publication of the National Ethics and Operational Guidelines for Research on Human Subjects in Nigeria. Although the National Ethics and Operational Guidelines for Research on Human Subjects apply to all research undertaken on human subjects, it was specifically designed to educate and guide researchers and the Press on HIV/AIDS-related information. Across the country, sensitization seminars and workshops were organized for researchers and newsmen. Today, such terminology as “AIDS patients;” “AIDS carriers;” “AIDS orphans” etc., have lost their resonance, replaced by “people living with HIV/AIDS (PLWHA)” “children affected by AIDS” or “orphan and vulnerable children (OVC)” (Michael, 2008). Such changes in common terminology were meant to mitigate the impact of HIV/AIDS in Nigeria since language was central to how AIDS stigma was expressed.

NACA also adopted the principle of Greater Involvement of People Living with HIV and AIDS (GIPA) as conceived by the representatives of 42 national governments at the Paris AIDS Summit in December 1994. This principle presupposes that the involvement of people living with HIV/AIDS is critical to ethical and effective national responses in all countries. In line with this, NACA was one of the key partners of the Network of People Living with HIV/AIDS (NEPWHAN) which is the administrative umbrella body of all registered groups of people living with HIV/AIDS in Nigeria (Network of People Living with HIV/AIDS, nd.: 12). The partnership between NACA and NEPWHAN resulted in improved national responses, since 2001.

AIDS stigma, discrimination and exclusion constituted some of the major problems militating against national control of HIV/AIDS during this research period. NACA, in collaboration with the Federal Ministry of Labour and Productivity, formulated, published and began the implementation of the National Workplace Policy on HIV/AIDS in 2005. This policy was formulated in line with the International Labour Organization (ILO) code of practice on HIV/AIDS in the world of work which emphasizes the principles of human rights, social justice and equity: all employers, employees and prospective employees, all workplaces and contracts of employment, all human resource policies and practices of any organization and all self-employed persons and workers in the informal sector are covered by the remit of such a policy.

III. A Critique of AIDS Interventions in Nigeria: The Gross Inadequacy of HAART

The control of HIV/AIDS in Nigeria was left to the sole attention of the health sector for several years while other sectors did not demonstrate meaningful contribution. Nigeria depended greatly on external donor funding to combat the epidemic, especially in the area of ARV treatment. HIV/AIDS curtailment efforts seem, at certain points, to have been turned into money making ventures by certain civil society groups in Nigeria: situations were exaggerated and huge amounts of financial resources from international donors were received. That there are thousands of such societies in Nigeria today (Odetoyinbo, 2009: 24) signals that there was a problem of proper harmonization of the multiple actors, multiple programmes and different planning/funding cycles involved in AIDS control at the various levels in Nigeria (National Agency for the Control of AIDS, 2007: 3).

Due to misconceptions about HIV/AIDS, there was still a high level of AIDS discrimination/stigmatization in Nigeria and this prevented people from undergoing tests, disclosing their status or undergoing treatment. Furthermore, for a very long time there was little effort targeted at preventing mother-to-child transmission of HIV/AIDS (PMTCT) which is the second major route of HIV transmission in Nigeria. It was not until 2001 that the federal government established a National Prevention of Mother-to-Child Transmission (PMTCT) task team with the PMTCT implemented in eight sites across the country’s six geo-political zones in 2002 (Federal Ministry of Health, 2007: 1-8). Yet it must be noted that many Nigerian women give birth at home or at herbalist centres and that although Community Home-Based Care (CHBC) is directly under the support component of NASCP, CHBC services in Nigeria were provided mainly by non-governmental organizations (NGOs) and Faith-Based Organizations ably supported by international donor agencies.

