Linking Policy to Real World:
Exploring Policy Objectives of HIV Program Funders in Nigeria

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Senior Thesis 2016
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Acknowledgments

I wish to express my sincere gratitude to: Dr. Akanmu, Dr. Odofin, Dr. Edopolo, Dr. Okonkwo, and Dr. Bashorun for the incredible and valuable insights they provided about HIV/AIDS in Nigeria and the Nigerian Health System. For the work you do and the time you took to answer my questions, I am eternally grateful.

I owe a deep sense of gratitude to: Mr. Makinde, Dr. Tolu Odukoya, and Dr. Bruce Agins for connecting me with their networks and pointing me to individuals who helped to ground my thesis.

A tremendous thank you to: Professor Chris Roebuck & Professor Jesse Shipley for imparting their knowledge and expertise in this work. Thank you for your guidance throughout the thesis process.

I am highly indebted to: Haverford’s Center for Peace and Global Citizenship and the Mellon Mays Undergraduate Fellowship for affording me the opportunity to travel to Nigeria to conduct interviews.

I also thank my Family for their never-ending encouragement, love, and support. This endeavor would have been impossible without them.
Abstract

This thesis explores the national and transnational climate that informs and influences Nigerian policy and approaches to combatting the HIV/AIDS epidemic. It seeks to draw the connections between the historical, political, social, and economic factors that have produced the current reality of HIV/AIDS in Nigeria. By exploring this issue within the context of HIV clinics in Lagos, Nigeria, I ultimately aim to demystify the notion of Africa, more specifically Nigeria, as an illness-ridden region that is inherently incapable of caring for its citizens as well as debunk half-truths of corruption and leadership deficits as the root-cause of Nigeria’s weak health system.
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Acronyms

AIDS  Acquired Immune Deficiency Syndrome
APIN  AIDS Prevention Initiative in Nigeria
ART   Antiretroviral Treatment/Therapy
ARV   Antiretroviral
BHSS  Basic Health Services Scheme
DFID  Department for International Development (UK)
GDP   Gross Domestic Product
HCT   HIV Counseling and Testing
HEAP  HIV/AIDS Emergency Action Plan
HIV   Human Immunodeficiency Virus
HSPH  Harvard School of Public Health
LACA  Local Government Action Committee on AIDS
LUTH  Lagos University Teaching Hospital
NACA  National Agency for the Control of AIDS
NASCP National AIDS and STDs Control Program
NEACA National Expert Advisory Committee on AIDS
NGO   Non-Governmental Organization
NSF   National Strategic Framework
OVC   Orphan and Vulnerable Children
PEPFAR President Emergency Plan for AIDS Relief
PHC   Primary Health Care
PI    Principal Investigator
PMTCT Prevention of Mother to Child Transmission
SACA  State Action Committees on AIDS
SAP   Structural Adjustment Program
STD   Sexually Transmitted Disease
STI   Sexually Transmitted Infection
UN    United Nations
UNAIDS Joint United Nations Program on HIV/AIDS
UNDP  United Nations Development Program
UNICEF United Nations Children's Fund
VCT   Voluntary Counseling and Testing
WHO   World Health Organization
Thesis Overview

This thesis explores the national and transnational climate that informs and influences Nigerian policy and approaches to combatting the HIV/AIDS epidemic. Although billions of dollars have been invested and national prevalence has declined from 5.8% in 2001 to 3.1% in 2014 (NACA, 2015; UNAIDS, 2014), the number of AIDS related deaths went unchanged from 2005 to 2013, less than 25% of adults living with HIV in Nigeria have access to antiretroviral therapy (ARVs) (UNAIDS, 2014), and Nigeria’s health system performance remains low with a rank of 187 out of 191 countries (WHO, 2000).

Almost four decades into the fight against HIV and AIDS, why have collaborative efforts between the Nigerian government and international donors such as the World Health Organization (WHO) and The President’s Emergency Plan For AIDS Relief (PEPFAR) among others not resulted in greater progress? In other words, why do health indicators for Africa, more specifically Nigeria, continue to lag behind the rest of the world despite transnational efforts to quell the epidemic? With these questions as its premise, my thesis draws the connections between the historical, political, social, and economic factors that have produced the current reality of HIV/AIDS in Nigeria to better understand how the current reality of HIV/AIDS in Nigeria came to be.

To ground my thesis, I observed and conducted interviews with health professionals at two HIV clinics in Lagos, Nigeria over the course of ten days. I also interviewed health professionals from the Ministry of Health via email. Drawing from authors such as Michel Foucault and Paula Treichler, I apply theories from the political economy of health and critical medical anthropology to show that a lack of government ownership of HIV policy and program initiatives continue to result in suboptimal health outcomes in Nigeria.
In Lagos, the day starts before sunrise. As early as 5:30 am, the city begins to come to life. No one wants to get stuck in the city’s infamous go-slow (traffic jam). By the time 9am or 10am rolls around, the streets already feel like mid-day with energy from people—students, street hawkers, professionals, families—and roaring vehicles or okadas (motorcycles) honking, pushing, and speeding past each other.

This megacity of struggle and promise where privilege and poverty intermingle is home to approximately 15 million people—a fusion of personalities, vibrant cultures, and various languages. It is this eclectic energy of the city that makes Lagosians in Nigeria or in diaspora fondly remark that “There is no place like home.” But this is a city you never want to fall sick in. Despite being the financial hub of Africa’s largest economy, minor health issues could lead to death due to the country’s weak health system.

This reality is what brought me back. Two days after landing in Lagos—the second time I’d been home in 13 years—I made my way to the first of two HIV clinics where I would spend the week observing, interviewing health professionals, and trying to get a better understanding of access to care in the country.

Although both clinics were very different from each other: Lagoon—a ‘tush’ hospital for ‘ajebutters’ (a private hospital that predominantly served the middle to upper class) and APIN—a clinic run out of a university teaching hospital that served individuals from a wider range of socioeconomic backgrounds, the realities of patients who frequented both sites were similar in many ways. Some patients had to travel long distances to get to their necessary medication and check-up; many mothers learnt of their status during pregnancy; and the clinics sometimes ran out of medication. It is important
to note that both HIV clinics provided free services (as their grants allowed) to individuals from all socioeconomic backgrounds.

Some lived realities of individuals living with HIV in Nigeria:
A lawyer, most likely in her thirties who recently became a wife, confides with the doctor that she is trying to have a baby but is afraid. Her sister, the only one who knew of her status is dead. She knows God will see her through.

****
A skinny middle-aged man complains to the doctor that he has been coughing, peeing blood, and ‘shitting.’ When the doctor asks if he has been taking his medications frequently and as prescribed, the man answers no. He explains that he and his wife are HIV positive. He has been unable to find a steady job in Lagos so he moved his family back to Ghana. There, he had to pay for medication but could only afford his wife’s. It’s been a year now and he’s back in Lagos to look for work. In fact, he had to borrow money for transportation to the clinic. First line medication will no longer work for him. The doctor will have to start him on second line medication.

***
The doctor tells an elderly woman she will need to come back in a week or so because the clinic is out of one of the medication she needs. The woman cries out and laments that that will not be possible. She has travelled a long distance and risks loosing her job. She cannot tell her employers her status and has to make up excuses every time she travels to the city for her check up at the clinic. Her boss is getting suspicious and told her she needs to choose between her job as a teacher or being a housewife.

***
A mother and child come in for check up. The mother is HIV positive and learnt of her status during her pregnancy. She receives a prescription for her medication and is happy to learn that her child does not have HIV.

***

A college student steps into the office and within minutes she breaks out into tears and the doctor tries to console her. The student explains that she is aware of her status but was tired of taking her medications so she stopped. She used to take her medications with her friend who was also HIV positive but her friend is now dead. Her friend was the only one who knew of her status. The doctor believes she has a sugar daddy.

**Background: HIV/AIDS in Nigeria**

Nigeria is an ethnically diverse West African nation with a population of 181,562,056 people and over 250 ethnic groups (CIA, 2016). As of 2014, Nigeria had an adult HIV prevalence of 3.2% and 3.4 million people living with HIV (UNAIDS, 2016). In comparison with the HIV prevalence of other Sub-Saharan African countries such as South Africa (19.1%) and Zambia (12.5%), Nigeria’s HIV prevalence is low but the size of its population means that it is home to 9% of all people living with HIV globally (Avert, 2015a; UNAIDS, 2014). To combat these stark statistics, billions of dollars are spent annually on HIV/AIDS initiatives as part of a transnational global response. For instance, in 2014, international investment in HIV programs by donor governments for HIV response in low- and middle-income countries was an estimated $20.2 billion (Avert, 2015b). The United States provided the majority of multilateral and bilateral funding (64.5%) followed by the United Kingdom (12.9%) (Avert, 2015b). According to
the most recent National AIDS Spending Assessment (NASA) Report (2011-2012), the federal government of Nigeria provided $132,240,797 (23% of total HIV and AIDS expenditure for 2012) for HIV/AIDS programs in the country. The other 77% was funded by international aid. Although this distribution of funding source is comparable to trends for Sub-Saharan Africa (In 2010, 80% of funding for HIV programs in sub-Saharan Africa was from donor governments (Avert, 2015c)), when Nigeria is compared to India—a country of similar economic profile—the difference in distribution of funding source is notable. India and Nigeria fall within the same income category (lower-middle income) and both countries are comprised of sizeable populations but unlike Nigeria, India is responsible for financing 90% of its HIV and AIDS programs (Avert, 2015d). Concurrently, India experiences a lower adult HIV prevalence (0.3%), has less people living with HIV (2.1 million), and a higher percentage of adults receiving antiretroviral treatment (36%) (Avert, 2015d). These differences in funding source and HIV intervention outcomes raise the question of whether or not nations with higher national contributions to HIV/AIDS initiatives experience better health outcomes. In other words, do governments that shoulder more financial responsibility and depend less on international funds, what I choose to describe as an aspect of having stronger government ownership of HIV interventions, experience better HIV related health outcomes?

