

Cost Implications of the Prevalence of HIV/AIDS on the Economic Development of Nigeria

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Abstract

HIV/AIDS emerged in the last three decades as visible threat to health and the socio-economic conditions of developing countries including Nigeria. Against this background, this study sought to determine the cost implications of the prevalence of HIV/AIDS on the economic development of Nigeria. The study adopted mainly qualitative approach sourced from National Bureau of Statistics-(NBS) and Central Bank of Nigeria-(CBN) statistical Bulletin respectively for analysis. Findings seem to support claims that the incidence of HIV/AIDS exert serious negative influences on the economic growth of Nigeria. This is due to the fact that HIV/AIDS reduces to a large extent the proportion of the working population with its huge corresponding cost implications, which in turn affect economic resources in the country. The policy interventions strategies recommended for stemming the scourge of HIV/AIDS include; prevention of new infections, cost reduction of treatments for patients, positive adjustments of patients to employment environment and development of activities like psycho-educational programme to motivate and foster HIV/AIDS prevention and management behaviours among the Nigeria populace especially the youth.

Keywords: Cost, Economic Growth; Employment, HIV/AIDS, Productivity

Introduction

The Human Immune Virus and Acquired Immune Deficiency Syndrome epidemics are both global phenomena threatening the health of various peoples, culture and population in the world. The Sub-Saharan Africa (SSA) with about 10% of the world's population has over two third of the people living with HIV. The first cases of HIV and AIDS were reported in 1981. Two decades later, it had already infected 40 million people worldwide out of which 28.5 million (approximately 75%) reside in Africa (UNDP, 2004).

HIV means Human Immune Virus. It is a virus that attacks, destroys and continues to deplete human immune system. The acronym AIDS means Acquired Immune Deficiency Syndrome. This suggests that the condition or illness is not inherited but acquired from possible environment factors such as virus infections. Similarly, immune deficiency means that the viruses have gradually caused deficient immunity as clearly manifested in poor nutrition and low resistance to opportunistic infections (Cox, 1997). HIV and AIDS are interrelated because AIDS is believed to be an advanced form of HIV infection. Thus, AIDS is a severe immunological disorder caused by HIV, resulting in a defect in cell-mediated immune response causing increased susceptibility to opportunistic infections like fever, tuberculosis, skin rashes and so on which ultimately lead to death (Aghulor, 2010).

There are at least two strains of the viruses that cause AIDS and AIDS related conditions namely HIV-1 and HIV-2. HIV-1 is the most common cause of AIDS world wide except in West Africa where the HIV-2 (which is less virulent) is common. Without doubt caring for somebody infected with HIV/AIDS is always a herculean task as it demands a lot of money, time, energy, risk and loss of man hours that would have been used in production of goods and services. HIV/AIDS entails a lot of alternative forgone or cost to the Nigerian economy. It was estimated by experts in 2005 that HIV infection will rise above 100 million and by 2010, life expectancy will begin to decrease, especially in Africa where the brunt of the infection is felt most (National Action Committee on AIDS, NACA, 2007).

The impact of HIV/AIDS extends beyond those living with the virus. This is because as families struggle with poverty when they lose a bread winner or have the added expenses of caring for economically disabled family members who may die sooner or later, household savings tend to decrease leading ultimately to wider financial depreciation. It also exerts impact on other members of the household (usually daughters or wives) who may miss school or work in order to take care of the sick person. Similarly, people infected with AIDS usually suffer from combination of severe weight loss, different types of infections and whereas that end in death one or two years after initial diagnosis and full occurrence of blown AIDS (Cox, 1997).

HIV/AIDS is contagious and can be transmitted mainly through sexual intercourse, intravenous drug usage, blood transfusion during surgery, pregnancy and child birth (Boler & Archer, 2008). Generally AIDS patients are vulnerable to opportunistic infections which take undue advantage of damaged immune system to thrive. Incidentally AIDS has no cure.