Indeed, HIV/AIDS treatment and management is one of the major areas of intervention that has been greatly criticized in Nigeria. Universally, the traditional role of physicians is to provide medical care and treatment to all categories of patients (Stine, 2000: 474). This is why the medical profession is uniquely entrusted with the knowledge to care for those with HIV/AIDS and it has a clear responsibility to do so (Stine, 2000: 474). Since the public awareness of HIV/AIDS in the summer of 1981, medical professionals worldwide have been making tremendous efforts to scientifically broker an effective cure or at least, effective treatment of the ailment. However, there is yet to be a known cure for HIV/AIDS and there is no medical vaccine for immunization against it (Irwin, Millen and Fallow, 2003: xxvii). In fact, at the beginning of the epidemic, the popular slogan was ‘there is neither a cure nor vaccine for AIDS’ (Soyinka, 2000: 13). Research on vaccines for HIV/AIDS is still being aggressively pursued by both the public and private sectors of the biomedical research community the world over, particularly in the developed world. The U.S. National Institute of Health (NIH) is the largest funding agency for HIV vaccine research worldwide (Soyinka, 2000: 14).

Despite the fact that there is no yet any curative drug or preventive vaccine for HIV/AIDS, orthodox medical practitioners have achieved advances in developing a number of anti-HIV drugs which are currently being used successfully in treating PLWHA. The current biomedical management of HIV/AIDS is through the use of antiretroviral drugs (ARVs) (McGowan and VD Weller, 2001: 46-48; Stine, 2000: 78-120; Connolly and Jenkins, 1994). Antiretroviral drugs are the medications used for the treatment of retroviral infections, which work by stopping the replication of HIV. Antiretroviral drugs are classified according to the phase of the retrovirus life cycle the drug inhibits, which are many. The most effective treatment is a combination of these drugs, referred to as highly active antiretroviral therapy (HAART) (Irwin, Millen and Fallows, 2003: xxvii). Treatment with HAART usually reduces the amount of virus in the blood stream, allowing the CD4 cells to be replenished and immune functionality restored.

One of the earliest antiretroviral drugs was Zidovudine (AZT/ZDV/Retrovir) which was approved by the United States Food and Drug Administration (FDA) and the World Health Organization (WHO) in 1987 (Irwin, Millen and Fallows, 2003: 1).⁷ The use of highly active antiretroviral therapy (HAART) was formally introduced in 1996 at the XI International Conference on AIDS held in Vancouver, Canada. Since then, AIDS mortality rates have been drastically reduced in the wealthy countries of North America and Western Europe. Contrastingly, in developing countries where the world’s HIV/AIDS burden is more heavily concentrated, more than 90% of PLWHA do not have access to antiretroviral therapy. This is due, not only to high levels of poverty but also to the weakness of health care systems (Irwin, Millen and Fallows, 2003: 13). This is why many of the international public experts are advocating HIV/AIDS prevention as opposed to antiretroviral therapy in the developing countries. This view has not gone unchallenged by people who believe that it is the duty of the international health agencies to ensure that every carrier of HIV/AIDS has access to antiretroviral therapy irrespective of his/her locality in the world (Irwin, Millen and Fallows, 2003:14).

It is sad to note that no antiretroviral therapy programme was initiated in Nigeria until 2001 when the multi-sectoral response was begun by the administration of President Oluseun Obasanjo. In April 2001, the federal government issued a directive to the Federal Ministry of Health (FMoH) for US Dollars 3.7 Million (N500 Million) to be allocated to the procurement of antiretroviral drugs and \$1.5 million for test kits (Federal Ministry of Health, 2005: 70). Specifically, the money was meant to procure Stavudine, Lamivudine and Nevirapine. In December 2001, a plan of action for broad access to ARVs in Nigeria was developed by an expert committee established by the federal government. In January 2002, the full implementation of the National ARV Access Programme began under the Federal Ministry of Health (Federal Ministry of Health, 2005: 72). The aims of the Programme were to provide

⁷ Others that have followed since then include Didanosine; Zalcitabine; Nevirapine; Delavirdine; Saquinavir and Ritonavir

affordable, highly subsidized ARV treatment to infected adults and children and prevent mother-to-child transmission. The Programme was hoped to place 10,000 adults and 5,000 children on antiretroviral therapy in its first year and scale up yearly by doubling the number accessing ARV treatment (Idigbe, 2006: 8).