In Nigeria, despite national and transnational efforts, there has been no reduction in the number of annual deaths from AIDS since 2005 and only 21% of adults living with HIV have access to antiretroviral treatment (ART) (Avert, 2015a). This falls below averages of ARV coverage for lower-middle-income countries (28%), Africa (37%), and the globe (36%) (WHO, 2015). Additionally, the nation’s health system is considered one
of the weakest in the world. According to the World Health Organization’s World Health Report in 2000, Nigeria’s health system ranked 187 out of 191 countries. The healthcare system in Nigeria is designed in such a way that all three tiers of government—local, state, and federal—have defined responsibilities. Local governments are responsible for the provision of primary health care (PHC), secondary healthcare is the responsibility of state governments, and the federal government handles tertiary care (Welcome, 2011). In reality, infrastructural and social challenges—unstable electricity, outdated data management and referral systems (paper archives), limited finances, and brain drain—have produced a health system where tertiary care facilities (usually federal teaching hospitals) and private hospitals are the only options for optimal care. Primary and secondary care are largely neglected and the responsibility of providing related services falls disproportionately on tertiary care facilities (Asuzu, 2004). This creates what professor of public health and community medicine, M.C. Azusu, calls an inverted healthcare pyramid on the brink of collapse (Asuzu, 2004).

These factors undermine national and international efforts to reduce HIV incidence, control the epidemic, and improve treatment, care, and prevention (NACA, 2015; Amor, 2007). They also compromise the strength of the nation’s health system and hinder its ability to adequately provide quality care for, in this case, individuals living with HIV. According to the WHO, the fundamental components of a strong health system include: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance (WHO, 2010). Examples of indicators for building blocks (ii) and (v) include density of health workers (per 10,000 population) and total expenditure on health as a percentage of gross
domestic product (GDP) respectively. In 2012, Nigeria’s total expenditure on health was 3.4% of the country’s GDP—a percentage that was lower than averages for lower-middle-income countries (4.1%), Africa (5.6%), and the globe (8.6%) (WHO, 2015). In terms of health workforce, the density of physicians and nurses is 4.1 and 16.1 per 10,000 individuals respectively (WHO 2015). This is higher than the average density of physicians and nurses for countries in the same region (2.7 and 12.4 per 10,000) but lower than that of other countries with the same income level (7.9 and 18.0 per 10,000) (WHO 2015). These numbers point to a need to employ system-wide initiatives to improve health outcomes and strengthen the health system. Additionally, it is important to realize that the realities indicated by these health indices do not occur in a vacuum. In other words, health and the mechanics that govern it (such as biology, institutions, and the environment) are an index of social conditions.

In order to begin to understand and answer questions of why health outcomes in Nigeria continue to fall short of global standards despite national and transnational efforts, it is necessary to draw connections between the historical, political, social, and economic factors that have produced the country’s current reality of HIV/AIDS.

Social Perspective: Representations and Understandings of HIV/AIDS in Nigeria

In an ethnically diverse nation such as Nigeria, how do multiple understandings and representations of HIV/AIDS co-exist and what are the ramifications of these interactions? As Paula Treichler states, HIV/AIDS is “more than an epidemic disease.” It is also, “an epidemic of meanings” (Treichler, 1999). In Nigeria, many believe that the cause of HIV or sickness in general is not as simple as biomedicine posits. For some who
ascribe to the Christian faith, HIV/AIDS is understood as a divine punishment from God and people living with HIV/AIDS are seen as morally irresponsible (Reis, 2005). Sexually Transmitted Infections (STIs) are understood as punishment for sexual sin under Christian doctrine and many believe epidemics are sent by God as a warning when societies ignore his teachings (Liddell, 2005). In one study that worked to assess HIV/AIDS related beliefs among adolescent and young adults in South-Eastern Nigeria, anthropologist Daniel Smith found that born-again churches provided powerful symbolic interpretations of contemporary Nigerian society (Smith, 2004). Churches essentially helped people to navigate and make sense of inequality by teaching social injustices in terms of morality and championed the idea of prosperity for those who had faith and lived righteously (Smith, 2004). Under this framework, HIV/AIDS was viewed as a social problem that was the result of immorality or Nigeria’s moral decline. Through evangelical TV programs and Christian literature, many Christians in Nigeria have come to believe HIV/AIDS is the direct result of a failure to live a good Christian life and a punishment from God for a society that has turned its back on religion and morality (Smith, 2004).

According to Beckman et al., “epidemics trigger movements of prophetic innovation within African religious traditions, Christianity, and Islam” (Beckman, 2014). The AIDS epidemic in particular made it possible for religious organizations to take a more prominent role in the public sphere (Beckman, 2014). As a result, faith based organizations have played a crucial role in the moralization of the disease and setting the moral agenda around sexuality, the body, and relationships (Beckman, 2014). In some cases, they have been extremely active in promoting sexual education and HIV
prevention programs but unfortunately, many of these efforts have also inadvertently increased the stigmatization of people living with HIV/AIDS because of overemphasis of abstinence and faithfulness and the condemnation of condom use (Beckman, 2014).

The case of the Redeemed Christian Church of God (RCCG) serves as an example of aspects of the aforementioned point. Founded in 1952, RCCG has become extremely popular for its charismatic qualities and healing activities (Adogame, 2007). It is believed to be the fastest growing and one of the most popular Pentecostal churches in Nigeria today (Adogame, 2007). The nature of this church also points to how the “demographic spread, global stature and international scope of new African churches” make them powerful players and partners in international health promotion and potential allies to address the particular challenges of the global HIV/AIDS pandemic (Adogame, 2007). It also points to how religion and spirituality acts as an integral and a vital component of health and healing in Nigeria.

As a church whose goal is to “make heaven...take as many people as possible,” and accomplish this through a lifestyle of holiness,” RCCG functions under the biblical purview that human life is lived in a context of continual warfare between the kingdom of God and the kingdom of Satan (Adogame, 2007). The devil is essentially represented by anything that hinders the attainment of good health and wealth—the spirit or demon of disease, illness, HIV/AIDS, barrenness, death, adultery, and poverty among others (Adogame, 2007). Within this context, the RCCG casts HIV/AIDS as a demonic spirit and those afflicted by the illness as victims of spiritual demonic attack. As a result, RCCG members engage in deliverance rituals, healing rituals, night vigils, prayer and fasting rituals, and thanksgiving rituals in order to counteract Satan’s evil work. Healing
is only attainable through attention to the physical, psychological, spiritual, mental, emotional and material aspects of a person.

RCCG also has a Redeemed AIDS Program Action Committee (RAPAC) that works to educate and reduce the spread of the AIDS epidemic in many African countries. With the aid of transnational ties, such as funding from USAID, RAPAC deals with HIV/AIDS from the spiritual and medical perspective (Adogame, 2007). The vision of the group is to “reduce the spread and transmission of HIV/STIs using innovative spiritual intervention skills amongst the church membership and the society, complemented by practical medical care” (Adogame, 2007). This characterization of HIV/AIDS as one of the several demonic spirits blurs the distinction between natural and spiritual explanations of disease and illness (Adogame, 2007).

**Understanding HIV/AIDS Through Language**

Christianity is not the only lens through which HIV/AIDS is understood in Nigeria. Analyses of languages also give insight into how members of different ethnic groups understand what HIV/AIDS is. In Yoruba (one on Nigeria’s major language and ethnic group), there are many ways individuals refer to HIV/AIDS:

1. Àísàn ńlú filá – disease of urban areas
2. Àísàń kò-gbóógún – incurable disease
3. Èèdì – spiritual spell or Yoruba phonological adaptation of AIDS
4. Àísàn máarù-máagbe – disease that makes its victims to be emaciated
5. Kòkòrò ďè – disease of the blood caused by micro organisms
6. Màguń Òyìnbo – white man’s version of Yoruba’s màguń
7. Pàsàn ìgbèrè – fornication or adultery inflicted disease
8. Àrùn olómoge/omidan – disease of mature ladies
9. Àísàn onígbájámo – disease that is contacted at barber shop
10. Àísàn adójútini – disease that makes one to be stigmatized
11. Àísàn àjesára – disease of the immune system
12. Àísàn gbajúmò tuntun – new disease of the celebrity
Analyzing and delving deeper into some of these names, one sees that there are multiple understandings of the disease even within the same ethnic group. For example, in Yoruba, when HIV/AIDS is referred to as “Àísàn ̀ilú ́idualá – disease of urban areas,” it implies that HIV/AIDS is understood as a disease that is located only in urban areas which is a misconception that bears huge consequences for how residents in rural areas assess their risk. For those who refer to HIV/AIDS as “Mágùn Óyínbo – white man’s version of Yoruba’s magun,” HIV/AIDS takes on a new meaning. “Magùn” is a Yoruba charm that is placed on a woman secretly as a nemesis for her secret lover. Mágùn Óyínbo is therefore understood as a white man’s charm that is secretly placed on a woman to kill her secret lover (Komolafe, 2010). This points to the skepticism and misconception people have had about HIV/AIDS as an imported disease. In fact, some refer to AIDS as American Invention to Discourage Sex (Komolafe, 2010).

Similarly in other languages spoken in Nigeria, there are multiple representations and understandings of HIV/AIDS. For individuals who speak Ibibio, AIDS is referred to as “Udoña itiata” which translates to “Eight disease” (Ekpenyong, 2008). It is important to note that this is a mistranslation that stems from a phonological mix-up over AIDS and the number “eight” due to the accidental resemblance between them (Ekpenyong, 2008). Paying attention to the language around HIV/AIDS is important because it affects the effectiveness of initiatives such as nation wide campaigns to raise awareness about HIV/AIDS. There have been accounts of how efforts to curb the rise of new HIV infection in Nigeria have been unsuccessful because of lack of acceptable local language or terminology for AIDS (Umeh, 1997). More importantly, when it comes to campaigns,
there is a lack of effective communication strategy that involves the use of indigenous languages in advocacy, awareness, and education on transmission (Komolafe, 2010).

