

CONFERENCE REPORT

Reframing the HIV/AIDS debate in developing countries II: case stories of Nigerian rural people living with HIV/AIDS

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ABSTRACT

Since it was first officially reported in Nigeria in 1984, HIV/AIDS has continued to spread in the country to the extent that today it constitutes a major problem. The two case stories of Nigerian rural people living with HIV/AIDS presented in this article were selected from 200 such stories that were compiled against the backdrop of the impact of scarcity of resources on care and support for People Living With HIV/AIDS from Nigerian rural communities.

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Key words: AIDS, HIV, NGO, Nigeria, stories.

Introduction

Since it was first officially reported in Nigeria in 1984, HIV/AIDS has continued to spread in the country to the extent that today it constitutes a major problem. With a population of 120 million and a national HIV sero-

prevalence of 5.8%, Nigeria is one of the most populous countries in the world to cross the 5% threshold. The country's economy has been dwindling for about two decades despite enormous natural and human resources. These two stories were selected from 200 such stories that were compiled against the backdrop of the impact of scarcity



of resources on care and support for People Living With HIV/AIDS (PLWHAs) from Nigerian rural communities.

The story of Affiong and Fibs

Affiong, or Afi as she was fondly called, was a very beautiful and promising young girl from one of the states in the Niger Delta Region of Nigeria. She showed determination for scholarship quite early in life, judging from her performance at the Senior Secondary School Certificate Examination in which she scored distinctions in all eight subjects and her university matriculation examination score, with which she gained admission to read her choice course, law.

This ambition could not be fulfilled however because of lack of funds. As the first child in the family, because her mother was no longer capable of providing for the family, Affiong had to take up some responsibilities at the age of 17, securing employment as an accounts clerk in one of the multinational companies. Despite this, it became increasingly difficult for her salary to meet the needs of four siblings and her mother, who suffered from diabetes mellitus. Affiong had to seek additional sources of income by keeping 'dates' with wealthy men.

With beauty on her side, she had what was needed to date the best of men and, in exchange for her body, she made enough money to take care of her mother's health, herself and the four siblings. After dating various men Affiong decided to settle down with one of them, Fibresima (or Fibs as he was fondly called), who was a multimillionaire originally from a remote village. Money was no longer a problem.

About a year later, Affiong started noticing changes in her health. She had diarrhoea that did not respond to treatment. She kept this development from Fibs who no longer spent so much time with her. One day, a reproductive health educator from a non-governmental organisation (NGO) called Health Sustenance Action visited her. As a result, after voluntary

confidential counselling, Affiong was tested for HIV. She tested positive but she kept the information to herself.

Fibs had not been too surprised when he tested positive for HIV. He had lived a risky life style for many years before he learnt about HIV/AIDS and decided voluntarily to have a test. Two weeks after the test, Fibs decided he would have to leave town for fear of stigmatisation. He resigned from his company on the pretext of going overseas for further studies. He withdrew all his savings and moved out of his official quarters back to his home village, in a remote rural area. He did not disclose his status to Affiong, and left her behind in the town.

Back home, Fibs told his parents and close relations that he was on 5 years' accumulated leave and that the leave would last for about 6 months. Handsome and rich, Fibs was like a 'hot cake'. Every girl in the community struggled to be noticed by him. In fact it was a thing of pride to be seen with him, especially to take a ride with him in his Porsche. He never revealed his HIV status to anyone, except his health providers, for he was able to afford the anti-retroviral drugs supplied to him through an NGO, at a highly subsidised rate.

By the time Fibs' 'accumulated leave' entered the twelfth month his parents started to worry. His purse was also getting lean. After giving one reason or another for not returning to work, Fibs confided his HIV status to his parents. By then, he had already been home for about 2 years and had had unprotected sex with quite a number of girls in his community.

Fibs found it increasingly difficult to procure his anti-retroviral drugs. He had to sell his car to be able to buy his drugs and eat at least once a day while his father had to sell some of his farmlands to assist him. Then his condition worsened and he went into coma from which he recovered at a nearby health centre. His parents' attention was now focused on Fibs' illness. More hands were needed to care for him 24 hours a day because he developed full-blown AIDS. More and more people living with HIV/AIDS who needed care and support were identified in the community. The



NGO's running costs became very high, so the care given to each PLWHA started decreasing both in quantity and quality. Because of fuel scarcity, the referral services became inefficient, as most of the referred PLWHA could not afford their own transportation. There were also increased demands for more health educators and home care providers. The anti-retroviral drugs became more costly and unaffordable. Eventually the NGO that was providing home-based care closed down those services.