In order to implement this Programme, there was a short and centralized training of teams of health workers such as doctors, nurses, pharmacists and counselors drawn from the designated ARV centres across the Federation (Bako, 2008). In all, by 2007, there were 25 designated ARV centres in the country including 12 university teaching hospitals, 5 federal medical centres, 4 clinics, 2 medical research institutes and one special hospital established across the six geo-political zones of the country (Federal Ministry of Health, 2005: 70). Quite expectedly, the National AIDS and STI Control Programme (NASCP) holds responsibility for the overall management of the ART programme. Its duties include overseeing programme design; overall programme management and coordination; formulating and disseminating national health sector HIV and AIDS policies; providing training and technical support and training to state and local governments. AIDS control programmes, health care facilities and development partners; facilitating the procurement of ARV drugs and Programme monitoring and evaluation (Federal Ministry of Health, 2005: 70).

In the area of funding, the ARV programme receives support from the Federal Government, the Global Fund (through NACA), the Bill and Melinda Gates Foundation (through APIN and CRS), the USG (GHAIN) Programme and other donor agencies. The bulk of the fund for the National ART programme comes from the development partners as the government contributes approximately five percent of this funding (Federal Ministry of Health, 2007). During the fledgling years of the ART programme, the total cost of ARV drugs was approximately 318 US Dollars per person per year which was approximately half of the total ART cost per patient in the public sector (Federal Ministry of Health, 2007). Each patient was supposed to pay a monthly access fee of N1000 and between N2500 and N3000 for the CD4 testing. In all, 80% subsidy was footed by the government and the remaining 20% by the patient (Idigbe, 2006: 10).

At inception, Nigeria's ART Programme was not only the first but also one of the largest ARV access initiatives on the African continent. Due to high demand for government ARVs in 2002, the National ART Programme started with more than 10,000 designated adults. Specifically, 13,888 adults (PLWHA) were included in the programme at its outset (Federal Ministry of Health, 2005: 70). In June 2005, the federal government under President Olusegun Obasanjo issued a directive that the ART programme should be scaled up to 250,000 PLWHA within a year with modalities for scaling up the programme to one million beneficiaries in 2009 was worked out.⁸

Out of the six classifications of antiretroviral drugs currently available globally, the National ART Programme procured those from three categories and made them available in all the 25 designated centres. It is also impressive that apart from the fact that these drugs were made available in all the ARV designated centres across the country, there was the development and publication of Guidelines for the Use of Antiretroviral (ARV) Drugs in Nigeria, developed in 2001 and updated and expanded in 2003 as part of the scaling up process (Federal Ministry of Health, 2003).

In sum, ARV treatment in Nigeria (that is, up until 2007) was conceived to receive a tremendous boost in all aspects of quality care. The government was able to provide a comprehensive package of clinical and laboratory monitoring, treatment roll-out and scale-up, program monitoring and evaluation, capacity building, prevention of drug stock-outs and drive for equity and spread of ARV treatment services to all geo-political zones of the country

⁸ A proposed scale-up of this magnitude at that time raised serious questions regarding capacity of the Nigerian health care system as well as questions about immediate funding and sustainability of a programme of this size. This was a mere dream which has never been achieved. For details, see Federal Ministry of Health (2005), *National Situation Analysis*, p.70-83

(Uzono and Adewumi, 2009). It is noteworthy that by 2006, more than 82,000 of PLWHA in Nigeria were benefiting from the government ART program (Idigbe, 2006: 15).

In spite of the numerous acclaimed successes of the program since its inception in 2001, there have been areas of inadequacies. In the first instance, a good number of PLWHA who were eligible for ART could not be enrolled because of the gross insufficiency of the drugs provided (Udoidiong, 2008). Equally, most of the enrolled people could not afford the N1000 monthly access fee and the N3000/N2500 charged for CD4 testing (Federal Ministry of Health, 2005: 71). In the private sector (or for private patients in the public facilities), the cost of first line regimens varied from N5950 to N12500 per month for ZDV/3TC/NVP and d4T/3TC/NVP respectively. Thus, the high cost and frequent use of laboratory tests, which was paid for by the patients, made the ARVs unaffordable to the less privileged Nigerian populace. Coupled with this was the fact that people had to travel long distance to few places where ART centres were located. Consequently, between 300,000 and 700,000 of PLWHA in Nigeria were in urgent need of ARVs but could not be enrolled during the period under study (Uzono and Adewumi, 2009).