Apart from posters, there is no serious literature on the disease in indigenous languages apart from English. This raises questions about the effectiveness of campaigns about a disease that is already seen by many as foreign being reported in a language that is not accessible to a large number of Nigerians. When indigenous language is used at all, it is usually one of the three major languages—Hausa, Igbo, and Yoruba (Jegede, 2008) which could still be ineffective in a country where there are over 250 different languages. As a result of this gap, there are numerous people who do not receive vital information about HIV and AIDS. Since language describes how events and realities are perceived, the literature on linguistic representations of HIV/AIDS in Nigeria suggests that many might be aware of the existence of HIV/AIDS through huge campaign efforts but they are still ill informed about aspects of the disease such as its modes of transmission, treatment, and prevention (Komolafe, 2010).

**Historical Perspective: Colonial Medicine, Health, & Wellbeing in Africa**

Historically, ‘Africa’ has been synonymous with disease, death, and uncontrolled sexuality. These ideas took root during the colonial expansion of Africa (1880s to WWI)—a period that coincided with the rapid advance of tropical medicine (Curtin, 1985). During the mid-nineteenth century, doctors and public health authorities were concerned with medical topography—the study of locations, soils, temperature, and rainfall as determinants of healthy and unhealthy places (Curtin, 1985). To many, health and disease were consequences of interactions between the body and its environment. It
was believed that temperature, humidity, and emanations from the soil were sources of danger (Curtin, 1985). Hot climates were understood as particularly dangerous because heat was associated with putrefaction and therefore with disease (Curtin, 1985). As a result, Africa was conceptualized as a land of heat, filth, foul odors, disease and death. So much so that colonial officials received more benefits for working in Africa than their counterparts in other parts of the world (Ngalamulume, 2012). Europeans in colonial Africa feared succumbing to ‘Tropical amnesia’—a term that was used to describe the debilitating nature of warm climate on European bodies (Ngalamulume, 2012). These notions, as well as concerns about sanitation and epidemics (yellow fever, cholera, bubonic plague, influenza) during the mid 19th century to early 20th century, affected health policy and other decisions of the colonial administration (Ngalamulume, 2012). Louise Pasteur and Robert Koch’s discovery of bacteria as disease agents—the emergence of germ theory—in the 1870s did little to change assumptions and approaches to public health within the colonies (Ngalamulume, 2012; Curtin, 1985).

A concern of the time that illustrates the medical anxieties of British personnel around sanitation and solving problems of life and death in a ‘dangerous’ environment was malaria—the biggest threat to Europeans in Africa at the time (Curtin, 1985). In an attempt to control the epidemic, the malaria committee of Britain’s Royal Society sent two doctors, S. R. Christophers and J. W. W. Stephens, to conduct research in West Africa between 1900 and 1903 (Curtin, 1985). Both doctors concluded that African mosquitoes could be expected to hover around African huts because they were race-specific and had more affinity for African blood than European blood (Curtin, 1985). Additionally, since blood samples from African adults rarely revealed actual plasmodia in...
the blood stream, but appeared in that of children with clinical symptoms, African children were thought to be the prime source of infection (Curtin, 1985). As a result, it was recommended that African children (age five and under) be kept away from Europeans, as doing so would “render Malaria a comparatively rare disease [for Europeans]” (Curtin, 1985). These recommendations were supported by the claims of another group of medical officials who claimed “destruction of mosquitoes and other measures are all very well, but segregation of Europeans at a distance from all the natives offers itself now as the only measure by which absolute freedom from the disease can be guaranteed”(Curtin, 1985). Thus began the residential segregation of the European population. By 1907, the Lagos government had condemned seven acres of urban land for conversion into an exclusive European settlement (Curtin, 1985). Rest houses built in many villages for colonial administrators on tour were built at least four hundred yards from the nearest ‘native’ dwelling, and Africans were forbidden to use them under any circumstances (Curtin, 1985). Despite growing knowledge of the parasitic nature of malaria, measures against the disease relied heavily on racial and miasmic beliefs that promoted sanitary segregation (Curtin, 1985). One colonial report described the “sanitary condition of the stations occupied by Europeans as improving gradually. However, the same could not be said for the ‘native towns’, which, with the exception of those in the vicinity of the European settlements remained in their ‘primitive condition’” (Ochonu, 2004).

The construction of medical knowledge on etiology and epidemiology of disease by public health authorities were premised on assumed connections between disease, landscapes, climate, and African bodies (Ngalamulume, 2012). Within the colonial
context, knowledge making was intertwined with colonial imagination, racial prejudice, political convenience, and economic advantage (Curtin, 1985). Colonial medical officers did not and could not operate outside the larger colonial objective of ‘civilizing’ and ensuring the “viability of colonial rule” which was done by reducing the threat posed by African bodies and tropical diseases (Ochonu, 2004).

These colonial modes of thought led to the creation of Africans as the Other. In the early colonial era, colonial officials developed ideas of Africans as people with distinct minds and personalities of “mendacity, drunkenness, hypocrisy, and immorality”—stereotypes that were increasingly rationalized by ‘science’ (Shadowsky, 1997). It was believed that West Africans differed from Europeans because they lacked the "intellectual, emotional, and ethical qualities" that Europeans possessed (Shadowsky, 1997). An exemplification of this mode of thinking or emphasis on difference is apparent in the Jungle Doctor memoirs and books written by British and North American doctors and nurses who worked in colonial Africa. The memoirs and books provide insight into representations of medical encounter in Africa. The publications were often characterized by heroic images of a white doctor facing physical and cultural obstacles and dangers—battling with nature and culture in encounters with mosquitos, witch doctors, and African patients (Vaughan, 1991). It is important to note that this plotline was not different from literary tropes of the time. The fear and sometimes hate expressed in memoirs and books worked to reproduce images of Africa as a dark continent—disease did not merely attack Africa; disease was Africa (Vaughan, 1991). These understandings and perceptions of African minds and personalities also translated to understandings of African bodies. Under colonialism, African bodies provided “raw material” that an emerging field of
biomedicine drew upon for the elaboration of its theories and evolving practice of medicine (Vaughan, 1991). As such, African bodies became sites of ‘scientific’ data production as colonial medical officials became increasingly sought after for their ‘scientific’ knowledge. For instance, in the 19th century, physical features and illnesses of Africans were studied not for their own sake but for how they supported theories of difference between sexes in Europe (Vaughan, 1991). As Megan Vaughan explains, the information gathered and lessons learnt were not used to develop a more effective and appropriate healing system for Africa but rather to contribute to larger European debates about health and medicine (Vaughan, 1991).

Colonialism was an important historical circumstance under which biomedicine evolved—undergoing a shift from a 19th century focus on sanitation and environmental science to the 20th century practice of a reductive and individualistic medicine centered on the ‘magic-bullet’ (drugs that had the ability to selectively target a disease without affecting other areas of the body) (Vaughan, 1991). As the field of biomedicine evolved, it became a tool of empire and a means of social control (Ngalamulume, 2012). For example, Missionary medical discourse on British perceptions of the African reveals the consistent attempt by medical missionaries to effect more than physical transformation (in terms of improving health)—they strove to create new subjectivities (Vaughan, 1991). Africans were understood as being integral features of a hazardous environment and potential hosts for dangerous pathogens so for medical missionaries, healing was a social and moral engineering through which Africans could be saved. In mission hospitals, individual patients were understood as potential converts—through the administration of “modern drugs” for illnesses like malaria, Africans were essentially asked to accept not
only a set of remedies but also a set of ideas and social practices as part of what constituted “modern medicine” (Vaughan, 1991). Biomedicine as a tool of empire and a means of social control can also be understood under Foucault’s concept of biopower—the regulation of the body through social, political and cultural fields of knowledge, especially medicine where it is exerted through the medical ‘gaze’ and through surveillance techniques (Glossary, 2012). The power of colonial medicine did not necessarily come from physical control of African bodies but more from the administration’s ability to naturalize and pathologize accounts of African bodies. The power of biomedical discourse on colonial Africa was essentially the ability to describe poverty, subordination, and exploitation as a ‘sickness’ of African people.

Understanding this history is crucial because it explains and highlights the beginnings of two phenomena that continue to affect Nigeria’s health system and the reality of HIV/AIDS in the country today—1) lack of ownership from the national government (at least as evidenced by HIV/AIDS initiatives), and 2) a system of knowledge production that establishes the West as experts and African bodies as sites of data production. In terms of lack of ownership, the colonial history of health and medicine in West Africa reveals that Nigeria’s health system was established and developed under a regime that did not seek to improve the health of Africans but was instead, focused on caring and protecting the health of colonial officials. As the case of malaria illustrates, care was only extended to Africans when they were perceived as threats to the health of Europeans and when colonial officials thought it in their best interest to mitigate this threat by providing medication. Under the colonial health system, if it is to be described as such, care for Nigerians was not primary; it was merely a by-
product of caring for colonial officials. The healthcare system that was inherited after Nigeria gained its independence in 1960 was one where standards and approaches to care were ill-suited to serve the Nigerian people. It is important to note that a ‘Nigerian healthcare system’ did not exist prior to colonization. This is because, as a nation of people, Nigeria did not exist until the 1914 British amalgamation of what is present day Northern and Southern Nigeria (Falola, 2009). In other words, prior to colonialism, the various ethnic groups that share the national identity of ‘Nigerian’ were not unified under one nation. It is therefore impossible to assess values of a Nigerian health system prior to Western colonization. Systems of healing and seeking care varied from one ethnic group to another. Asuzu explains that:

The Nigerian health care system can be said to have experienced five past reforms […] from the traditional health care system that existed in the individual Nigerian communities and ethnic groups before western (British) colonization till date. […] While the system naturally had to develop in the wake of the British colonization, the first Nigerian Colonial Development Plan of the 1940s gave some limited framework for the health system. It was a unitary health service system. Then came the era of regionalization in the 1950s. Even though no specific documentation or specific effort at such a reform exists, the national health system stopped being unitary; and the regional governments started to run independent and sometimes parallel health systems with the federal government. Then came the Second National Development Plan of the immediate post independence era in the 1960s. Again the plan did not articulate a system with clear levels, or the assignment of responsibilities to the three levels of government. The Third National Development Plan of the 1970s was a rather ambitious plan with the Basic Health Services Scheme as its focus. It was quite elaborate in its health reform attempt. It was far too heavy in infrastructure and auxiliary health manpower development. It [also] failed to share responsibilities between the three levels of government for resources generation, manpower development, the services to be delivered, and especially on the health professional manpower for the services. All these happened in the absence of a clear policy framework.

