NATIONAL AGENCY FOR THE CONTROL OF AIDS (NACA)

Federal Republic of NIGERIA

GLOBAL AIDS RESPONSE

Country Progress Report

Nigeria GARPR 2014

2014

ABUJA, NIGERIA

Contents

ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Ante-Natal Clinics
ART	-	Anti-Retroviral Therapy
ARV	-	Anti-Retroviral
BSS	-	Behavioural Sentinel Survey
CSO	-	Civil Society Organization
CSW	-	Commercial Sex Workers
DoC	-	Declaration of Commitment
FCT	-	Federal Capital Territory
FMOH	-	Federal Ministry of Health
GARPR	-	Global AIDS Response Progress Report
HCT	-	HIV/AIDS Counselling and Testing
HEAP	-	HIV/AIDS Emergency Action Plan
HIV	-	Human Immunodeficiency Virus
IBBSS	-	Integrated Biological and Behavioural Surveillance Survey
ICAP	-	International Centre for AIDS Care and Treatment Program
IDU	-	Injecting Drug Users
LACA	-	Local Action Committee on AIDS
LAC	-	Local Government Action and Communication
LGA	-	Local Government Area
MDA	-	Ministries, Department and Agencies
MDG	-	Millennium Development Goals
M & E	-	Monitoring and Evaluation
MARPs	-	Most at Risk Populations
MOT	-	Modes of Transmission
MSM	-	Men who have Sex with Men
NACA	-	National Agency for the Control of AIDS
NASA	-	National AIDS Spending Assessment
NARHS	-	National HIV/AIDS Reproductive Health Survey
NARHS Plus	-	National HIV/AIDS Reproductive Health Survey Plus
NDHS	-	Nigeria Demographic and Health Survey
NGOs	-	Non-Governmental Organization
NNRIMS	-	Nigeria National Response Information Management System
NOP	-	NNRIMS Operational Plan
NSF	-	National Strategic Framework
SKM	-	Strategic Knowledge Management

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FOREWORD

In 2013 Nigeria continued her commitment towards meeting the vision of Millennium Development Goal (MDG) to halt and reverse HIV and AIDS epidemic in the country and promote the achievement of universal access to HIV/AIDS prevention, treatment, care and support in line with global commitments. With the valuable support of local and international partners, the country has seen the epidemic profile change significantly from HIV prevalence of 5.8% in 2001 to 4.1% in 2010. Attaining the status of a country with stable HIV epidemic among adults 15–49 years old between 2001 and 2011 is a significant achievement, though there are still gaps and challenges with access to HIV/AIDS service by eligible persons.

Reviews of the national response further helped to identify some other key challenges which revolve around limited domestic financing of the response, weak coordination at national and state levels, inadequate state government contribution to resourcing for the response; challenges with human resources for health, weak supply chain management systems; limited service delivery capacity and access to HIV services.

In a bid to address these challenges and strengthen the national response towards ensuring we reach our set national response targets, the Federal Government of Nigeria led by his Excellency President Goodluck Ebele Jonathan launched the President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP). The PCRP incorporates these tenets and provides a unique opportunity to achieve greater ownership of the response at sub-national levels and thereby guarantees improved access and sustainability. It is also anticipated that this will inject the required momentum into the HIV response and attainment of our national commitments.

The 2014 Nigeria GARPR report highlights the progress in the national response and the collective efforts stakeholders have made in Nigeria in the year 2013 while providing evidence that will further strengthen the need to do more towards ensuring that we reach our country goals, objectives and targets for HIV response.

I present to you the Nigeria 2014 GARPR report and also use this opportunity to thank all our Donors, Partners, Civil Society and Government Ministries, Departments and Agencies for your continued financial and technical support.

Professor John Idoko,

Director General, National Agency for the Control of AIDS (NACA)

ACKNOWLEDGEMENT

I wish to thank the Director-General of the National Agency for the Control of AIDS (NACA), Prof. John Idoko for providing the institutional and leadership support needed for the development of the Nigeria 2014 GARPR report. On behalf of NACA, I also wish to recognize the technical and financial contributions of the UNAIDS team led by Dr. Bilali Camara and ably supported by the UNAIDS M&E Advisor for Nigeria, Dr. Masauso Nzima.

Similarly, NACA appreciates the contributions of all the members of the Nigeria 2014 Report Steering committee for their technical and financial support towards the entire process leading to the submission of the Nigeria GARPR report. Our national response has been successfully built and sustained on this collaborative and participatory approach. Let us continue in this same spirit as we work together to ensure that we meet our target of halting and reversing the HIV/AIDS epidemic in the country.

The immense contributions of the GARPR core team is also acknowledged and appreciated. The team implemented the approved work plan for 2014 GARPR report writing and was directly responsible for all of the activities involved including the HIV/AIDS estimates meeting; NCPI survey meeting, data analysis, stakeholder validation meeting; submitting the data for the indicators using the online reporting tool and drafting the narrative report.

