Impact of HIV/AIDS on Rural Households in Taraba State Nigeria

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Abstract

Despite the progress made globally and locally across different parts of the country in the fight against the spread of HIV/AIDS, the problem has remained a great source of concern in Taraba State. This concern is as a result of increasing number of new infections, decline in the funding and weak health care facilities to contain the spread of the disease. Recent studies have shown that HIV/AIDS is no longer a disease of urban residents alone as there has been increasing spread in the rural areas in recent times. The study employs online literature search and analysis of policy documents, technical reports and memos from government ministries and agencies. Findings of the study showed that the funds for the fight against HIV/AIDS in the State is international donor driven. International donors contributed the bulk of funds. Findings further revealed that coverage of antiretroviral programmes for prevention of mother-to-child transmission is very low resulting in high number of annual newly infected persons. HIV/AIDS counselling and testing and treatment coverage in the State is very low with very high unmet need for antiretroviral treatment resulting in high number of deaths. The State is an agrarian in nature, dominated by subsistence agriculture. Therefore, increasing incidence of HIV/AIDS retards agricultural production, and threatens food security, in several ways especially in loss of labour and other forms of household assets. HIV/AIDS control and treatment is capital intensive and cannot rely on normal budget of the State government. The study, therefore, recommends private sector support and health insurance scheme to assist in managing HIV/AIDS challenges in Taraba State.

Keywords: Healthcare, HIV/AIDS, Impact, Rural Households and Taraba State

Introduction

Despite the increase in the knowledge and awareness of HIV/AIDS, the required attitudinal change to halt the spread of the disease is proving a seemingly insurmountable problem. The increasing rate incidence of HIV/AIDS in Nigeria, especially Taraba State is becoming

a source of concern that if nothing is done to halt it, may degenerate into humanitarian crisis situation. At a time when many people are thinking that the fight against the disease is already won, statistics have shown that the prevalence rate has doubled in Taraba State, placing it as the second largest HIV/AIDS burdened State in the country (10.5%) in 2013. There exist wide gaps in HIV/AIDS treatment in the State. Out of over 110,000 people living with HIV/AIDS in the State, only 27,000 were placed on ART. The infrastructure to support quality services of HIV/AIDS is lacking in the State. The State and country lack the political will to face the challenges of HIV/AIDS. The funding of HIV/AIDS activities in the State and country is handled by international donor partners who are responsible for 70% of funding, while 27% is catered for partly by Federal Government and few State Governments and the private sector providing 2% (Daily Trust, 2017). It cost about ₦50,000 to deliver HIV care to patient a year in Nigeria (Daily Trust, 2017). This is far beyond the affordability of the rural dwellers in the State. This reveals the need for resources to be mobilized in order to address the established need and gaps in the State's HIV response especially as regards to adolescents and young people. It is against this background that Taraba State was included in the Presidential Comprehensive Response Plan for HIV/AIDS (PCRP) in 2014.

According to NACA (2013) there were about 220,393 new HIV infections in 2013. The high numbers of new infections showed that the fight against HIV/AIDS was far from been won. Until now, Taraba State had a HIV/AIDS prevalence of 10.5 per cent, which was over three times the national average and the highest in Northern Nigeria. Despite this, only very few partners have situated their HIV projects and programmes in the State. Only two projects are presently ongoing in the State; the World Bank-supported HIV/AIDS Program Development Project 2, which end in February 2018 and the NACA Comprehensive AIDS Programme with States (formerly known as NACA SURE-P HIV/AIDS Programme). None of the 16 LGAs in the State benefited from the COP 15 PEPFAR HIV/AIDS intervention targets by LGAs in Nigeria in free counselling and testing and ART enrolment

among others in 2015. The State, therefore, lags behind despite, its dire need of support to sustain and scale-up the gains made so far in the response to HIV/AIDS.

In the past, HIV/AIDS was thought of as a disease of urban residents, but the increasing spread of the disease to the rural areas in recent times has become a source of concern. This is more so when we consider the high level of deprivation of rural areas in Nigeria and Taraba State in particular in terms of social amenities and poor health care facilities. Although recent studies have shown a reduction of 4.190 in new HIV infections in the urban areas, the same cannot be said of the rural areas (NACA, 2013). The number of people requiring access to HIV/AIDS counselling and testing and support services in rural areas of the country and the State in particular, seem to be growing by the day. This paper attempts to provoke discussion on the impact of HIV/AIDS on rural households and rural development efforts in Taraba State.