(Asuzu, 2004)

Since its independence, Nigeria has worked to develop a health system that adequately provides care for its citizens—an objective it continues to work towards today as it also
strives to keep up with global standards of health. As illustrated by the history of the nation’s health system, health policies and systems of care have historically neglected to fully account for Nigerians, their diverse understandings of health, illness, and ways of seeking care. Policies have failed to truly address what it means to provide healthcare for a nation with a multitude of cultural practices and ways of being in the world.

In addition to establishing Africans as Other, another colonial phenomenon that continues to surface in approaches to health in Nigeria is the positioning of Western professionals as experts and African bodies as sites of data production. This was the case with the emergence of biomedicine during the colonial era and as the field of study continues to evolve today, the same themes are evident in current transnational initiatives to combat HIV/AIDS in the country. These phenomena will be discussed in further details in following sections of this thesis but it is important to note that both factors affect how national and international agencies interact and work with each other, as well as the health outcomes of their joint endeavors.

**HIV Care in Lagos: Lessons From APIN Clinic**

One of the sites where I conducted my interview was APIN clinic (AIDS Prevention Initiative in Nigeria) run out of Nigeria’s oldest and largest teaching university hospital. The clinic—a one-story building—was perched in the corner of the 92-acre university campus that housed a teaching hospital and a medical school complex. As a comprehensive HIV clinic, it served over 7000 patients, provided HIV counseling and testing services, adult and pediatric antiretroviral treatment, prevention of mother to
child transmission of HIV (PMTCT) services, and home based care which entailed tracking patients that were “lost to follow up.” Another aspect of the clinic that health professionals spoke favorably about was the fact that the clinic was able to keep an electronic database of its patients. My first day on site, I walked past charred remnants of a building I would later find out was the former HIV clinic that had burned down in an accidental fire in August 2013. Doctor Amuwo, the clinic’s supervisor, recounted the incident as we sat in a sparsely furnished room that served as an examination area:

Initially, when I joined, we had a building that got burnt. Each doctor had their own room. You had your examination couch. Very conducive. I loved working when I just joined. The waiting area – if you’re coming into this place, nobody knew what clinic you’re going into because it was that beautiful. But after the fire incident, the whole thing just…That data room was our lunch room. That consulting room was our seminar room so this area [referring to the clinic] was our waiting room. We also have the pharmacy section. Everything was well arranged but since the fire, it’s been just…

Inside the clinic, a short and narrow dimly lit hallway gave way to an open area that doubled as the clinic’s pharmacy, consultation room, and counseling area. It was only 9AM on a Wednesday morning but the clinic was already moving at full speed—simultaneous consultations with multiple doctors had already begun in the open multi-purpose space that accommodated various units of the clinic; a sizeable amount of patients, young and old, had gathered along the hall of the clinic as they waited to be attended to; and patients and health professionals alike had to weave in and out of the crowd to get from one place to another all while conversations and pleasantries were being exchanged by those present. Amidst all this energy, I sat with the Principal Investigator of the clinic, Mr. Gbadamosi, in his office full of stacks of files and paperwork to learn more about his work and the facility.

As a seasoned researcher, a professor of hematology at the teaching university,
and the chairman of the National Antiretroviral Treatment (ART) task team, Mr. Gbadamosi had been involved with efforts to provide care for Nigerians living with HIV/AIDS for over two decades. In the three hours I spent with him, he recalled some of the notable events that happened during that time: the teaching university’s initial efforts to routinely screen every donor blood for HIV/AIDS antibodies in 1989; the establishment of NACA—National Action Committee on HIV/AIDS by the Nigerian government in 1999; the president’s attempt to fund HIV treatment for 15,000 Nigerians (10,000 adults and 5000 children) in 2000, and the establishment of APIN clinic through the partnership between Harvard’s School of Public Health and PEPFAR in 2004. During our conversation, professor Gbadamosi also discussed the need for more attention to treatment as way of combatting the epidemic as well as the barriers to ensuring treatment availability:

[Now, according to WHO and International AIDS Society (IAS) guidelines]…2.8 million people in Nigeria should be on ARV. I can tell you that from most conservative estimate that we have, the maximum number that are currently on antiretroviral treatment program in Nigeria is 800,000. Far below the number that is required to be put on therapy. But that is not the only problem that confronts us. This 800,000 – are they taking the drug effectively? This 800,000 – are they achieving the goals of therapy? (which is to ensure that viremia is completely controlled). They’re aviremic because they’re on treatment. If we achieve that goal of treatment to ensure that in all of those that are on treatment, the viral load is not detectable, then we’ll be fine because the public health importance of achieving that goal of treatment is that those people will no longer be able to infect previously uninfected people. Because today, we’re now using treatment as the most important weapon of preventing spread of the disease in the community…For everyone that is effectively treated, 5-10 new infections is prevented in the community so this is the major reason why we should put so much money into the treatment program. Where we stand today in Nigeria is that we have a huge gap when it comes to treatment. [A] very huge gap.

HCT [HIV Counseling and Testing] services has to be expanded. [It] has to be funded so that the number of people we think are living with the virus in our community can be identified. If they’re identified, then we have to expand the program in such a way that we should be able to provide ARV services. But these
are huge things that we’re talking about.

We need more commitment from the government of Nigeria into providing treatment services for HIV infected people. We need more commitment from the government of Nigeria to be able to provide HTC services so that we can identify those that will need to be placed on antiretroviral therapy. We need to identify everyone that is HIV infected. If everyone that is infected is effectively placed on treatment we can stop the transmission of the virus.

NACA appears to be looking for sources of funding for HIV and AIDS program outside of Nigeria. And of course if they bring the money in, now how do they use the money? Do they just focus on HCT? Do they just focus on what they call patient or client empowerment? These are the issues. I am not so much into the way they’re doing it now but I know that the treatment program appears to be the least on the table of priority of NACA. I can say that because they [have] funds and [they use the] fund to support HIV/AIDS program in other areas—maybe supporting HTC; maybe supporting patient empowerment; maybe supporting all sorts of things. But the treatment program, its like the US program [referring to PEPFAR] is leading [in that area] because as we speak, we still have nearly 80-90% of ARV that is being used in country from PEPFAR fund. Nearly all the laboratory that are providing CD4 viral load services are actually still being funded from PEPFAR fund... So the money that is coming from Nigerian government [for] HIV and AIDS programs [goes] largely to NACA ([who also receives funds from the Global Fund]) and they’re using it to support maybe other services including what they call Orphan and Vulnerable Children (OVC).

Although Professor Gbadamosi emphasizes that these are just his opinions and in no way reflect how NACA actually allocates its funds, the sentiments he shares point to an important factor that affects HIV health outcomes in Nigeria: the difference in values and objectives of national and international agencies working to combat HIV/AIDS in the country. His account also highlights lack of collaboration and communication between these agencies. This divergence is exacerbated by overdependence of one entity on international funds which gives rise to issues of national government ownership when it comes time for the government to “pick up” where the international NGO left off. This was an issue that came to light in an interview with APIN’s Chief Executive Officer,
Dr. Victor Emeli, who was tasked with transitioning the clinic from a Harvard-led program to an “indigenous NGO” in 2008:

APIN was set up initially as a project of the Harvard School of Public Health, and since 2008, as an indigenous NGO, but still well-funded by PEPFAR. What therefore happened was that we essentially inherited HSPH’s portfolio and so we did not have much funding or service disruption challenges. Again, as part of the transition, HSPH helped to strengthen our systems (financial, technical, managerial, etc.) and this gave the US government the confidence to fund us to a high of about $50m annually, though this has reduced now to about $25m year, due to generally reduced funding, occasioned by the global economic stress. The challenge we had at the initial stage, was that of the perception from our Nigerian collaborators, that we would not support services at the level that Harvard did, but that was assuaged after a little while, since quality was still maintained.

The transition that is currently affecting every PEPFAR partner is one occasioned by the decision of the US Government to stop funding certain components of the service delivery package, with the hope that the Nigerian government would pick up the bills. This had not happened, and so HIV patients are now having to pay for some lab tests out of pocket, since insurance coverage is quite low at less than 10%.

While not a challenge at the present time, we are working hard to diversify our funding portfolio, knowing the risk of most of our funding coming from PEPFAR and Global fund, which are prone to political uncertainties.

The accounts given by Professor Gbadamosi and Dr. Emeli highlight tensions that arise when there are gaps between the standards of care made possible by international donors and services the national government is able to provide. It also brings to the forefront, the dangers posed by overdependence on international funds because as demonstrated by the case of APIN clinic in its transition to an indigenous NGO, overdependence on international funds can undermine local trust and progress in terms of available resources and health services. According to Professor Gbadamosi, HIV/AIDS activists are the reason PEPFAR funding is still available. The program was originally supposed to last from 2004 to 2009 but in 2009, activists claimed the United States was morally bound to continue and were able to convince the U.S. Congress to extend the
program for another four years. At the end of the extension in 2013, the United States began to reduce its PEPFAR funds. In addition to patients who had to start paying out of pocket for services that were previously covered (such as blood work), the reduction in funds also affected health professionals whose salaries were covered by the PEPFAR grant. Fortunately, the Nigerian government was able to absorb 70-80% of salary costs but the cost of generators for electricity and patient lab tests were not covered. The rationale behind this was that non-HIV patients were expected to pay for those services so the same should follow for individuals living with HIV.