The number of people living with HIV/AIDS (PLWHA) as well as number of deaths as a result of the epidemic has increased across the globe (UNAIDS, 2001). This is even more alarming as majority affected are adults and women who are the key components of the labour force, which has serious implications for economic development. In Nigeria, it is estimated that 3.2 to 3.8 million people are living with HIV, which implies that one out of seven Africans living with HIV is a Nigerian. On the whole, although the overall percentage of adults infected seems to have remained stable over the last few years, the number of people living with HIV is still on the increase with the poor youths, children and pregnant women being the most vulnerable (Boler & Archer, 2008).

Available literature show that the prevalence rate of HIV/AIDS in Nigeria is still high across the geographical zones even though it has narrowed down significantly between urban and rural areas. According to National Action Committee on AIDS-NACA (2007) the nation is at the threshold of severe and widespread growth of the epidemic. The 2001 National HIV/Syphilis Sentinel Survey estimated a national HIV prevalence rate of 5.8%. Regional prevalence rates are high though varied from a high of 7.7% in South-South to low of 3.3% in the North-West (Federal Ministry of Health-FMOH, 2001; National Population Commission-NPC, 2004). This means that HIV is spreading through the general population rather than being confined to populations at higher risk, namely sex workers and drug users.

In Nigeria the disease is spread mainly through commercial sex workers, long moving truck drivers, wandering female hawkers, unscreened blood transfusion and host of other deep rooted unhealthy cultural practices (Azuh, 1999). The stigma associated with people living with HIV and AIDS and those affected by AIDS lead to further isolation and mental hardship. Losses in productivity created by deaths and illnesses associated with HIV and AIDS can result in slowing down of growth and other developmental objectives (United Nations Development Programme, UNDP, 2004).

A healthy work force is fundamental to an industrious, vibrant and prosperous nation. Acquired Immune Deficiency Syndrome (AIDS), constitutes a serious challenge not only to the health sector but also the economy with seeming cost implications (Akerlele, 2005). This is largely so because the epidemic is likely to affect the working population which is predominately youths. Thus, although HIV infects all age groups in Nigeria, the prevalence rate has been higher among young adults (20-29 years) who are at the prime of their lives. Invariably the epidemic is likely to take its greatest toll on the young segment of the population where the majority of new infections occur within the 15-29 years age brackets. The high morbidity and mortality among these age groups could have serious implications not only on the population structure, life expectancy at birth but also the gains of economic growth.

Universal coverage with respect to health related matters implies that everyone should be able to have access to quality health services without being inhibited by financial hindrances (WHO, 2010). Thus, universal health coverage promotes two common aspirations namely providing financial risks for all (100% from the costs of health care and enabling access to needed health care for all (100% financial and geographic access) (Onwujekwe, 2013). Basically universal coverage promotes affordable Health care services through malaria HIV/AIDS intervention and other related Human Resource Health Management Information System.

Universal Coverage (UC) became part of the global agenda in 2005 when the World Health related Assembly adopted a resolution requesting member States to pursue universal coverage in health and other related matters (WHO, 2005). The major part of this resolution was to “reduce the reliance on out-of-pocket payment and to promote pre-payment health care financing mechanisms” (Onwujekwe, 2013:14). Incidentally, Nigeria has not made any visible progress in Universal Coverage since the adoption of the resolution in 2005. As argued by Onwujekwe (2013) “the coverage levels with most health services (including free services) and pre-payment financing mechanisms are very low” p4. For instance, he further observed that less than 5% of the population is covered by financial risks protection mechanisms such as health insurance. This current low universal coverage in Nigeria undoubtedly could be attributed to weak health system where “more than 60% of health-care financing comes from households’ out-of-pocket payments” (Onwujekwe, 2013: p4). This has far-reaching implications on economic growth.