Rural landscape of Taraba State

There is no universally accepted definition of rural settlement. Most national census bodies, international organizations and scholars often produce and use their own definitions, many of which have serious limitations (Weinert and Boik, 1995). In Nigeria, for instance, the single criterion of population size derived from national census is still been used to define rural settlement (Madu, 2008). The Nigerian 1991 population census defines a rural area as a settlement with less than 20,000 inhabitants. In describing the settlement pattern in the State, the Rondinelli (1983) demographic approach has been used. This is because the approach requires data (census figure) that can be easily obtained from the national census result or population projection. The nature of size distribution of settlements may be a reflection of changing socio-economic conditions. This is because the 'genetic processes' of settlement growth in the State are usually subject to a wide spectrum of political, cultural, social and economic forces (Oruonye and Abbas, 2011).

According to Bashir (1993), an analysis of the rural settlement pattern in the State using the nearest neighbour technique yielded an Rn statistical value of 1.2 which indicates a more or less random distribution of settlements with serious implication for the provision of infrastructure, especially health care facilities. After over twenty years, the situation has not changed remarkably. On the other hand, in a study on the structure of rurality in Nigeria by Madu (2008), Taraba State ranks 7th in the country after Gombe, Kogi, Plateau, Bauchi, Kwara and Kebbi States with rurality index of 4.973. The State thus falls within the States in the federation with very high rurality index. This implies that most parts of the State still lack the basic socio-economic infrastructures that aid rural transformation and as such lag further behind in rural development in the country.

Taraba State has about 1,932 settlement localities from the 1991 National Census. At the time of creation of the State, there were too many small village and hamlet type of settlements. The great majority of the people of Taraba State live in rural settlements consisting of small hamlets and villages. There were about 802 settlements with less than 500 inhabitants (Oruonye and Abbas, 2011). The compound which houses the family is the basic unit of settlement. The pattern of rural settlements in any area is basically a product of past and present economic, cultural, historical and ecological factors (Gana, 1978).

By all standards, Taraba State is predominantly rural (Bashir, 2000). The villages and hamlets which consist of the usual round huts with conical roofs are found over a large part of the State. The walls may be of mud or wooden framework covered with grass matting and the roof is made of grass thatch or from the stalks of grains (Oruonye and Abbas, 2011). Both in the villages and towns, the huts are arranged in groups or compounds which may be enclosed by a mud wall or a mat screen.

Table 1. Number and Category of Settlements (based on 1996 projected population)

S/NO	LGAs	1-500	501-999	1000-1999	2000-4000	4001 and Above
1	Ardo Kola	34	29	7	-	2
2	Bali	84	138	43	10	09

3	Donga	62	45	13	03	02
4	Gashaka	12	39	05	01	01
5	Gassol	26	32	12	04	02
6	Ibi	20	27	07	01	03
7	Jalingo	20	16	06	03	02
8	Karim Lamido	77	89	15	08	03
9	Kurmi	41	22	07	03	01
10	Lau	24	44	07	03	03
11	Sardauna	86	102	27	06	04
12	Takum	30	32	07	02	01
13	Ussa	44	40	15	05	02
14	Wukari	112	32	07	03	08
15	Yorro	69	35	07	03	Nil
16	Zing	61	45	10	02	01
	Total	802	767	195	57	44

Source:(Oruonye and Abbas, 2011)

The basic problem of most rural settlements in the State is the desperate lack of essential social amenities, such as healthcare facilities, potable water supply, electricity, efficient marketing services and good transport service. The preponderance of small settlements in the State makes the provision of social amenities in the State harder. This is so because human and economic development most often revolve around settlements, as development projects usually involve large capital outlays and much risk. Hence, they are located in areas where profit or potential use can be maximized. In view of the small size of most rural settlements in the State and the inadequacy of financial resources, it is clearly not possible to provide all essential social amenities particularly health care and educational facilities for all rural settlements. Perhaps, it is only through a hierarchy of service centres that it may be economically possible to ‘‘put within reach of the rural dwellers all the amenities and opportunities of life such as health care facilities, which are regarded nowadays as the normal inheritance of every townsman in Nigeria’’ as argued by Gana (1978).