When national and international agencies have different priorities and capabilities, the results are usually suboptimal. Although the PEPFAR initiative underlines “supporting host countries’ leadership and ownership of their responses to their HIV/AIDS epidemic” (Amor, 2007) as one of the program’s main component, the experience of APIN clinic proves otherwise. The PEPFAR program was established as part of the U.S. Global AIDS Initiative that was launched as a result of the United States Leadership against HIV/AIDS, Tuberculosis, and Malaria Act passed by the U.S. Congress on May 27, 2003 (Amor, 2007). The U.S. Global AIDS Coordinator was in charge of coordinating all PEPFAR activities and tasked with the development of policy and programmatic guidance for focus countries among other responsibilities (Amor, 2007). Representatives from the recipient countries were absent from this process as well as the development of the 5-year strategic plan. Harmonization as far as PEPFAR was concerned was being committed to implementing its program within the “Three Ones” framework of harmonization—One HIV/AIDS Action Framework, One National AIDS Coordinating Authority, and One country-level Monitoring and Evaluation System—
formally endorsed at a “high level meeting” with the United Kingdom, UNAIDS, and other major donors in April 2004” (Amor, 2007). Again, recipient countries were not present at this meeting. Of important note is the fact that the principles were initiated by UNAIDS, the World Bank, and the Global Funds—all donor institutions (UNAIDS, 2005). Had the Nigerian government (and other Africa countries) been involved with the initiative from the very beginning,—in its conceptualization phase (thereby having more ownership)— it is more likely that APIN’s transition to an indigenous NGO would have occurred with less financial uncertainties. An analysis of Nigeria’s response to HIV/AIDS reveals that the country has historically adopted best practices and policies without intentional development of its own vision, parameters, and capacity to reach established objectives—a strategy that compounds restrictions imposed by having limited resources.

**History of HIV Response in Nigeria: Authorities, Best Practices, and Ownership**

The first case of HIV in Nigeria was identified in 1986 (Adeyi, 2006). Despite this revelation, the government was slow to respond as many in the country were still under denial about the existence of HIV. The denial was fueled by the nation’s colonial history, which led Nigeria, like many other African countries, to believe that HIV/AIDS was an attempt from the West to destabilize their newly gained independence (October 1st, 1960). Some held the view that Africa was a place of stability and morality where sexual practices fell under traditional norms and AIDS was a western disease caused by the degeneracy of the West and its practice of homosexuality (Vaughan, 1991). By the
time Nigeria decided to take HIV/AIDS seriously, guidelines, recommendations, and best practices from international agencies had been established. As time would later reveal, adopting these best practices did little to improve the state of health for a vast majority of individuals living with HIV/AIDS in Nigeria. In essence, Nigeria’s response to the epidemic can be understood as a timeline that moves from denial to the adoption of international best practices with little account or serious consideration for the Nigerian context.

In 1987, after initial denial had phased out and panic set in, the government created the National Expert Advisory Committee on AIDS (NEACA) (Adeyi, 2006). The creation of this committee coincided with the promotion of the World Health Organization’s Global Program. In fact, the creation of the committee was a result of the recommendations made by the WHO Global Program. Spearheaded by Jonathan Mann, founder of the Global Program and renowned physician known for this work on AIDS and his promotion of linking human rights to health issues, the eight year program which lasted from 1987-1995, pushed for focus on four priorities—1) screening blood supplies in poor countries, 2) Training medical staff in clinical management and counseling of those who tested positive, 3) supporting public education about the epidemic as there was no cure or vaccine, and 4) preventing discrimination (WHO, 1997; Iliffe, 2006).

The World Health Organization could only intervene in a member country’s medical affairs if the country made a request so nation states were encouraged to invite WHO for assistance on crafting short to medium term plans to fight AIDS. Accordingly, Nigeria requested the assistance of WHO in 1987. The WHO was asked to assist in 151 countries and their assistance usually took the shape of sending two to three foreign
Public Health experts that worked to accomplish the four strategies of the Global Program once on ground (Iliffe, 2006). Working with the country’s government, the experts established a national AIDS committee with a small executive staff within the ministry of health.

They provided equipment to screen patients and blood before blood transfusion, provided lab support, and designed programs for staff training and public support. They also assisted with the preliminary assessment of HIV prevalence and the preparation of measures to outlaw discrimination (Iliffe, 2006). The medium term plans (3-5 years) drafted in conjunction with health officials on ground worked to create a more representative national AIDS council, conduct a sentinel survey of HIV prevalence measured from taking blood of women at antenatal clinics, and target high risk groups such as sex workers (Iliffe, 2006). They also supported countries with arranging donor conferences to raise funds.

These strategies had been informed by the realities of HIV/AIDS in the United States where most strategies targeted vulnerable groups. In essence, in the US, strategies were designed to counter epidemics in stigmatized populations like men who have sex with men and injection drug users. The strategies championed by Mann focused on rights of individuals within these groups and little attention was given to the protection of the uninfected and the general population. For instance, in 1986, “approximately 75,000 cases of AIDS had been reported to WHO, predominantly from the USA and other [western] countries where the epidemic was seemingly concentrated in [gay men and injection drug users” (WHO, 1997). In Nigeria, a country that was experiencing a generalized epidemic, the epidemic was not spreading through minority groups but
instead heterosexuals in the general population. The earliest national survey showed a range of varying HIV prevalence across the different states in the country with heterosexual mode of transmission accounting for 82% of all transmissions (Adeyi, 2006). As a result of these differing contexts, strategies of the Global Program ultimately proved to be ineffective in Nigeria. Focusing on the wrong population at such an early stage of the epidemic in Nigeria facilitated the growth of the epidemic and led to the compromised quality of care experienced by individuals living with HIV/AIDS in Nigeria today.

In Nigeria, the same year assistance was requested, with the assistance of WHO, Nigeria established the first of nine HIV testing centers. NEACA ‘created’ a medium term plan and with WHO assistance and guidance of NEACA, the federal ministry of health implemented the medium term plan. NEACA was also a key actor in providing initial epidemiologic information that was used for planning prevention and control strategies. It is important to note that all of these actions were in line with the objectives set and championed by WHO and its Global Program. While the intentions of these strategies were good and the WHO Global Program were well meaning, it is important to realize that these strategies failed to account for the African context—America’s marginalized populations was irrelevant to Nigeria’s mass heterosexual epidemic (Iliffe, 2006). The actions of this time period, the late eighties, exemplifies what can be understood as intellectual imperialism and highlights a lack of ownership of HIV policies and program initiatives from the Nigerian government—a reoccurring trend that would continue to affect action and initiatives around HIV/AIDS in the country.

In 1988, still displaying a tepid response to the epidemic, NEACA advisory board
was replaced by the National AIDS and STDs Control Program (NASCP) (Adeyi, 2006). Under the federal ministry of health, the program expanded in 1991 to include STIs. These changes shifted the multisectorial approach the government had been employing to an approach that focused primarily on the health sector’s response to HIV and STIs. Key areas of intervention that the NASCP established guidelines for included: the syndromic management of STI, voluntary counseling and testing (VCT), prevention of mother to child transmission (PMTCT), management of HIV, and treatment of opportunistic infections, administration of ARVs, and home-based care. The program also supported monitoring and evaluation of the epidemic (Adeyi, 2006).

In 1991, the federal ministry of health began to conduct a country-wide survey of pregnant women with HIV to estimate HIV prevalence rates. The survey revealed that prevalence rates differed from state to state and ranged from 1.2% in Osun state to 12% in Cross River State. In the same year, Jonathan Mann resigned from his position as program director of the Global program because of his disagreement with the WHO director general who supported African countries that wanted to stop the Global program from overshadowing the primary health care sector and decentralize the program’s structure and staff to regional offices (which Mann had deliberately bypassed). During this time, the WHO and its Global Program was also under fire from other international bodies who perceived the program as being uncoordinated and lacking effectiveness. Many noted that the global program in many countries had lost their direction. For instance, the AIDS committee of 14 out of 27 countries had not met in 1991 (Adeyi, 2006). In 1992, an external review of the global program also suggested that responsibility should be shifted away from WHO and its narrow medical perspective.
In addition to this, many donors had become discouraged from working with governments they felt were corrupt and as an example, by 1995, USAID was providing 87% of its aid to NGOs and the private sector (Iliffe, 2006). During this period, NGOs increasingly began to play a key role in negotiating access to resources controlled by transnational institutions. As a result of these factors, the 1990s gave rise to a number of new AIDS policies and programs led by institutions like the World Bank, UNICEF, UNDP, and the European Union. As one author put it, “National AIDS plans, ‘hatched like chickens by groups of international consultants’, who sought to impose identical structures – hierarchy, medicalization, verticality, dependence that smothered local initiatives that were emerging before WHO intervened” (Iliffe, 2006). Again, this speaks to an atmosphere that enabled a lack of government ownership of HIV/AIDS policies, which was true for Nigeria. By the mid-nineties, Sub-Saharan African governments provided only 9% of public HIV/AIDS spending (Adeyi, 2006). Many governments did not want to contribute even money they promised to programs because they saw the initiatives as being led by and therefore the responsibility of WHO agencies. Nigeria AIDS Spending Assessment Report still reflects this trend with the government being responsible for 23% of the country’s total expenditure on HIV/AIDS.

Some scholars argue that the International AIDS policies in Africa of the late 20th century failed because they came too late. I propose that they failed because governments lacked national ownership of policies and initiatives around HIV/AIDS. In other words, as evidenced by the creation of NEACA, subsequent national AIDS committees, and the adoption of ‘best practices’ like the WHO Global Program, although there were a lot of action and effort around implementing best practices, there was little attention given to
identifying and understanding the nature of epidemic in Nigeria by Nigerians. There was little account given to identifying factors that made sense for Nigeria, and was within the capacity of the government to accomplish. The misguided steps of the early AIDS response in Nigeria laid a rocky foundation for future work in the field. Another contributing factor to the ineffectiveness of policies of this time worth mentioning is that the biomedical approach underlying international policies often conflicted with Nigerian perceptions and understandings of the epidemic. This particular tension will be discussed in another section.