The National ART Programme also faced the serious problem of low stock supplies in most of the ARV centers across the country. According to the FMOH and WHO assessment in 2003, stock-outs had been reported in many of the ARV centres owing to additional patient numbers and because some supplies of the drugs had already expired (Federal Ministry of Health, 2005: 72). Similarly, storage facilities for ARVs were also inadequate in some of the centres. As reported by the Rapid Assessment of HIV and AIDS Care in the Public Sector (2005), only one facility offered a comprehensive HIV/AIDS care and services programme which includes, in addition to ARV treatment, patient education; counseling; adherence support; patient monitoring and management of drug toxicities. Yet another problem associated with the ART programme in Nigeria relates to the inadequacy of laboratory equipment at ARV centres. In truth, out of the 25 centres nationwide, viral load tests were performed at only four facilities country wide. These were at the National Hospital, Abuja; the Nigerian Institute of Medical Research (NIMR), Lagos; the Nigerian institute of Pharmaceutical Research and Development and Jos University Teaching Hospital (JUTH).⁹ All other facilities in the country referred to these four centres for specimen testing and it was reported that patient monitoring tests were rarely conducted due to the inability of patients to afford such tests (Federal Ministry of Health, 2005: 72). A major defect in the national ART programme is that up until 2007, the child ART programme which was scheduled to start along with that of the adult program had not yet begun in the country (Adu, 2008).

On the part of the PLWHA who are on the National ARV Programme, there were problems experienced relating to adherence to ART which is required for effectiveness of the drugs. According to operational research conducted by the NIMR and FMOH/WHO survey (reported in 2005) the problems militating against a successful National ART programme in Nigeria on the part of the PLWHA include drug sharing with other patients; peripheral neuropathy; stigmatization; adverse effects of the drugs; the reduction in dosage when feeling better; fatigue; weight loss; jaundice and diarrhoea (Federal Ministry of Health, 2003: 72-73). It is however important to state that the efficiency and effectiveness of ARVs depend greatly on the patient's strict adherence to the drug regimens. It has also been noted that the National Guidelines on ART treatment which could adequately inform the patient on the basic requirements of ARVs are not routinely distributed. This is particularly the case with private sector ARV services (Federal Ministry of Health, 2005: 73).

A historical examination of the National ART programme in Nigeria since 2002 reveals that demand for ARV therapy and HIV/AIDS care is increasing in the country and that there is a need for stronger government, development partners and private sector involvement in ARV provision. Further revealed is the fact that some of the major problems hindering the consistent and equitable performance of the National ART programme are rooted in

⁹ these all conduct the CD4 count test

the lack of sufficient funding; improper coordination; erratic drug supplies; the shortage of trained staff; the poor condition of basic amenities and a high level of poverty among the Nigerian populace (Federal Ministry of Health, 2003: 76; Oyekanmi, Agugua, Nwanna, Nnorom and Oyefara, 2009: 2).

Above all, due to all these impeding factors and inadequacies, and premised on the continued beliefs, by Nigerians, in the efficacy of African traditional medicine in curing all forms of ailments, many people living with HIV/AIDS in Nigeria sooner resort to local medicine men for solution. It is in these particular circumstances that the claims of HIV/AIDS's cure by some indigenous Nigerian medical practitioners became, and have become, issues of national importance which continue to attract the disavowal of Nigeria's Federal Government and its policy-makers.

IV. Official Government Responses to HIV/AIDS Cure Claims in Nigeria

There is no gainsaying the fact that Africa is the worst-hit continent by the scourge of HIV/AIDS.¹⁰ Nigeria, being an African country, is not an exception to this generally acknowledged fact. Historically, the first cases of HIV/AIDS in Nigeria were identified in 1985 and reported at an international conference in 1986. Since this period, the disease has continued to spread in the country, having reached its epidemic level in the 1990s. By 2005, the situation of the epidemic in Nigeria ranked the country third among those with the highest number of PLWHA (Federal Ministry of Health, 2005). As previously indicated, there is no known cure for HIV/AIDS and the search has continued in the biomedical world. As part of its own contribution to the global search for an AIDS cure and as a reflection of the diversity in the African health care system, indigenous medical practitioners have publicized claims of cure. The response by government to such claims has been both negative and unaccommodating.