Poverty is severe in the rural areas of the State where social services and infrastructure are limited or non-existent. The majority of those who live in rural areas in the State are poor, and depend on agriculture for food and income. The Nigerian Bureau of Statistics (NBS) 2010 poverty profile report shows that only 31.1% of the people in Taraba State fall within the non-poor category, while 68.9% are core poor. The State ranks low in all major development and household indicators.

Materials and methods

The study employed literature search, review and analysis of compilation of policy documents, technical and non-technical reports, newsletters, public statements, research documents and conference papers held in key government departments, ministries and non-governmental organizations, tertiary institutions and research centres that are involved in the HIV/AIDS awareness creation and control effort. The search was through online search and personal contacts with some key policy makers who have been directly responsible for policy design and formulation on HIV/AIDS in the State and LGAs at one point in time or the other.

Result of findings

HIV/AIDS funding in Taraba State

The national and State response for HIV and AIDS is largely donor-funded by international organizations with Nigeria's contribution comprising of 25% only. In 2010, it was proposed that the Government of Nigeria would increase its contribution to 50% of the total funds for HIV/AIDS interventions by 2015. Although funding for HIV has increased from 415 million (in 2009) to 577 million dollars (in 2012), the proportion spent on prevention remains low (12.5% in 2012) and out-of-pocket expenditure for HIV services are considerably high. International donors contributed the bulk of funds, with PEPFAR accounting for 64 percent and the Global Fund reportedly for about seven percent (note: Global Fund spending appears to be under- reported in the NASA 2014). Procurement data from October 2014 through September 2015 shows that about US$150.7 million was spent to procure HIV commodities for the National program for the largest share of the ARV procurement and nearly the full supply of HIV rapid test kits. PEPFAR purchased the majority of the CD4 lab reagents (60 percent), viral load reagents (80 percent) and half of the early infant diagnosis (EID) bundle kits. Overall PEPFAR and the Global Fund

contribute 62 percent and 35 percent of the HIV commodity investment respectively (NCOP, 2016). This is despite the assertion that prevention remains the most important and feasible means of halting the spread of HIV/AIDS.

Under the former President Goodluck Jonathan, the Government of Nigeria committed $40 million of the fuel Subsidy Re-investment Program (SURE-P) funds for the implementation of President's Comprehensive Response Plan (PCRP) for HIV/AIDS, a domestic funding initiative for HIV/AIDS launched in 2014. These funds were used to support the transition of PEPFAR-funded HIV treatment sites in two States of the Federation; Taraba and Abia States, to the National Agency for Control of AIDS (NACA) in 2015. Following the discontinuation of SURE-P by the Buhari's administration, funding has been provided to NACA in the Government of Nigeria 2016 budget to continue to engage the State Government Ministries, Departments and Agencies in these two States to manage the HIV/AIDS program. The spending by PEPFAR per person living with HIV/AIDS (PLHIV) in Taraba State was $28 (NCOP, 2016). In Taraba State, the government approved ₦500 million to fight HIV/AIDS in 2015 (Onwumere, 2015). Taraba State government equally earmarked 600 million naira in the 2017 budget for HIV/AIDS to compliment the Federal Government Ownership and Sustainability drive. However, different studies and reports indicated that domestic resource is grossly inadequate to match global drive for the eradication of the disease. This funding gap in HIV/AIDS control shows clearly that Nigeria is not on track to achieve the universal access targets (Table 2).

Table 2. Funding Landscape of HIV/AIDS in Taraba State (2011-2013)

Funding Landscape	**2011**	**2012**	**2013**
Total Budget for HIV	₦200,000,000	₦200,000,000	₦200,000,000
Total Expenditure on HIV	₦1,033,655,343.93	₦1,171,470,894.99	₦566,309,984.31
Government Expenditure on HIV	Nil	₦19,000,000.00	₦11,635,040.00
Receipt from World Bank on HIV from NACA	₦68,406,438.93	₦439,078.59.	Nil
Govt. Exp. on HIV including WB	₦68,406,438.93	₦19,436,078.59	₦11,635,040.00

State Govt. Expenditure from World Bank Funds	Nil	₦102,667,360.49	₦306,158,772.31
Expenditure by Donor/IPS	₦965,248,905.00	₦1,049,803,534.50	₦248,516,172.00

Source: Taraba State SHEIA (2013).