In 1996, there were changes in the Global and African response to HIV/AIDS as leadership on the issue moved from the WHO to UNAIDS (Adeyi, 2006). This change was galvanized by the development of antiretroviral drugs (ARVs) and the resulting addition of actors invested in the epidemic—namely pharmaceutical companies and activists. UNAIDS was tasked with coordinating all international action against the epidemic, although they did not take over the WHO’s medical role and did not function as a funding agency. Their objective was to coordinate, define, and publicize policies through ‘theme groups’—country teams made up of representatives from national cosponsors and UN agencies—and essentially bring together local representatives and international agencies. As the first director general of UNAIDS, Peter Piot stressed the continuity between UNAIDS and WHO’s global program. He championed the idea of addressing human rights, the needs of young people, incorporating gender into policy and programs, and involving individuals living with HIV and AIDS into all levels of decision making. Piot believed vulnerability had social and economic roots, and as a result, promoted a multi-sectoral development approach to fighting the epidemic. He pushed for
a move of HIV/AIDS programs from the ministry of health to office of the president or prime minister that would be tasked with creating a council with representatives from government departments and NGOs. With rhetoric that emphasized multisectoralism, mainstreaming, and political commitment, UNAIDS strove to put AIDS on the political agenda of many governments and ensure that the epidemic remained a global issue and not just a problem of the global south.

During this time period (1994-1999), Nigeria had undergone a military coup and advancements regarding HIV/AIDS and healthcare in general that had been made in the previous years were reversed. Namely, because the regime was uninterested in healthcare and the withdrawal of donors who did not want to operate within a country that was under military rule. With the return of democracy in 1999, the newly elected president Obasanjo, was proactive and increased local activities and external donor support. To show his commitment to HIV/AIDS, the president initiated a Nigerian National ART program funded by the government of Nigeria. Notably the only HIV/AIDS response that had full ownership of the Nigerian government, the program sought to provide ARVs for 10,000 adults and 5,000 children across the country. Generic drugs from Indian multinational pharmaceutical company Ranbaxy were procured and Hospitals across the country (one of which I conducted my interviews) were identified as care centers. Unfortunately, the government was unable to keep up with the demands of the population as more than 15,000 sought to get access to medication. To prove his commitment to HIV/AIDS, the president also hosted the first Organization of African Unity Summit on HIV/AIDS, TB and Other Related Infections.

In 2000, the government decided to employ a multisectoral approach which was
in line with recommendations made by UNAIDS. Under Obasanjo’s rule, a presidential committee on AIDS was established as well as the National Action Committee on AIDS (NACA) that is still in place today. With the goal of creating a “broader AIDS program,” State Action Committees on AIDS (SACAs) and Local Government Action Committee on AIDS (LACAs) were also established. This was to ensure that there was representation and input from all tiers of the government. On the federal level, NACA was charged with developing policies for prevention and control. Their mandate also included developing effective multisectoral response strategies nationwide. As its first project, NACA created a multisectoral medium-term plan of action—a 3 year HIV/AIDS Emergency Action Plan (HEAP) that lasted from 2000-2004 (Adeyi, 2006), the execution and implementation of which it was in charge. The plan, which covered advocacy, prevention, care, and treatment, had two components: 1) Break down barriers to HIV prevention at the community level and support community-based responses, and 2) Provide prevention, care, and support interventions directly (Adeyi, 2006). Despite these efforts, there were still gaps in prevention, treatment, and care services especially at the community level. The committee also ran into challenges with scaling up the program. It is important to note that during the years that HEAP was in action, Nigeria’s direct HIV/AIDS related budget was US$236 million with the contribution of the Nigerian Government being US $40 million (Adeyi, 2006).

In 2005, Nigeria adopted the “Three Ones” principles which as mentioned earlier, was a mechanism to enhance harmonization and effectiveness of national and international HIV/AIDS responses (NACA, 2015). Under this framework, NACA was (and continues to be) the national coordinator of HIV/AIDS response. In line with the
“Three Ones” principles, the committee employs one national framework—the National Strategic Framework (NSF)—and works with one country-level Monitoring and Evaluation System—the Nigeria National Response Information Management System (NNRIMS) (NACA, 2015). This period of time also coincided with the WHO’s “3 by5” initiative—a scheme that aimed to treat 3 million people infected with HIV in poor and middle income countries with antiretroviral treatment by the end of 2005 (Kim, 2004).

All in all, efforts put forth by UNAIDS and global health partners such as the WHO did not have as much practical impact as anticipated. For example, by the end of 2005, targets set by the WHO’s “3 by5” initiative were not met—only 1.3 million people in low- and middle-income countries were receiving treatment (WHO, 2006). Although global health institutions, especially UNAIDS, did not intend to create national AIDS programs like the WHO Global Program had done, that is exactly what happened. The only difference was instead of a focus on the medical aspect of the epidemic, the focus turned to donors. In fact, similar to the global program, UNAIDS held workshops that instructed governments on how to draft action plans. As a result, one author notes that “many [plans] lacked distinctive national character and [government officials] showed signs of weariness.” Once again, the Nigerian government had little ownership of policies and initiatives. All the plans and policies that were devised incorporated UNAID values such as multi-dimensionality, multi-disciplinarity, multi-sectoriality, decentralization, and communitarianism but in reality, many plans remained under the ministry of health.

In an interview with Dr. Baruwa, an HIV Strategic Information specialist with over 10 years with HIV Surveillance and HIV Quality Improvement programs in Nigeria, I asked,
“Does Nigeria employ a multi-sectorial approach to combat the HIV epidemic?”

to which he replied,

“Yes. But the multi-sectorial approach has lost its focus as it feed[s] more entirely on the health sector, thereby weakening the coordinating organ for HIV in the health sector.”

In Nigeria’s case, the government ascribed to all the rhetoric but sustainable action behind the rhetoric was lacking.

Although Nigeria has stayed up to date with the latest recommendations and best practices in approach, it has yet to determine the right mix of policies and programmatic approaches for tackling the HIV/AIDS crisis. The nation has gotten to its current point by essentially following the trend in approaches recommended or dictated by global health and aid institutions—such as the WHO and UNAIDS—and other international organizations. Over the course of the epidemic’s history in Nigeria, approaches have ranged from a primarily biomedical approach to the promotion of behavior change—essentially switching from a health sector response to an attempted multi-sectorial approach. To date, apart from the voices of academics that have raised questions about the Nigerian health system, there has been no attempt by the Nigerian health sector to critically appraise its response to its HIV/AIDS epidemic. Intentional efforts to do this outside the parameters or guidelines set by international donors (indicative of better national ownership) must take place in order for optimal health outcomes to become a reality.
Valuable Inequalities: Research, Data, and African Bodies

The new millennium brought with it a revitalization of donor interest in Nigeria. Funding available for AIDS programs increased from US$300 million in 1996 to US$6.1 billion in 2004 (UNAIDS, 2005). Nigeria was able to attract funding from the World Bank, USAID, DFID, the Ford Foundation, and the Bill & Melinda Gates Foundation among others. Bourne of these opportunities was the relationship APIN clinic was able to establish with Harvard’s School of Public Health and PEPFAR. It is the subtle implications of these types of partnerships—research institutions, donor agencies, and African health centers—that often go unnoticed and unmentioned in accounts of HIV/AIDS responses that I choose to analyze in this section. Professor Gbadamosi’s account of how APIN clinic came to be is particularly helpful in demystifying a reality that can get lost in the flurry of data publication that this millennium has come to highly value.

Now in 2003, the then president Bush of United States of America somehow for one reason or the other decided that he has to wade into the fight against HIV and AIDS. The United States announced 15 billion US dollars to be spent in some African countries and the Caribbean to fight HIV and AIDS…Nigeria was enlisted in 2003. The program was such that it [was] open to US institutions to apply for PEPFAR fund but [the institutions must have been working in at least three African countries] in order to qualify to apply for PEPFAR funding. Luckily we [(the university teaching hospital)] have been working with the Harvard school of public health. They [came] here, they were doing PMTCT program. They were doing a lot of prevention activities program. Our PI professor Phyllis Kanki of Harvard School of Public Health was working in [Nigeria, Senegal, Botswana, and Tanzania]. It is not only Harvard school of public health…There were several groups in the United States that got the Harvard PEPFAR and all of them were working in different countries in Africa. So we were part of Harvard school of public health PEPFAR program so that is how we got in there. The application was in 2003 and the [program] actually started here (at University Teaching Hospital) in 2004.
Professor Gbadamosi’s narrative highlights one global health issue that points to greater trends in the world of global health science and HIV/AIDS care in Sub-Saharan Africa—the link between U.S. universities, research, and HIV care in Sub-Saharan Africa. Anthropologist Johanna Crane’s concept of valuable inequalities and how Africa came to be “in vogue” in her ethnographic account of HIV/AIDS care in Uganda is especially useful in understanding this relationship. In order to fully understand the term “valuable inequalities,” it is necessary to begin with an explanation of the development of antiretroviral treatment (ARVs). In 1995, multi-drug antiretroviral cocktails were made available for AIDS patients in the U.S. (Crane, 2013). However this regimen was not readily available in African countries despite the fact that people living with HIV in Sub-Saharan Africa make up approximately 70% of the global total (Avert, 2015c). This was because of the medication’s high cost and arguments from international donors that poor patients would not be able to take the medications properly and would consequently cause the emergence of dangerous strains of a drug resistant HIV virus (Crane, 2013). With the advent of the manufacturing of generic antiretroviral combinations from countries like India and Brazil, access to medication increased. In fact, it was this occurrence that made it possible for President Obasanjo to create the Nigerian National ART program that sought to provide ARVs for 10,000 adults and 5,000 children across the country (Adeyi, 2006). Although, the program ultimately proved to be unsuccessful as disclosed by professor Gbadamosi, Indian pharmaceutical companies like Ranbaxy made it so that antiretroviral treatment that originally cost $15000 a year were now available for $30 a month (Crane, 2013). This shift in availability began at the turn of the millennium (2001)—at the end of what has become known as the first decade of the
treatment era of HIV/AIDS (1995 – 2005) (Crane, 2013). During this time however, deaths from AIDS in many African countries went unabated. In Nigeria, there were no significant reductions in AIDS-related deaths between 2005 and 2013 (Avert A). Other elements that galvanized the change, in terms of access to antiretroviral treatment, were activists and the Bush administration’s framing of AIDS as an emergency because of the national and global security threat it posed (Virbeto, 2011).