One of the earliest claims of an HIV/AIDS cure in Nigeria emerged in 1987 when Dr. Paul Olisa Adaka-Ojeih, medical director of the Iris Reflex Therapy Clinical Institute, Benin City, revealed that he could cure PLWHA through the application of reflex therapy (Awogbemi, 1985: 3). Quite expectedly, the Federal Military Government of Nigeria, then under General Ibrahim Babangida, set up an investigative panel steered by Dr. Ogunye in order to investigate the veracity of Adaka-Ojeih's claims. Upon further investigation by the panel, it was discovered and reported that Dr. Ojeih's therapy was effective.¹¹ The Panel also recommended that Dr. Ojeih be assisted and funded to improve upon his discoveries so that Nigeria may blaze the trail in global efforts in cure procurement. In spite of this, the military government refused to ratify the reflex therapy of this local medical practitioner.

Arguably, the most prominent of AIDS cures and vaccines claimed in Nigeria has been that of Dr. Jeremiah Ojonemi Alabi Abalaka, the founder and director of Medicrest Specialist Hospital, Gwagwalada, Abuja, which became solicited national consciousness in 1997 (Spier, 2004: 317). Dr. Abalaka, a general Surgeon with some training in Immunology, claimed to have conceived and developed a safe therapeutic HIV vaccine prepared from the blood of HIV-infected persons. He had allegedly applied the treatment to over 3,500 people living with HIV/AIDS in Nigeria with their informed and written consent. He also developed a safe HIV preventive vaccine from the same source and applied it to himself and over 300 willing HIV antibody negative persons (Spier, 2004: 318).

¹⁰ In 2007, the African continent had the highest number of people living with HIV/AIDS, HIV/AIDS orphans, AIDS death and most profound impact of the AIDS epidemic. In fact, in contemporary period, AIDS is more seen as an African epidemic than a global scourge. See Iliffe, J. (2006). *The African AIDS Epidemic: A History*. Oxford: James Currey.

¹¹ Dr. Ogunye was the Director of Medical Research and Natural Sciences at the Federal Ministry of Science and Technology of Nigeria during this period. For details on Dr. Ojeih's Reflex therapy story, see "At a time like this AIDS: AIDS, the futile direction of awareness", *Vanguard*, September 8, 1997, p.6

During this period, hundreds of Nigerian people living with HIV/AIDS thronged to Abalaka's clinic on a daily basis to receive this new-found HIV/AIDS cure and vaccine. Before the end of 1997, Abalaka claimed to have cured hundreds of people living with the virus. One major aspect of Dr Abalaka's story was that he not only became a national figure but gained international recognition as his activities were reported on the international stage. A major plus for Abalaka was that a senior General in the Nigerian military announced in 1998 that 30 soldiers who had had the AIDS virus were cured by Abalaka and that the military was receiving more vaccines from him. This came from the head of the Nigerian Army Medical Corps, General A. Adefolalu (Phillips, 2008).

The reaction of the government to Dr. Abalaka's claim is also worthy of note here. Although the Nigerian Army defended Dr. Abalaka's claims, the Federal Government was opposed to the public use of his curative vaccines. The reasons for this included the refusal of Dr. Abalaka to surrender his vaccine to scientific verification. The government's claim was that the vaccines carried adverse effects and that the vaccine had killed more people than it had actually cured. The Nigerian Academy of Sciences also maintained that since Dr. Abalaka refused to subject his vaccines to any objective immunological/ scientific evaluation, then all sales should be prohibited. The issue of Abalaka's vaccine went through a series of court injunctions between 1998 and 2000, until the federal government, under President Olusegun Obasanjo, suspended the public use of all locally produced vaccines and intervention, claiming to prevent or cure HIV/AIDS.