From Table 2, it can be seen that despite budgetary allocation to the fight against HIV/AIDS, there was no money released for HIV expenditure in 2011. From the Table, it can be seen that budgetary allocation does not necessarily guarantee release of funds for HIV/AIDS intervention. Table 3 shows a wide funding gap between HIV/AIDS budget and expenditure in the State. With such wide funding gap, it is practically difficult for the State to make meaningful progress in the fight against the spread of HIV/AIDS.

Table 3. Taraba State HIV/AIDS Budget and Expenditure Gap (2011-2013)

HIV/AIDS Funding	**2011**	**2012**	**2013**
State Govt. Budget for HIV	₦200,000,000	₦200,000,000	₦200,000,000
State Govt. Expenditure on HIV	₦68,406,438.93	₦19,436,078.59	₦11,635,040.00
State Govt. HIV Expenditure Gap	₦131,593,561.07	₦180,563,921.41	₦188,364,960.00

Source: Taraba State SHEIA (2013).

The State has over the years received support and assistance from international non-governmental organizations such as the Community Life Advancement Project (CLAP). CLAP was able to access the *MSH ProACT* grantof ₦2,450,000.00 between August 2012 to July, 2013 for Expanding Schools and Communities Action for HIV/AIDS prevention in Gashaka and Donga LGAs of Taraba State. The grant facilitated the provision of comprehensive HIV/AIDS prevention intervention to over 4,500 beneficiaries and over 7,300 HIV/AIDS free counselling and testing services in Gashaka and Donga LGAs of the State.

CLAP was also able to access the AIDS Prevention Initiative in Nigeria (APIN)/GFR8grants of ₦6,500,000.00. CLAP used the grant to provide free HIV/AIDS Testing and Counselling services to 2,167 pregnant women under ante natal care setting in

5 LGAs (Takum, Gassol, Jalingo, Lau and Kurumi LGAs) of Taraba State from September to December, 2012.

HIV/AIDS prevention and advocacy programmes

HIV Counselling and Testing (HCT) is the entry point to prevention, treatment, care and support services of the HIV/AIDS control programme. It is a strategy aimed at identifying new HIV cases, and reducing the spread of the HIV virus through adequate counselling services (NACA, 2014). This include all forms of enlightenment campaigns and advocacy programmes that are aimed at educating the people on the dangers of HIV/AIDS and ways of avoiding infection by the disease. The activities include free HIV/AIDS counselling and testing services to individuals, from 15 years and above and issuing them with results of the test to enable them know their status. Thus, the counselling is done before and after the HIV/AIDS test. The counselling enables them to adjust their behavioural attitude that will prevent infection if the person tests negative and attitude that will reduce or prevent the spread of the disease if the individual tests positive. NACA and its National Comprehensive Programmes in States (NCAPS) has 21 comprehensive supported sites in the State at present, with 66 Primary Health Care (PHC) supported sites.

In Taraba State, 104,591 persons were tested for HIV/AIDS and 9,517 were positive in 2013 (Table 4). Also in 2014, 102,370 persons were tested for the virus and 5,464 were positive according to 2014 Annual HIV/AIDS Report (NASCP 2014). The President's Emergency Plan for AIDS Relief (PEPFAR) with the support of World Bank Funding, have trained over 17 Civil Society Organizations (CSO) and carried out different HIV intervention across the State. The State was the first to build capacity on HIV/AIDS programming for adolescents and young people in 2016 (The Guardian, 2016).

Table 4. Positivity rate among persons tested for HIV (all ages) (2013 and 2014)

Year	No. of HIV CTR	No. of HIV Positive	Positivity Rate (%)

2013	104,591	9,517	9.1
2014	102,370	5,464	5.3

Source: (NASCP 2014).

People get to know their HIV/AIDS status only through HIV/AIDS counselling and testing. This service can be accessed through personal decision making that is enhanced by counselling before and after HIV/AIDS test. Most clients access this service at public and private health care facilities or a stand-alone or mobile counselling and testing facilities established by NGOs. Sadly, HIV/AIDS support facilities and services have been limited in reaching a lot of people especially the rural dwellers.