This rhetoric, which was characterized by the CIA’s report, “The Global Infectious Disease Threat and its Implication for the United States,” brought about initiatives such as the Global Fund and President Bush’s announcement to support the cause with the President’s Emergency Plan for AIDS Relief (PEPFAR) in 2002 and 2003 respectively. By the end of 2004, free ARVs were available in many African clinics. This scenario was true for Nigeria as detailed by Professor Gbadamosi and his account of the establishment of APIN. The AIDS Prevention Initiative in Nigeria (APIN) was initially endorsed by the Bill and Melinda Gates Foundation who gave $25 million to the Harvard School of Public Health (HSPH) to establish the program for HIV/AIDS research and prevention initiatives in 2000 (HSPH, 2016; APIN, 2016). In 2004, the HSPH project started implementing HIV/AIDS prevention, care and treatment programs with support from PEPFAR (APIN, 2016). HSPH Professor Phyllis Kanki, director of APIN, became principal investigator of the PEPFAR grant to help eradicate HIV through the expansion of antiretroviral therapy programs (HSPH, 2016). Professor Gbadamosi expounded on the program in the interview with him:

I told you that it was the Bill and Melinda Gates program that we were running. And it was focusing primarily on preventive activities; what and what to put in place to contain the spread of HIV and AIDS. They were doing what we call injection safety; they were doing PMTCT, collecting data and reporting data. It’s
a kind of prevention program and a research program that we were doing. Of
course, a laboratory was actually established here in this hospital, collecting the
data. We were being trained on how to do western blot (in house) and viral load.
All those things were what we were gaining from our relationship with Harvard
school of public health. That relationship was already in place by the time the
PEPFAR grant was announced by Bush administration so it was easy to know
who are the people that you’re working with. It’s just like a continuation.

In Nigeria where access to quality care is not readily available due to infrastructural and
financial barriers among other factors, a partnership with HSPH and PEPFAR provided
health professionals at the University Teaching Hospital working with limited resources
the opportunity to provide quality care to many who would otherwise not have it. Though
immediately beneficial in terms of gaining the capacity to administer comprehensive HIV
care—through the establishment of a laboratory and an electronic database—
transnational scientific networks exemplified by the relationship between APIN, Harvard,
and PEPFAR are often wrought with buried inequalities; inequalities that become
valuable and necessary for global health to flourish.

Johanna Cane explains that this period, starting in 2001, brought a shift of policy
discussions from Africans not being able to take drugs properly to a focus on concerns
over clinic and laboratory infrastructure, staffing shortages, and long-term sustainability
of foreign funded treatment programs. According to Crane, in addition to ARVs, donors
also pursued “a rapidly expanding and largely U.S. funded scientific apparatus focused
on studying the rollout of antiretroviral treatment in Africa and the impact of the
powerful drugs on thousands of never-before-treated patients” (Crane, 2013).

The biological “blank slate” that African bodies possessed was not available in
wealthy countries where access to medication had been available for almost a decade.
This particular phenomenon of treatment naïve or virgin population (individuals who
have never been exposed to antiretrovirals or other drugs) is one that often surfaces in discourses about treatment for HIV & AIDS because populations that have not built resistance to the ARVs or other drugs are important to researchers. The emergence of increased interests in Treatment Naive or virgin populations in low-resource countries coincides with a shift from prevention tactics to combat the spread of HIV to one that focused more and more on treatment (Nguyen, 2010). Treatment Naive goes hand in hand with Vinh-Kim Nguyen’s concept of therapeutic citizenship or Foucault’s biopolitical citizenship which describes “a system of claims and ethical projects that arise out of a conjugation of techniques used to govern populations and manage individual bodies.” (Foucault, 1978). This is because for many people living with HIV & AIDS, being treatment naive becomes the only way to gain access to ARVs and other medication. In middle to low-income countries like Nigeria, governments usually lack the finance and tools to establish public health infrastructures that are capable of providing ARVs to citizens. This is often times the consequence of structural adjustment programs (SAPs) imposed by transnational institutions such as the World Bank and IMF.

For instance, the effects of SAPs on Nigeria included a continued decline in agricultural and industrial production; unemployment in all sectors of the economy; chronic shortages of consumer goods; inflation; reductions in real wages; reduction or elimination of essential social services; increased crimes and violence (Okome, 1998). The implementation of SAP did considerable violence to social fabric in Nigeria in that the standard and quality of life of majority Nigerians deteriorated with the fall in the value of naira (Nigeria’s currency). As a result, consumption of food, health and social services declined due to the inability of majority of Nigerians to afford these necessities
(Okome, 1998). When Nigeria’s Basic Health Services Scheme (BHSS) was originally designed in 1974, the financial situation of the government was not seen as a constraint—the federal government accepted to fund the entire program. The scheme was supposed to increase the coverage of medical services to the nation from 25% to 60% by 1980 but by the time of the implementation for the scheme, the government was only able to assist states in the implementation of the scheme (Onokerhoraye, 1984).

As a result of these obstacles to access to care, NGOs are used to fill in the gap and negotiate access to resources controlled by transnational institutions which leads to the emergence of therapeutic economy comprised of networks of AIDS activists, health-based NGOS, biomedical researchers, international aid donors and pharmaceutical companies. This trend—the NGO-ization of care—was one that rose to prominence during the 90s. With the adoption of social safety nets, NGOs became responsible for preventative work and support of people living with HIV in countries with governments struggling with economic depression and structural adjustment. With regards to HIV/AIDS care in Nigeria, the establishment of APIN and how it became inserted into the fabric of HIV/AIDS care and treatment speaks to this reality. One social implications of this NGO-ization of care and rhetoric around increasing access to treatment in low-resources countries was that the bodies of Nigerians living with HIV/AIDS essentially become sites of research. As Crane puts it, “Patients were no longer targets of care but fodders for the generation of scientific knowledge” (Crane, 2013).

A historical grounding of this phenomenon provides another perspective—one where the role of international donors that provide substantial funding and services to countries where state power has been compromised by structural adjustment programs
can be understood as being similar to the role played by former colonizers. Crane describes this as the “postcolonial geopolitics of illness and poverty,” which calls attention to how transnational biomedical science is shaped by wealthy countries that often serve as providers of medical aid and health development funding to indebted countries. This perspective reveals that illness and medicine are inseparable from power and inequality—a reality that been proven by the AIDS epidemic. Additionally, critical medical anthropology warns against the tendency to naturalize processes of health and illness. Instead, social contextualization and utilizing the concept of structural violence are necessary to elucidate the factors that influence health realities in different places around the world. Michel Foucault’s concept of biopower—the control of bodies and populations through forms of management and administration—is also useful in that it makes known how even benevolent efforts to govern or improve social welfare can become symbolic violence or therapeutic domination that works to produce docile, self-disciplined bodies.

In one decade, Nigeria like many other African countries went from being excluded from the advancement of HIV treatment to being an area of central concern and production of knowledge within the increasingly popular field of “global health science” (Crane, 2013). There was essentially a shift away from understanding Africa as a place of “antiretroviral anarchy” and a “petri-dish for new treatment resistant strains” (Crane, 2013). African countries became increasingly courted by prestigious research universities in the world who were scrambling to find resource poor hospitals to base their international HIV research and global health programs (Crane, 2013). As Johanna Crane claims, Africa was now in Vogue. Crane provides a critical analysis of this phenomenon
by explaining that AIDS in Africa has not only been a source of tragic misfortune and death but also a generator of profound institutional and intellectual opportunities—opportunities that are allocated unevenly and produce new inequalities. This analysis is particularly useful because it recognizes the active participation or agency of African health professionals and policy makers but also highlights the cost at which this is attained and its limits. In other words, the relationship between Nigerian health professionals, the APIN HIV clinic, and Harvard’s school of public health is one where individuals living with HIV/AIDS in Nigeria benefited and health professionals on ground were actively involved in the program. This challenges the tendency to place Africa and Africans at the periphery of scientific knowledge making (Crane, 2013). As professor Gbadamosi claims, some of the benefits gained from the relationship with APIN and HSPH were training programs that gave lessons on how to conduct in house western blot and viral loads, how to collect data and store it electronically, and the establishment of a lab. These benefits, however, are attained within what Crane calls an uncomfortable mix of preventable suffering [inequity] and scientific productivity. It points to the rise of global health science and how it paradoxically embodies and even benefits from the very inequalities it aspires to resolve. “Resource-poor” settings become the sites of “global” research and educational opportunities unavailable in “resource-rich” settings creating what can be understood as valuable inequalities. It is important to note that beneficiaries of these inequalities are not only American researchers but also African collaborators whose positions serve as currency in transnational research economy fueled by data (Crane, 2013).
With regards to APIN clinic in Nigeria, this is highlighted by the relationship between Nigerian health professionals, the APIN HIV clinic, and Harvard’s school of public health. I have already discussed the participation of Nigerian health professionals and what was gained from the relationship with Harvard’s school of public health. Another aspect of this relationship that needs to be accounted for is the role of HSPH and the advantages that were obtained by their involvement with APIN clinic and providing ARVs in Nigeria. One way to deduce this is by examining the positionality of APIN’s initial director, Phyllis Kanki, professor of Immunology and Infectious Diseases at Harvard’s School of Public Health and Northwestern University’s Center for Global Health (HSPH, 2016b; Center for Global Health, 2016). As a professor within this discipline, Kanki’s research or research interests focus on virology, pathogenesis and molecular epidemiology of HIV in Africa (HSPH, 2016b). More specifically, her research has dealt with pathogenicity, transmission, and immune correlates of HIV virus infections in West Africa (Center for Global Health, 2016). While APIN has been able to provide ARVs for many Nigerians living with HIV/AIDS, its establishment also contributed to Kanki’s research in that it facilitated the monitoring of the efficacy and impact of ART treatments as well as ART drug resistance. Kanki describes her work as operational research dealing with HIV diversity and drug resistance, ART adherence and HIV co-infections including tuberculosis and hepatitis infections (HSPH, 2016b). The data collected from patients that are serviced by APIN clinics in Nigeria and other African countries where similar work has been done, has provided a database from which operational research (using analytical tools to make better decisions) questions dealing with the efficacy of ART and prevention of mother to child transmission (PMTCT)
interventions can be obtained. It has also facilitated the publication of materials such as Kanki’s "The HIV/AIDS Epidemic in Africa—Implications for Pathogenesis and Vaccine Research" (HSPH, 2016b).