Indeed, Nigeria has the resources needed to achieve universal health coverage but needs other sustainable measures and related intervention policies to ensure adequate working of equitable health delivery system without which cost of treating, maintaining or managing HIV/AIDS will be very high and perhaps economically attractive. This position is based on the premise that access to health care is a fundamental human health right which is enshrined in many global resolutions and declarations and even in the Nigerian constitution (Federal Republic of Nigeria, 2011; Obiajulu, 2009). The Alma-Ata Declaration-1977, sees health as fundamental human right and most important world wide social goal. It is according to the World Health Organization (WHO) cited in Okeibunor (2011; p.5) “a state of complete physical, mental and social well-being and not merely, the absence of disease or infirmity”. Similarly, Onwujekwe (2013) sees health as a state of the human body and mind and health care as pertaining to those chemicals, devices and services utilized by people to improve their health. A health system therefore includes all the organizations, institutions and resources whose major function is to

improve health and related services ranging from service delivery to policy-making and implementation (WHO, 2010). Thus, a viable health system needs to promote services which are not only responsive to needs but also generally accessible and affordable in terms of cost (Okeibunor, 2011). Invariably expectations from good health system include, improved health status (improved health efficacy) good health at low cost, equity (accessibility), affordability, responsiveness, universal coverage and financial risks protection (WHO, 2005).

From both human capital/resources and economic perspective, good health generates wealth hence the popular saying that “health is wealth”. Indeed with respect to economic cost, healthcare is seen as a special good and should be accorded commensurate attention in order to ensure Universal Health Coverage. This is particularly so because no one is certain about when illness will occur and the envisaged related expenditure that could be incurred. According to the World Health Organization, WHO (2005) a strong or good health system contributes to good health because it caters for all interests (economic, political, racial and religion) and segments of the population especially the poor and perhaps the most vulnerable and disadvantaged groups. Above all, it develops human resources (strong economic capital) through investment and financial services that are responsive to prevailing health-care needs such as HIV/AIDS.

Incidentally, the World Health Organization ranked the Nigeria Health system 187th out of 191 countries surveyed (WHO, 2000). Basically, a major criterion used in the ranking “was the issue of poor levels of financial access to health care services” (Onwujekwe, 2013: p7). This implies that health care system should be organized based on the principle of Universal Coverage which provides that every citizen regardless of income, socio-economic status, residency, gender, etc should be empowered to access the same range of services according to needs and preferences (Okeibunor, 2011, Marmot et al 2008). These expectations are predicated on the World Health Organizations’ proposed four target indicators for countries, towards achieving universal health coverage. These indicators emphasize that:

- (1) Total health expenditure should be at least 4%-5% of the gross domestic product;
- (2) Out-of-pocket spending should not exceed 30-40% of total health expenditure
- (3) Over 90% of the population is covered by pre-payment and risk pooling schemes; and
- (4) Close to 100% of population with social assistance and safety-net programme (WHO, 2010, Okoli, 2011).

Onwujekwe et al 2006) argue that inequality to and use of health care services could actually result from differences in distribution across socio-economic status and geographic groups and other factors. That is particularly so because the household as the lowest socio-economic status/group, apart from experiencing the possibility of increased exposure to diseases (due largely to high poverty level) are usually less likely to purchase and access healthcare services. However, even if it does, it leads to depletion of household resources meant for other basic household needs such as food and education (National Bureau Statistics; 2007, Okeibunor, 2011)

Indeed, over the years, the overall performance of the Nigerian health system has been disappointingly low (National Population Commission, 2009; Okolo & Clearly, 2011). For instances, 2013 budgetary allocation of 5.7% to health falls short of the expected funds required to achieve the health related millennium development goals, especially with respect to reversal of high infant mortality rate, maternal death and spread of HIV/AIDS and other diseases that afflict humanity by 2015 (Onwujekwe, 2013) consequently “publicly financed health services barely reach the poor raising the need for over dependence on out-of pocket spending” (p. 19). This suggests evidently that Nigeria will not be able to achieve the health-related MDGs in 2015.