Special thanks to Mr. Francis Agbo and Mrs. Doris Ogbang of the Strategic Knowledge Management Department of NACA for their leadership and coordination role of the day to day activities in the process of generating Global AIDS Response Progress Report. The diligent efforts of all members of the core team including: Funso Adebayo (FHI360); Mercy Morka (FMoH/NASCP); Modupe Taiwo and Uzoma Anaso (CISHAN), Adedayo Adeyemi (MEASURE), Fati Murtala Ibrahim and Eunice Ekong (IHVN); Kogi Joseph (ENR/DFID); Dare Onimode (USDOD); Lawrence Kwaghga (NACA); Oluchi Obi (NACA) and Abu Ibrahim (NYNETHA) are also recognized and appreciated

My sincere gratitude also goes to staff of the Strategic Knowledge Management Department at NACA for their logistic and technical support towards the timely completion and submission of this report.

Dr. Kayode Ogungbemi,

Director, Strategic Knowledge Management Department,
National Agency for the Control of AIDS

Section One: Status at a Glance

Nigeria Country Profile

Nigeria lies within latitudes 4° 1' and 13º 9' North and longitudes 2º 2' and 14º 30' East, and is bordered in the North by Niger Republic; in the East by the Republic of Chad and Cameroun; in the West by the Republic of Benin and in the South by the Atlantic ocean. The country occupies a total surface area of approximately 923,768 square kilometers and 800km of coast line.

Nigeria's climate varies with an equatorial south, a tropical center, savannah and arid north. Natural resources include: natural gas, petroleum, tin, iron ore, coal, limestone, niobium, lead, zinc and arable land. Nigeria has southern lowlands which merge into central hills and plateaus; while mountains abound in the southeast, and mostly plains dominate the north.

The country has 36 states and the Federal Capital Territory (FCT) with the states further divided into 774 Local Government Areas (LGAs). The states are grouped into six geopolitical zones based on geopolitical considerations; North East (NE), North West (NW), North Central (NC), South West (SW), South East (SE) and South-South (SS). Each geopolitical zone is distinct in character with its own unique size, composition of population, ecology, language, norms, settlement patterns, economic opportunities and historical background.

Nigeria is the most populous African country with an estimated population of 177,071,561 as at July-2013 and Total Fertility Rate (TFR) of 5.5. Nigeria's annual growth rate is estimated to be

2.54% in 2013. Nigeria has over 250 ethnic groups. The languages include English (Official), Hausa, Yoruba, Igbo and over 500 other indigenous languages. Approximately 50% of the population lives in urban areas with the rate of urbanization estimated at 3.75% annual rate of change.

Table 1 Nigeria Basic Indicators

Basic Indicators	
Under-5 mortality rate, 2013	128
Infant mortality rate (under 1), 2013	72.97
Neonatal mortality rate, 2013	46
Total population, 2013 estimates	177,072,561
Annual number of births (thousands), 2013	31828
Annual number of under- 5 deaths (thousands), 2013	861
GNI per capita (US$), 2011	1280
Life expectancy at birth (years), 2011	52
Total adult literacy rate (%), 2005-2010	61
Primary school net enrollment ratio (%), 2013	58
% share of household income, lowest 40%, 2000-2010	15
% share of household income, highest 20%, 2000-2010	54

Inclusiveness of Stakeholders in the Report Writing Process

The report writing process commenced in earnest in January 2014 with the formation of the Global AIDS Response Program Report (GARPR) Steering Committee by the National Agency for the Control of AIDS in January 2014. The Steering committee was led by NACA and had membership from a broad spectrum of stakeholders that included FMOH (HIV/AIDS Division); UNAIDS; USDOD; ENR/DFID and CISHAN. The Steering Committee was tasked with the responsibility of approving the GARPR reporting work plan; resource mobilization and responsible for ensuring that the country report is submitted to UNAIDS Geneva on or before the deadline of 31st March 2014.

The Steering Committee then approved the establishment of GARPR core team of technical experts from various key stakeholders to implement the approved GARPR report writing work plan. The main responsibilities of the core team included the following: guide data collection, collation, analysis, interpretation and reporting. Essentially, the team reviewed epidemiological, programmatic and financial data to describe the national HIV response. Financial and technical assistance was provided by some development partners that are present in Nigeria, including the United Nations system, bi-lateral and other multi-lateral agencies.

For this 2014 reporting, a decision was taken to have members of the core team compile the report and to a large extent conduct the data analysis and collation. This is an effort to build the capacity of government staff (i.e. NACA and FMoH) and other relevant stakeholders in the HIV/AIDS response. The work of the core team was however monitored for quality and adherence to standards by the steering committee.