Fibs and other PLWHAs suffered the impact of this. About a week after the last visit of the care provider, Fibs went into coma from which he never recovered. A similar fate befell most of the other PLWHA in the community.

Meanwhile, back in town Afiong continued to date other rich men after Fibs returned to his village, she needed the additional income. She did not disclose her status to the men she dated. Eventually she also developed AIDS and died, not being able to afford anti-retroviral drugs.

The Story of Fyne

Fyne was the fifth child in a family of seven girls and one boy, named Obolom. The family depended entirely on subsistence farming and fishing, and were part of a culture that placed emphasis on male-child education while the females helped out at home and on the farms. The family was doing very well economically, at least by the community's standards, until Fyne's mother suffered a severe stroke, which absorbed a lot of the family's human, financial and material resources. This had a very negative economic impact on the family. Obolom, who was already in the Senior Secondary Class, dropped out of school.

Eager to assist in decreasing the demand on the family's food reserves, a maternal aunt offered to facilitate employment for two of the children as factory helps in a commercial city. Fyne was engaged as house help to the factory's Deputy Managing Director, George, who was a neighbour to Fyne's aunty. Fyne met George's expectations in all aspects of housekeeping, so that within 3 months

George willingly doubled Fyne's salary, with which Obolom was sponsored in school. However, a few aspects of her master's life gave Fyne cause for worry; George was an alcoholic and he also had many girl friends, despite being married with children.

One day, on his return from a club, George made his first sexual advance to Fyne. She thought it was due to the influence of alcohol, but the demands became increasingly frequent thereafter, even when George had not seen a bottle. She thought of resigning but she had to consider her life situation: her parents were now aged; Obolom, by Fyne's effort, had completed secondary school and was getting ready to enter the university, she herself was enjoying a salary increase of 300% and the services of a private teacher courtesy of George, and two of her sisters were factory helps. She therefore decided not to resign.

One night, whatever resistance Fyne had broke down and she gave in to George. From then on Fyne and George had sexual intercourse almost on a daily basis. George's frequency of travelling increased with his responsibility in the factory. This gave Fyne enough time to socialize, and she attended a seminar on HIV/AIDS organised by an NGO. After the seminar, a peer health educator who had become Fyne's friend during the seminar, paid frequent visits to her home. After voluntary confidential counseling Fyne had an HIV test. Her status was found to be positive and she was requested to reveal her status to George on his return. She refused to do this and maintained a normal relationship with George, until her health started deteriorating, when she left George's house to return to the village. Her sisters remained as factory workers. Although Fyne had heard about anti-retroviral drugs, she could not afford them because of her poor socio-economic status at home.

By now, Fyne would have joined the thousands of other Nigerians who have already died of HIV/AIDS, if not for government's HIV/AIDS control program that includes care and support for PLWHAs. Anti-retroviral drugs are now available and highly subsidised. Fyne has been on the



medication for 6 months now. Her health is already showing remarkable improvement.

Comments

The stories bring to the fore the intricate relationship between poverty and HIV/ AIDS. They reveal that:

- Poverty leads to the spread of HIV/AIDS and, conversely, HIV/AIDS, with its attendant socio-economic impact, leads to poverty. A vicious downward spiral results.
- Stigmatisation has led to concealment of information on one's HIV status with its devastating effect on unsuspecting community members. Nigeria's poorly financed and poorly managed healthcare system places the burden of care for PLWHAs on families.
- The overwhelming number of PLWHAs that seek care and support further burdens and threatens the healthcare system.

Affiong was only one of the many who has fallen victim to the poverty engendered by approximately two decades of

military administration. The present democratic government in Nigeria appears determined to eradicate poverty in the Niger Delta Region through its poverty eradication program, and those programs of the Niger Delta Development Commission. Such effort may contribute to the control of the spread of HIV/AIDS in the region.

Conclusion

For effective care and support of PLWHAs in resource-poor settings, the first target should be improvement in resources through increased budgetary allocation and a community health insurance scheme. Proper health education with emphasis on the ABC of HIV/AIDS control could go a long way to controlling and /or preventing HIV/AIDS in resource-poor settings.

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