Similar evidence abound to support the above claims with respect to declining state of health care system in Nigeria despite purported increased budgetary allocation. For instance, the total health expenditure is 0.7% of GDP instead of the WHO recommended 4%-5%; out-of-pocket spending is more than 60% of total health expenditure instead of WHO recommended 30-40%; less than 5% of the population is covered by pre-payment and risk pooling scheme instead of WHO recommended 90% and less than 2% coverage of population with social assistance and safety programme instead of WHO recommended 100% (Onwujekwe, 2013). This trend is also supported by Annual Review (Federal Ministry of Health 2012) which shows that there are still low level of access to health care services, poor health indicators, rising poverty, equity and how level of coverage and use of IPT on the whole while there seemed to be increased immunization coverage and increased ITNs Ownership (42%). This position or trend calls to question not only the viability of the Nigerian health policy and Health care system in achieving universal coverage, but also the cost implications for citizens living with HIV/AIDS and economic development in general.

2. Theoretical Framework and Review of Related Literature

The theoretical perspective of this study revolves around classical economist position which perceive health as a product of the developmental process. That is wealth, and improved health are intricately interwoven. The theory holds that in a global development, income should increase for health to improve (Giorgianni, Grama & Scipioni, 2002). In this regard, when people have money (income) they could afford to pay for goods and services, other things being equal, this would make them healthy because they can access better food, clean water supply, efficient sanitation system and medical care.

To the classical economists, a robust economy has a major influence on improving and maintaining the health of communities and nations. For individuals with little disposable income, insufficient income may limit the ability to receive the care they need or place them in situation with additional health risks. Though classical economists view health as a product of development process, others such as Meers *et al* (2003) argued that the direction of causation between health and wealth remains an open issue. For instance, African Development Forum-ADF (2000) reported that more recent researches have begun to establish that countries with healthy population tend to grow faster than the contrary. This means that health of a population is the most reliable indicator of future economic growth (Giorgianni *et al* 2000).

The issue of human capital development is of great importance in any economy particularly developing economy like Nigeria. The twentieth century has become the human capital century. People and skills matter a lot because the wealth of a nation is embodied in its people especially the active or working population. The HIV infection is therefore capable of provoking monumental crisis by arresting every index of development and depleting rapidly the resources badly needed to contain it. Human capital covers a broad range of concepts but the most essential feature is increase in production through skilled and healthy employees.

According to UNDP (2004), Human Development is a process of enlarging people's choices by raising both the knowledge and skills acquisition level of the citizens of a given country. Enlarging people's choices is achieved by expanding human capabilities. At all levels of development, the three essential capabilities for human development are for people to lead long and healthy lives, to be knowledgeable and to have a decent standard of living. If these basic capabilities are not achieved, many choices are simply not available and many opportunities remain inaccessible. The realm of human development goes further: to include essential areas of choice highly valued by people, ranging from political, economic and social opportunities which are requirement for being creative as well as having sense of belonging in a community. At present pace of HIV/AIDS prevalence there could be enormous cost on health, human capital and largely on economic development of Nigeria.

Cost to economists involves not only the money spent in buying or producing something but also the alternative forgone in order to acquire/satisfy, purchase or produce a given item. It is simply the nominal money value paid or used to purchase an item or as the money value paid out or given up/sacrificed in the process of production. The Dictionary of Modern Economics (1985) defined cost as a measure of what must be surrendered or given up in order to acquire, obtain or produce an item.

Economic development refers to both quantitative and qualitative increase in a country's output of goods and services, a more equitable distribution of income, a rise in per capita income and standard of living coupled with a fall in cost of living, people's access to basic necessities and infrastructure and so on. Development is a social construct that can be analysed from different perspectives. It can be applied to the individual, social group, economic, political, technological points of view and so on. This is why authorities usually refer to development as a multi-dimensional or multi-faceted phenomenon. Development as it applies to the individual is the process by which the individual increases his/her skills and capacity, self-discipline, creativity, freedom and material well-being. At the social group level, development is an attack on the chief evils of the world today. These include malnutrition, diseases, poverty, illiteracy, unemployment, inflation, slums and inequality (Bulya, 2011). Thus, according to Seers as cited in Bulya (2011) development occurs amongst a people if poverty, disease, unemployment, inflation, illiteracy and inequality have declined from high levels to low levels. Development is also perceived as a process through which society moves from a given developing socio-economic condition to another more desirable condition as a consequence of education. For any given country to witness development, all sectors of the economy of such a country, for example social, economic, political, cultural, technological, psychological, scientific, military and industrial must be seen to grow.