Prevention of Mother to Child Transmission(PMTCT)

Prevention of Mother to Child Transmission (PMTCT) is a service that allows pregnant women to be tested for HIV/AIDS and issued with the result. It is aimed at eliminating transmission of HIV from mother to child during pregnancy, labour, delivery and breast feeding (NASCP 2014). HIV positive pregnant women are placed on ART and other medication that prevent transfer of the virus to the unborn child. About One hundred and twenty-two (122) HIV/AIDS positive pregnant women were provided with PMTCT services in 2012 with only 2 out of the 182 pregnant women delivered HIV positive children. In 2013, the PMTCT need in the State was 9,591 and the achievement was 1,874, given coverage of 20%. In 2014, the need was 9,896 and the achievement was 2,592, given (26%) coverage (Table 5). As at December 2016, over 30,000 women were said to have benefited from PMTCT services in the State. Coverage of antiretroviral programmes for prevention of mother-to-child transmission is very low resulting in high number of annual newly infected children (Table 5).

Table 5. Coverage of ARV Prophylaxis among HIV Positive Pregnant Women in Taraba States

Year	**PMTCT Need**	**Achievement**	**PMTCT Coverage (%)**
2013	9,591	1,874	20
2014	9,896	2,592	26

Source: (NASCP 2014).

HIV/AIDS treatment (ART support)

The national Anti-Retroviral Therapy (ART) programme commenced in 2001 in 25 tertiary hospitals and targeted 10,000 adults and 5,000 children (NASCP 2014). The goal of National Strategic Plan (NSP 2010-2015) is to ensure that "All eligible Persons Living with HIV (PLHIV) receive quality treatment services for HIV/AIDS and Opportunistic Infections (Ois) as well as TB treatment services for PLHIV co-infected with TB". The ART needs based on CD4 350 eligibility in 2014 was 71,426. The total HIV population was 167,243 and 35,598 were placed on ART given 21.3% achievement (NASCP 2014). As at June 2016, the number of adults with advanced HIV infection receiving anti-retroviral combination therapy in the national programme in Taraba State was 34,972, and the number of children was 1,793 (NASCP 2014). The number of HIV infected women, who received anti-retroviral drugs to reduce the risk of mother- to- child transmission in the State was 413. As at December 2016, 39, 818 persons with advanced HIV infection were receiving Antiretroviral Therapy (ART).

Despite the claims in different parts of the country over efforts at controlling HIV/AIDS in Nigeria, Taraba State is not among the States according to estimates from NACA and FMoH that have achieved 50% ART coverage as at mid-2017. These States include: Enugu, Benue, Delta, Adamawa, Anambra, Federal Capital Territory (FCT), Plateau, Kogi, and Ekiti States respectively (Muanya, 2017). Instead, Taraba State falls under the nine States in the country with the highest ART unmet need (greater than 75,000 persons). The States in the group are (Oyo, Akwa-Ibom, Lagos, Sokoto, Edo, Taraba, Kaduna, Imo and Rivers).

Impacts of HIV/AIDS on rural dwellers

Given the poor rural condition of the State and country, rural residents naturally have poor access to HIV/AIDS support care such as free counselling and testing and medical care. In

addition, rural households experience HIV/AIDS in ways that are specific to their environment and distinct from their urban counterparts. These distinct impacts are often related to the high level of dependence on agricultural production as the primary food supply for rural households. Subsistence farming which is the dominant systems rely heavily on human labour, most often women, for tilling and tending crops (UNAIDS, 2000). The extent to which HIV/AIDS makes people ill, disables them when very ill, and then causes deaths, places considerable strain on rural agricultural production and household livelihood.

It has been observed that in sub-Saharan Africa, 65 percent of the power for land preparation is provided by human labour, with 25 percent by draft animals and only 10 percent from machines (Brian and Josef, 2006).Clearly, adequate agricultural production depends on available power, especially human labor in regions with lower technological inputs like Nigeria and Taraba State. The State is an agrarian State dominated by subsistence agriculture. HIV/AIDS retards agricultural production, and threatens food security, in several ways in the State especially in loss of labour and other forms of household assets. HIV/AIDS, therefore, reduces labor availability for agricultural production, thereby impacting greatly on food security and household livelihood.

When most people are affected by AIDS and are seriously sick, they are taking back to their villages for fear of death in urban centres and subsequent cost of conveying corps home for burial. Tradition and culture for most people in Nigeria requires the corps of adult members to be buried in the ancestral land. This usually imposes heavy financial burden on households in rural communities. HIV/AIDS related mortally affects food production greatly in rural communities. In regions where land tenure is not secure, households may lose rights to land that are not cultivated regularly. This is of particular concern for widows and child-headed households in traditional communities with patriarchal land rights since widows may lose their assets to their deceased spouse relatives. In addition to lost wages,

HIV/AIDS-affected households incur new expenses related to health care and funerals, which further predisposes rural households to poverty.