Kanki emphasizes training on issues such as clinical ART for adults and children, principles of research ethics, laboratory methods, pharmacy, and data management and analysis as being a critical goal of APIN (HSPH, 2016b). She makes known that these training sessions have been given to over 6,000 health care providers in Nigeria’s APIN program and that the capacity of over 22 laboratories in Nigerian teaching hospitals and research institutes have been built to point where they are able to provide state of the art HIV diagnosis and monitoring (HSPH, 2016b). While this relationship might not conjure up immediate feelings of unethical experiments like examining the effectiveness of new ARVs and other drugs on African bodies, it still points to the imbalance of power between transnational scientific networks that Crane talks about. It points to Nigerian bodies as sites of data production even though many are still unable to gain access to care. In fact, according to UNAIDS’ 2014 gap report, only 21% of adults living with HIV in Nigeria are on ARVs (AVERT, 2015a). While Nigerian expertise has been present in the processes of knowledge production that occurs at APIN clinics, I argue that this expertise has been developed and employed within the framework prescribed and parameters set by Kanki’s research objectives. In other words, the ability of Nigerian scientists and health professionals to formulate and act on or carry out “home-grown” research objectives due to financial and infrastructural issues that Nigeria still contends with. As Crane states, “providers of funding and aid enable projects that may otherwise
be impossible but they bring with them sets of expectations and priorities determined elsewhere, in much wealthier settings” (Crane, 2013).

From Crane’s analysis of valuable inequalities, it is easy to see how global health science both generates and relies upon inequalities. It also highlights how good intentions and compassionate action are not immune to the power imbalances and the inequalities as is the case with APIN clinic in Nigeria. There is often an “uneasy symbiosis” of transnational scientific networks in which the relationship of power becomes one where the more powerful institution has something to offer (often a great deal), leaving the less powerful institution with “many grounds for ambivalence about resisting the relationship” (Crane, 2013). This tension is one Crane describes as the “grip or friction of numerous encounters” and it is one that is present in the relationship between American HIV researchers and Nigerian HIV researchers (Phyllis Kanki and Professor Gbadamosi); humanitarian and scientific ambition; and global and local health priorities.

**HIV, Power, and Global Health Science**

The relationship between power and knowledge production raises questions about the ethics and politics of international biomedical research as well as the conundrums of producing useful scientific knowledge and interventions in low resource settings. This begs the questions—Who is global health science for? Who benefits? And how? In the case of APIN clinic in Nigeria, what happens when donors decide to pull their funds?

Donors have influence and control over the sustainability of programs they fund. More importantly, the case of APIN and HIV medication in Nigeria shows how realities
of individuals living with HIV/AIDS in Nigeria are dependent on the whim of international donors like the U.S government. In a 2010 article titled “The Politics of Paying for HIV Care,” author Elizabeth Gudrais details how in 2010, U.S. funding for ARV via PEPFAR “flat lined” as Obama administration’s Global Health Initiative attempted to reorient the emphasis of U.S. global health funding towards maternal and child health (Gudrais, 2010). In 2012, although the administration closed the Global Health Initiative Office and shifted its work elsewhere, the Office of Global AIDS Coordinator remained open. While the office still remains open, the shift in initiative focus points to a dwindling interest in continuing to provide sustained funds for HIV/AIDS programs much longer. Interestingly in her article, Gudrais also notes that although U.S. government funding for global health was unsteady, global health programs from U.S. and Canadian universities tripled between 2006 and 2011.

The same article makes known that within the context of global health care in low-resource settings, Harvard’s typical role is that of advising and conducting research. Gudrais also states that “whenever a country’s health programs depend on foreign aid and on a foreign university, those programs are not sustainable in the long run.” This is true for Nigeria. Even though Harvard’s PEPFAR program has paid for antiretroviral therapy (ART) for more than 130,000 people, provided regular medical care for many more, and has funded training for more than 16,000 healthcare workers in the three countries, this reality can become a thing of the past if research interests change and if funding is withdrawn. For instance, Harvard’s PEPFAR may come to an end soon. In 2008, the United States congress allocated $48 billion for the program till 2013 with plans to redirect funds to efforts around maternal and child health under President Obama’s
administration (Gudrais, 2010).

Even when funds are available, other factors can still influence whether or not patients in low-resource settings will get access to much needed care. A 2005 article—The Harvard Drug Scandal—by John Wolfson details how internal disputes within Harvard’s administration and the politics surrounding control of funds led to a five month delay in the implementation of the APIN program in Nigeria and other countries. As of the time Phyllis Kanki received her PEPFAR grant, the Harvard School of Public Health was under the scrutiny of the administration and faced the possibility of being closed. However, the fact that Kanki’s grant was the largest grant in Harvard history ($107 million dollars over five years) abated fears of having the school’s assets reallocated and its staff reassigned (Wolfson, 2005). Notwithstanding, Harvard's central office tried to take control of Kanki’s grant with the argument that her team lacked the administrative experience necessary to manage it. This issue was exacerbated by the internal competition between Harvard’s School of Public Health and the school of Medicine. Harvard Medical School also applied for the PEPFAR grant but was unsuccessful with securing the award. The other recipients of the award were Columbia University, the Elizabeth Glaser Pediatric AIDS Foundation, and Catholic Relief Services (Wolfson, 2005). The implications of these internal issues went beyond the delay in program implementation. Wolfson argues that as a result of these delays, a number of lives were lost unnecessarily. At the time of the incident, he rejected the argument of B. D. Colen (Harvard spokesman) that:

“Like our PEPFAR partners, Harvard has a set amount of money for medication, an amount of money that will only allow us to treat a woefully small proportion of the HIV/AIDS-infected individuals in the countries in which we are [in] operation…For example, in Nigeria, the program as it is now constituted will
eventually provide treatment for only 40,000 of the 500,000 infected individuals.
So whether the program began treating people in month one, month two, or month three, the program will treat the same number of people.”  

(Wolfson, 2005)

As a rebuttal to this stance, Wolfson points highlights reactions from doctors he interviewed:

I could point out the stunned reaction this response elicited from AIDS doctors, such as the one who says, “If you are faced with a drowning child and have one life preserver, would you rationalize letting the child drown because you wanted to save the life preserver for other potential drowning victims?” I could tell you that doctors and researchers believe early intervention is the key not only to saving the life of a sick patient, but also to ensuring the patient doesn't infect others, including her own unborn child.

(Wolfson, 2005)

**Bio-Power**

The occurrences detailed in the previous section epitomize how outcomes of global health endeavors can be uneven due to power dynamics. It brings to mind Michel’s Foucault’s concept of “biopower” which aims to describe the regulation of bodies through states. According to Foucault, biopower has to do with the control or discipline of bodies and populations (Foucault, 1978). It is “fostering life or letting die” and its “affirmative productivity distinguishes it from sovereign power, with which it today co-exists, whose negativity is expressed in the formula ‘kill or let live’” (Foucault, 1978).

Foucault argues that this is made possible by public health initiatives and different modes governance, which in the case of HIV in Nigeria, can be understood as access to HIV medication. Bio-power essentially describes the ability to decide between life and
death and as a result, the lives and health of bodies often becomes the site of political struggle. Foucault’s claim that power has shifted its focus from deciding who dies to one that acts as a means of deciding whose life counts is particularly useful in understanding and analyzing the relationship between APIN-clinic, Harvard University, the United States government. Through a critical analysis of the transnational network that exists between these three entities, one begins to understand how the lives of Nigerians living with HIV are regulated by the actions of a government 5.418 miles away. In essence, distance is of little significance because the United States exercises biopower over Nigerians living with HIV through the mechanisms that have been put in place for access to HIV treatment. With the gradual withdrawal of funds from program such as APIN clinic, clinics run the risk of experiencing a reversal of access and enrollment to care and patients run the risk of experiencing resistance to medication. Ironically, this was the very fear and argument articulated by international donors who were opposed to making HIV treatment available in Nigeria but instead of lack of adherence to medication among patients being the cause, the cause becomes lack of sustainability of initiatives supported by donors.

Conclusion

National and transnational attempts to improve health outcomes in Nigeria have resulted in suboptimal health outcomes primarily because of lack of government ownership. By lack of ownership, I mean that the government has not taken the time to critically appraise the reality of HIV/AIDS in Nigeria as well as the country’s response to the epidemic. In order to maximize its limited resources, Nigeria has to make intentional
efforts to understand the factors that contribute its epidemic outside the parameters or guidelines set by international donors. In addition to this, it must synthesize the knowledge gained from these endeavors and use it to inform health policy to engender better health outcomes.