3. Statement of the Problem

The prevalence of HIV/AIDS in Nigeria constitute a cog in the wheel of development because by 2007, 170, 000 Nigerians have died, while 2.6 million people were already living with the disease. Furthermore, 1.2 million Nigerians were already orphans due to the epidemic (Akpochofo, 2010). Deductively, HIV/AIDS takes a big toll on human lives in Nigeria and possibly the economy. This could have corresponding consequences on the human capital stock in Nigeria as well as potential labour force or manpower of the nation. In addition, catering for the people living with HIV/AIDS (PLWA) could take away a lot of investible funds from both individual (the infected, relations and friends) and government for subsidizing and providing of drugs for the infected citizens. In the same vein, the country could also lose a lot of man hours of both the infected and their care-givers. Indeed the probable cost of HIV/AIDS in terms of both human and capital resources could be enormous especially in Nigeria with very fluid and vulnerable economy. The cost of HIV/AIDS on the implications on the economic development of Nigeria constitute the problem of this study.

4. Research Questions

The following research questions guided the study:

1. What are the general cost implications of the HIV/AIDS prevalence in Nigeria?
2. To what extent can the prevalent trend of HIV/AIDS determine economy growth in Nigeria?

5. Methodology and Qualitative Presentation of Data/Findings

Secondary data were sourced from National Bureau of Statistic (NBS, 2005) and Central Bank of Nigeria (CBN) Statistical Bulletin (2007) for the purpose of answering research questions 1 and 2 respectively. These relevant data were presented in tables 1 and 2. Table 1 presents information on HIV/AIDS prevalence with deductive cost implications. (Table 1).

HIV/AIDS has very serious impact on the epidemiological and demographic profiles of the country as well as on health delivery system and manpower development. When an employee's health is threatened by sickness and disease, his general output or contributions to productivity, economic development and nation's growth would fall. Thus, AIDS reduces the human development potentials and at macro level it will impact significantly on economic growth negatively.

Table I: HIV/AIDS and Economic Growth in Nigeria (1996-2007)