Challenges

It will be good to articulate the challenges militating against the efforts to curb the HIV/AIDS menace in the State and country at large. There is no recent national population based survey with up to date data on the current burden of the HIV/AIDS epidemic in 36 States and FCT (Muanya, 2017). This lack of data makes it difficult to appreciate the level of progress made and the extent of the burden.

The cost of HIV/AIDS baseline laboratory test is now ₦16,000 ($48), while the cost of delivering HIV care to patient in Nigeria is ₦50,000 ($150). However, PEPFAR was only able to spend ($28) per PLHIV in the State. This shows a funding gap in HIV/AIDS care delivery. For Nigeria to meet the 90-90-90 target, it requires at least N50 billion yearly to sustain the treatment of 1,050,594 PLHIV and N150 billion to treat all the 3,228,842 PLHIV. Unfortunately, the national budgetary allocation for health in 2017 was just about N303 billion (Muanya, 2017) and that of Taraba State was ₦4.9b which is 4.5 percent of the total budget. The cost of HIV/AIDS care is very high and unaffordable to most rural dwellers who are already impoverished by poverty and economic recession in the country. HIV/AIDS control and treatment is capital intensive and cannot rely on normal budget of the State government. At the moment, HIV/AIDS care in Nigeria is donor agency driven and donor funds like local funding by the State government are continuously dwindling, thereby by making it difficult to sustain the present gains made so far.

Findings from many studies have shown that there is low level of uptake of HIV/AIDS counselling and testing services in urban areas where the services are available and free of cost. The problem, therefore, become worst in rural areas where the support services are not available. In situations where they are available, they are often not affordable by the rural households. Most of them resort to traditional treatment with local herbs. The main

causes of the low uptake of HIV/AIDS counselling and testing services include fear of stigmatization and low level of education of the people.

Nigeria may not be able to meet the National Strategic Framework (NSF) 2017-2021 Targets and the United Nations 90-90-90 ambitious treatment plan to end Human Immuno-deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) by 2030 (Muanya, 2017). Many people have expressed fear that Nigeria may not be able to meet the NSF and UNAIDS targets; sustain the free national treatment programme; and put more PLHIV on treatment. Studies have shown that if PLHIV stop taking ART, they will die of AIDS within a short time. On the other hand, if there is delay or interruption in the ART medication, it will lead to the development of drug resistance which will make the firstline medication ineffective, thereby necessitating the secondline medication which often times is very expensive and unaffordable to patients.

Conclusion

This study has examined the impact of HIV/AIDS on rural livelihoods in Taraba State. The study employed online literature search, review and analysis of technical and policy documents. Findings showed that HIV/AIDS burden is high in the State and rural areas in particular and this requires a strategic response. The study also reveals that HIV/AIDS treatment coverage for adults and children is very low with very high unmet need for antiretroviral and PMTCT treatment resulting in increasing number of deaths. The study also shows that the cost of HIV/AIDS care is very high and unaffordable to most rural dwellers who are already impoverished by poverty and economic recession in the country. HIV/AIDS control and treatment is capital intensive and cannot rely on normal budget of the State government. Given the wide gap in the funding of HIV/AIDS programmes and magnitude of the problem, it is evidently clear that the State government alone cannot be able to contain the challenges posed by HIV/AIDS in the State.

Recommendations

Base on the findings of the study, the following recommendations are made;

i. There is need for the Governments, both at the national and state levels to be more proactive in their approach to the problem of HIV/AIDS in Taraba State in particular. This will be clearly demonstrated in more budgetary allocation and prompt release of funds for HIV/AIDS control in order to consolidate the gains so far recorded.

ii. There is need to intensify efforts at public enlightenment campaigns through the use of jingles, posters and mass media. The focus of this should be on the need for people to know their HIV status and avoid stigmatization. Effort should be made to get the private sectors involved in the fight against the spread of HIV/AIDS in the state because the challenge is beyond the capacity of the state government

iii. There is the need for private sector support and health insurance scheme to assist in managing HIV/AIDS challenges in the State.

iv. Taraba State government needs to put in more effort aimed at strengthening the monitoring and evaluation systems for HIV response activities in the state.

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