Sub-activities for the GARPR report commenced on the 5th of February 2014 with formal letters dispatched from the NACA Director General to Federal Line Ministries, Departments and Agencies as well as key Development Partners in the national HIV/AIDS response to solicit their support for the process. The core team met at various times to review the GARPR reporting guidelines and map out activities and timeline towards ensuring that the country meets the deadline for submission of the report. The team also reviewed data sources for the GARPR indicators and ascertained availability of new data particularly population surveys where relevant.

The Federal Ministry of Health worked closely with NACA, to guide the collation of all health sector data. Since the last reporting period, the national reporting system has improved considerably. As a result, ART and PMTCT program data were extracted directly at the level of the facility. The data were then consolidated with data from implementing partners funded by the US government and the Global Fund. An internal process of validation was conducted by a team made up of NACA, FMoH and Development Partners. This step was taken to ensure that reported data was of acceptable and high quality.

The full compilation of the report started with a desk review of background documents on the HIV epidemic and response in Nigeria. Documents reviewed included the following:

a. Strategic documents: National HIV/AIDS Strategic Framework (NSF) 2010-2015(1)

b. Programmatic Reports: National AIDS Control Programme annual reports.

c. Population based survey reports: Nigeria Demographic and Health Survey (NDHS) 2003 and 2008; National HIV/AIDS and Reproductive Health Survey (NARHS) 2005, 2007 and 2012.

d. Sub-population survey reports; Antenatal HIV sentinel surveillance 2008 and 2010. Integrated Biological and Behavioural Surveillance Survey (IBBSS) 2007 and 2010.

e. Specialized surveys in specific population groups, patient tracking systems, programmatic data, National AIDS Spending Assessment reports of 2007/2008, 2009/2010 and 2011/2012.

f. Programme Reviews: the National Commitment and Policy Instrument (NCPI), Nigeria Country UNGASS Report, 2003, 2005, 2007 and 2010, Nigeria Global AIDS Response Progress Report 2012, Joint Annual Review of the National Response to HIV/AIDS 2011 and the combined NSF Mid-Term Review Report 2013.

g. National HIV/AIDS Epidemiology Impact Assessment 2014, program data and other relevant data sources.

h. Modes of HIV Transmission report 2009

i. Universal Access report 2010

GARPR reporting activities continued with the compilation of the National Composite and Policy Instrument (NCPI) section. The NCPI questionnaire was first circulated to Government Department and Agencies, Development Partners and Civil Society organizations contributing to the national response to HIV. This was done at the early stages of commencement of the exercise to enable stakeholders prepare responses ahead of the NCPI response collation workshop. Part A of the NCPI questionnaire was completed by NACA and the HIV/AIDS Division of the Federal Ministry of Health. Part B was administered to representatives from national and international CSOs, bilateral and multi-lateral partners and the UN. Responses to the questionnaires were collated with agreement obtained on unified responses to NCPI questions at the NCPI workshop.

Similarly, a two day HIV/AIDS estimates workshop was held to revise the HIV/AIDS estimates for the country. UNAIDS Geneva provided technical support while UNAIDS country office in Nigeria provided financial support for the workshop which was led by the Federal Ministry of Health (HIV/AIDS Division)and ably supported by NACA and the GARPR core team.

After the estimates workshop, the core team spent a week in GARPR report writing workshop to draft the narrative report which was then circulated for inputs and comments by the Steering committee.

In preparation for submission, a two day stakeholders' meeting was held in Abuja to present data on the GARPR indicators and other findings for validation prior to final submission to UNAIDS Geneva. This stakeholders' meeting also included finalization of the report prior to submission.

Using login access and password given to the country designated focal person for the GARPR report by UNAIDS, the final validated data was submitted using the GARPR online reporting tool.

Status of the Epidemic

The first case of AIDS in Nigeria was reported in 1986. Consequently, and in line with guidelines from the World Health Organization (WHO), the government adopted ANC sentinel surveillance as the system for assessing the epidemic. Sentinel survey data showed that the HIV prevalence increased from 1.2% in 1991 to 5.8% in 2001. After 2003 the prevalence declined to 4.4% in 2005 before slightly increasing to 4.6% in 2008. Results from the latest round of sentinel survey shows that the national prevalence was 4.1% in 2010. (FMOH, 2010) Trend analysis of HIV prevalence from sentinel surveillance in Nigeria indicates that the epidemic has halted and is showing signs of stabilizing at about 4% from 2005 till date.

Similarly, based on projected HIV estimates of 2013, about 3,229,757 people now live with HIV while it is estimated that 220,394 new HIV infections occurred in 2013. A total of 210,031 died from AIDS related cases. It is also estimated that a total of 1,476,741 required anti-retroviral drugs (ARV) in 2013.