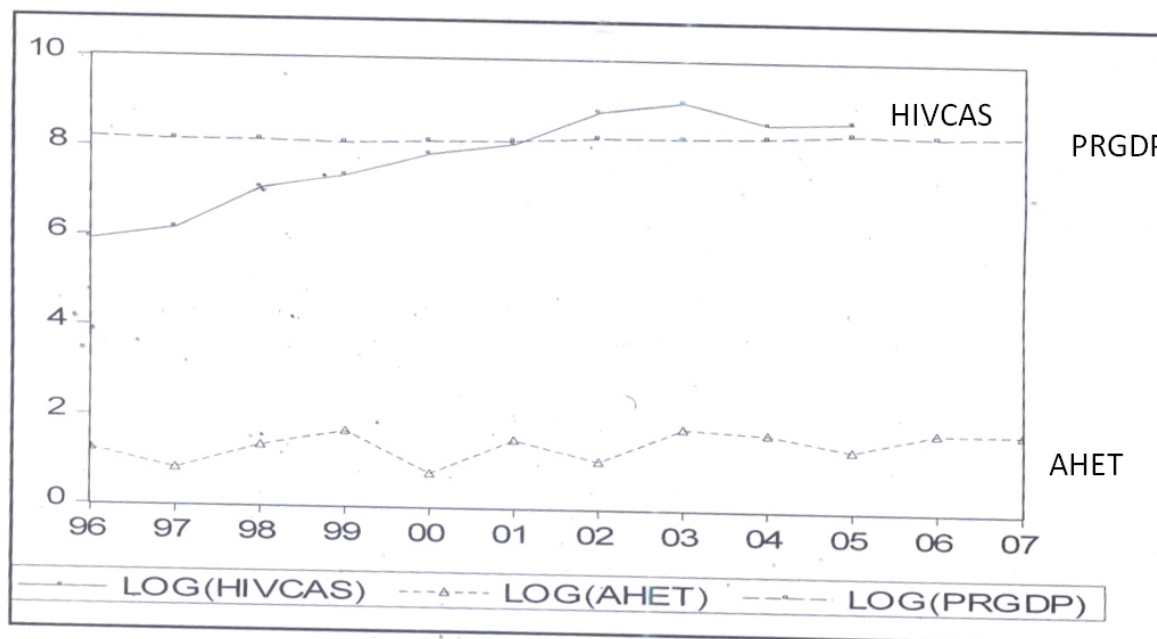
YEAR	CASES	HIV/AIDS Per Capita Real	
		GDP	ALLOCATION TO HEATH SECTOR (%)
1996	367.00	3631.11	3.46
1997	478.00	3454.58	2.26
1998	1189.00	3465.27	3.84
1999	1608.00	3335.60	5.39
2000	2633.00	3505.99	2.11
2001	3371.00	3587.19	4.53
2002	7052.00	3912.69	2.87
2003	8918.00	3955.20	6.07
2004	5529.00	4099.00	5.48
2005	5937.00	4476.40	3.88
2006	n.a.	4339.29	5.82
2007	n.a.	4501.11	5.79

Source: National Bureau of Statistics-NBS (2005) and Central Bank of Nigeria-CBN Statistical Bulletin (2007)

The data in Table1 points out that the cases of HIV/AIDS reported in Nigeria have been increasing over the years with the highest value of 8,919 in 2003. Though it somehow fell in 2004, it later increased in the following year. On the other hand, the value of the per capita real gross domestic product (PRGDP) is increasing at a very slow pace. This interaction between increasing incidence of HIV/AIDS and slow growth of PRGDP depicts the negative implication of the epidemic in Nigeria's economic growth. Taking the argument further, the federal allocation to the health sector as presented in Table1 clearly show that the sector has not received sufficient attention from the government. In this table, the allocation to the sector ranges from low values of 2.11% in 2000 to 6.07% in 2003. The impact of HIV/AIDS is seriously felt by the health sector. The effects involve direct costs such as expenditure on medical treatments, supply, and personnel, among others and indirect costs such as reduction in the number of medical providers and increasing strain on the health sector. Similarly, people living with HIV/AIDS (PLWHA) have wide range of health needs such as primary care, basic treatment, hospitalization and psycho-social counseling that are to be met. However, the paltry amount allocated to the sector can hardly handle it.

The relationship between PRGDP and HIV/AIDS incidence becomes much clearer when one takes a look at the line graph as presented in Figure 1.0. The figure shows that the per capita real GDP is more or less constant over the period (1996-2007), whereas the incidence of HIV/AIDS in the country keeps on rising even far beyond what the per capita real GDP can contain. The very low and undulating national health budget which had highest value of paltry 6% of the total budget allocation is unable to meet the growing burden even if HIV/AIDS usurp all the budgetary allocation of the sector. Thus, it can be argued that the low commitment by the government as well as low information base of the populace on the epidemic has serious implication on the economic growth of the country. This is because the inadequate health sector allocation will put untold pressure on the activities of the sector which can worsen the already heated situation. This finding calls for urgent intervention that will curtail the surge of the epidemic-HIV/AIDS.