V. Conclusion

We have sought to examine the history and particular tensions defining the African health care system, through the optic of Nigeria's situation and its quest for a HIV/AIDS cure. Our article posited that the colonial government in Nigeria, as with those of other African countries, pursued a policy of imposition where Western medicine was implanted, this, ultimately leading to the illegalization of traditional medicine. Presently, the Federal Government of Nigeria has continued to propagate the policy of relegation of indigenous medical achievements, in its promotion of modern Western solutions. While this is neither negative nor unproductive, the provision of modern medicine is not adequate in the country and programs are failing. There is, in short, a continued logistical and territorial discrepancy. An indigenous medical system should be developed and incorporated into the mainstream of Nigerian healthcare for improved responses to the HIV/AIDS epidemic. Diversity and indeed, the generally acknowledged bio-diversity, offers multiple opportunities for the development and improvement of human well-being (McGinley 2009: 2). This is imperative for an improved health care system in contemporary Africa, one that is cultural synchronic.

Critical reflections and recommendations

The examples we have drawn upon reveal how Nigerian governments at all official levels have shown contempt for indigenous scientific discoveries. As a result, HIV/AIDS and other disease epidemics plaguing the Nigerian state, remain manageable but not controllable. The inability of Nigerian government to acknowledge the reality and critical necessity of diversity in the African health care system has remained the bane of our aspiration in the field of therapy (Lambo, 2006: 7). In Nigeria today, the official campaign favors the total rejection, denigration and relegation of traditional medicine. This is arguably true to colonial tendencies, which levered a cultural different health and scientific system into Nigeria through the Missionary milieu.

Indeed, Nigerian governments have failed to acknowledge the basic fact that modern Western medicine is eluding a good number of Nigerians particularly in the rural areas of the country. Even in urban centres where facilities of modern health care services are concentrated, the high level of poverty among the majority of Nigerians still prevent them from having access to these services (Oyekanmi, Agugua, Nwanna, Nnorom and Oyefara, 2009: 2). As an alternative, recourse is made by the people of Nigeria to indigenous health options for their medical ailments. African indigenous medicine has remained resilient, albeit sidelined, and relevant, albeit eclipsed and

illegalized, in the healthcare system of the African people. It is equally important to emphasize that the contemporary patronage of African indigenous medicine in Nigeria knows no bounds as a good number of men and woman, educated and non-educated, literate and non-literate, old and young, Muslims and Christians at home and abroad still make use *aspects* of traditional medicine (Lambo, 1990: 9)

Given the fact that traditional medicine is the closest and most accessible form of health care in Africa despite the popularity and official promotion of modern medicine, the diversity in health care should be officially acknowledged and indigenous medicine legitimized for optimal exploitation. In this sense, the following recommendations are put forward for the recognition of indigenous medical discoveries in order to structure and broker better, more equitable and consistently effective responses to epidemics on the African Continent:

- The more complete integration of traditional African and Western medicine into a comprehensive health system model could be achieved if tolerance and mutual understanding of the various methods for herbal and allopathic medicine is facilitated.
- African traditional medical practitioners and practices should be recognised and guided to conform to prescribed standards, through outreach programs and government platforms of professionalization.
- The promotion of research into African traditional medicine; related remedies and techniques should be facilitated through an enlightened interdisciplinary cooperation, especially in the context of indigenous tropical and endemic ailments.
- Encouraging healthy professional attitudes and mutual respect can forestall the prevailing antagonism and suspicion of traditional medicine by Western orthodox health practitioners.
- Establishing an appropriate study of locally produced herbs in Africa, with proper nosographic classification can aid in the standardized of indigenous remedies.
- The setting up of national herbal research institutes with the aim of research into botany, herbs, roots and stems of proven efficacy as used by traditional medical practitioners, would facilitated a professional space and voice for indigenous medicine.
- The setting up of traditional medical technology in collaboration with traditional medical practitioners (Oso 2007: 185-229) would provide a cultural resonant service

The realization and acknowledgement of the reality and diversity underpinning African health care system is required for more efficient and culturally comprehensive health interventions on the continent.

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