Figure 1: Trend of HIV/AIDS and Economic Growth in Nigeria



6. Discussion of Findings

With regards to HIV/AIDS occurrence, it could be said that the initial orientation of academic and policy research was to see the epidemic as a public health problem, not a developmental one as such. However, there is now general agreement that relationship between HIV/AIDS and economic development exist. It be argued that there is a relationship between health and wealth (Sen. 2004). HIV/AIDS has a negative effect on the economy and the economy in turn affects the level of distribution of HIV. For instance, Kassalow (2001) explained that improvement in health and nutrition were among the major forces driving Britain's steady wealth.

HIV/AIDS is a very serious health and social threat capable of affecting economy in many ways. For instance, poor returns of human capital could render the health of the active labour force ineffective thereby leading to both a reduction in the quality and quantity of labour force and a corresponding rise in the health care cost of treating patients. Other possible ways include changing the structure of population against the labour force, shortening the expectation of life, reduction in both returns to private and public investment in human capital and hence economic development would be affected.

HIV/AIDS can also lead to low domestic capital formation. This is because the rate of savings by households, businesses and government undertakings lead to poor capital formation. As demands for both curative and preventive health care rises as a result of HIV/AIDS related morbidity, more financial resources are channeled to health care expenses. This will lower the level of marginal propensity to save and the long-run effect is reduction on domestic capital formation. Invariably there is an erosion of potency to save and invest in economic activities (productive ventures) due to the priority given to HIV/AIDS epidemic treatment. The situation hinders the capacity for future economic growth.

In addition, HIV/AIDS has significant impact on government finances as a result of declining productivity and incomes of both individuals, public and private organizations. This would lead to recurring fiscal deficit with its attendant consequence of high inflation and given the relationship between inflation and growth, the real out come would decline while growth would be compromised. In order words, it affects macroeconomic stability and growth through effects on labour supply leading directly to a reduction in sectoral output in most economic sectors.

Furthermore, the nature of relationship between health and wealth has been in most cases a dialectical one. However, they could be intricately and unquestionably related (Hammoudi and Sachs 1999). Thus, it could be noted that depending on the overall policy environment, the relationship between the health and wealth could either produce a "virtuous circle" in which improved health promote economic growth or a "vicious circle" in which poor health and poverty become mutually reinforcing. In this case, a link can be drawn on how good health could produce rapid economic growth through the formation of robust human capital made possible by the ability of individuals to access good health facilities. This is demonstrated in Figure 1a.

On the other hand, the influence of limited access to health facilities as a result of poverty (low income level)

would produce low human capital and consequently low level of economic growth, as represented in Figure 1a. The G-8 at the Okinawa summit in June 2004 premeditated when they declare. “Health is key to prosperity, and good health contributes directly to economic growth whilst poor health drives a country into poverty”.

Figure 1a: Virtuous Circle

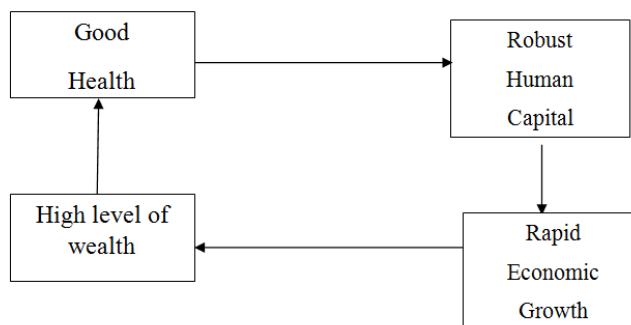
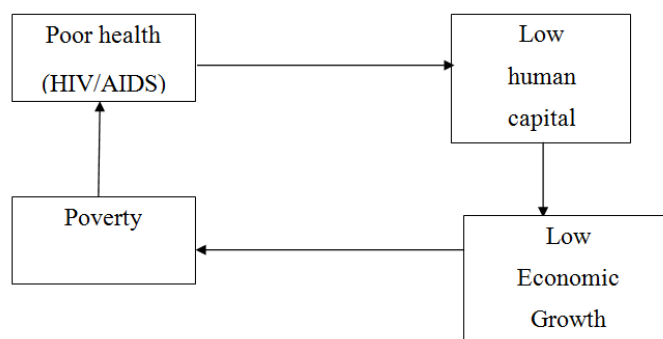


Figure 1b: Vicious Circle



HIV/AIDS has posed a great challenge to the entire world since its cure remains a mirage (Ogwu & Tsebam, 2011). This situation is worsened by the fact that most teachers in the public schools have little or no in-depth knowledge about the HIV/AIDS epidemic and its consequences. Again, most of the children in public schools and the children with special needs, both the visually and hearing impaired are ignorant of the consequences of toying with the disease. This calls for the need for HIV/AIDS education and information, especially as the hearing impaired are the most active among the people with disability. The provision of this requisite education demands, extra funding to the education sector. Of course, this required extra budgetary allocation to both the health and education sectors will be at the opportunity cost of investment in Agriculture and/or other productive sectors of the economy. This is because the battle against HIV/AIDS has both health and educational implications for the future of this country.

7. Policy Implications and Recommendations

The issues raised and discussed herein in this paper have some notable implications that demand the attention and consideration of the federal government. Some of them include:

- ❖ The Nigerian health sector is not adequately equipped/prepared and supported to be able to cope or grapple with this dreaded epidemic of HIV/AIDS. Both the health and education sectors should be given bigger budgetary allocation and support.
- ❖ That HIV/AIDS is silently spreading/affecting the Nigerian populace while the Nigerian government is boasting and promising to be fighting against and controlling the spread of the dreaded virus.
- ❖ A state of emergency should be declared on HIV/AIDS epidemic in Nigeria.
- ❖ That the HIV/AIDS is not only taking an alarming toll on the health and lives of Nigerians but has now constituted a cog in the wheel of economic growth and development of the Nigerian economy by sapping investible funds/resources from both the government, infected Nigerians and their supportive relations/friends.
- ❖ That this country may sooner or later be experiencing a declining population with its attendant negative economic consequences.
- ❖ That this country needs concerted efforts of both government, NGO's and possible foreign support to be able to combat the disease. This could best be achieved through sustained subsidy of drugs international agencies.
- ❖ That HIV/AIDS education in Nigerian schools as currently obtains is not adequate and effective for controlling the disease. In-service orientation courses, seminars and workshops should be organized for

teachers and students to further strengthen HIV/AIDS education in schools.

- ❖ The National Orientation Agency (NOA) should in addition to NACA be empowered/mobilized to embark on media campaigns and public awareness programmes about the disease. Knowledge they say is power and in this case one required for proper decision making and corresponding attitudinal change and value re-orientation for stemming the prevalent rate of HIV/AIDS in our society.

8. Conclusion

The devastating impact of HIV/AIDS is capable of rolling back the decades of gains in the development progress in Nigeria if urgent measures are not taken to address the trend. This impact is heavily felt by the health sector through direct costs such as expenditure on medical treatments, subsidized drugs and so on, as well as through indirect costs such as reduction in the number of medical providers and increasing stress on health system. The HIV/AIDS epidemic is a serious challenge in Nigeria-a country that is already faced with difficulties in meeting basic health care needs of the population.

The very low national health budget in the total budget allocation is unable to meet the growing burdens even if HIV/AIDS usurp all the budgetary allocation of the sector. This paper found out that the low government commitment to the health sector is unable to adequately address the rising spate of the disease. It was equally observed that the per capita real GDP can be reduced with the increasing incidence of HIV/AIDS in the country. Thus, the fluctuating health sector allocation puts undue pressure on the health sector activities leading to the worsening scenario witnessed in that sector. The observations made in the paper calls for dramatic intervention measures to curtail the upsurge of the epidemic. In addition to increase in health sector budget ensuring economic independence by a way of employment, less discrimination against PLWHA, development of activities such as psycho-educational programme to motivate and foster preventive behaviours among the entire population especially the working class are needed.

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