Although most-at-risk populations contribute to the spread of HIV, heterosexual sex, particularly of the low-risk type, still makes up about 80 percent. Mother-to-child transmission and transfusion of infected blood and blood products, on the other hand, account for the other notable modes of transmission.

Another National HIV/AIDS and Reproductive Health Survey (NARHS) was conducted in 2012, with a national prevalence of 3.4%. There was a slight decline from the previous estimates of 2007 which was 3.6%.The overall national prevalence also masks several nuances and variations in Nigeria's epidemic at the sub-national (state) levels and among population groups. The 2012 NARHS HIV prevalence was highest among those aged 35 to 39 (4.4%), and lowest among the 15-19 age group (2.9%). The prevalence for males aged 35 to 39years was highest at 5.3%, while women aged 30 to 34 years was 4.2%.

Geographically, the HIV prevalence was highest in the South South zone. The prevalence of 5.5% recorded, in the NARHS 2012, depicting an increase from 3.5% in 2007 [NARHS 2012]

Key drivers of the HIV epidemic in Nigeria include low personal risk perception, multiple concurrent sexual partnerships, transactional and inter-generational sex, ineffective and inefficient services for sexually transmitted infections (STIs), and inadequate access to and poor quality of healthcare services. Entrenched gender inequalities and inequities, chronic and debilitating poverty, and persistence of HIV/AIDS-related stigma and discrimination also significantly contribute to the spread of the infection.

Policy and Programmatic Response

Policy

HIV/AIDS remains a threat to population health in Nigeria; it continues to strain the struggling health system and reverse many developmental gains of the recent past including maternal and under-five mortality rates. Nigeria has enacted a number of laws and policies to guide the multi-sectoral response to HIV/AIDS. The policies have been well articulated in and draw on a number of documents including the following:

A. The **National Policy on HIV/AIDS** was developed in 2009 by the National Agency for the Control of AIDS. The policy provides regulations and guiding principles on topics ranging from prevention of new infections and behavior change, treatment, care and support for infected and affected persons, institutional architecture and resourcing, advocacy, legal issues and human rights, monitoring and evaluation, research and knowledge management and policy implementation by the various stakeholders in the national response. The national policy was developed in agreement with key national and international frameworks relevant to the HIV/AIDS response in Nigeria, including:

- The 1999 Constitution of the Federal Republic of Nigeria, which affirms the national philosophy of social justice, and guarantees the fundamental right of every citizen to life and freedom from discrimination.
- Complementary government policy documents which provide the framework for the National HIV policy, including the NACA Act, Medium Term Strategy, National Economic Empowerment and Development Strategy (NEEDS) I and II, National Gender Policy, and the Seven Point Agenda of the Federal Government of Nigeria.
- Commitments to and ratification of numerous international conventions including Universal Declaration of Human Rights (1948), the Convention on Economic, Social and Cultural Rights (1976), the Convention on the Elimination of All Forms of Discrimination Against Women (1979), Convention on the Rights of the Child (1989), and the African Charter on Human and People's Rights (2003)
- Nigeria's ratification of agreed international community goals including the Programme of Action of the International Conference on Population and Development ICPD (1994), The Political Declaration and further action and initiatives to implement the Beijing Declaration and Platform for Action (2000), Political Declaration at the World Summit for Social Development (1995), The United Nations Millennium Declaration (2000) which target 2015 for the reversal of the epidemic trajectory, Greater Involvement of People with AIDS (GIPA) and Meaningful Involvement of People with AIDS (MIPA) principles, The Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and other related diseases in Africa (2001) and the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (2001).
- Nigeria's Commitment to Universal Access and to comprehensive HIV prevention, treatment, care and support as enunciated in the following: the 2005 Gleneagles G8 Universal Access Targets, the 2006 United Nations Political Declaration on HIV/AIDS, the African Union's Abuja Call for Accelerated Action towards Universal Access for HIV/AIDS (2006), and the Brazzaville Commitment on scaling up towards Universal Access to HIV and AIDS prevention, treatment, care and support services in Africa by 2010

B. The Nigerian government has been pro-active in its efforts to confront the HIV scourge with its overarching strategy elaborated in the bottom-up poly-stakeholder and multi-sectoral National Strategic Plan (NSP).The NSP is derived from the architecture of the **National Strategic Framework 2010-15** (NSF II) and has targets to halt and begin to reverse the spread of HIV infection, as well as mitigate the impact of HIV/AIDS, by 2015. With the condition that where appropriate, the targets of the NSP should be population-based, the Federal Government of Nigeria implicitly recognizes HIV care and treatment as a national public health good.

To this effect, the NSF II was developed to provide direction and ensure consistency in the development of the strategic plans by all stakeholders including all the 36 states of the Federation and the Federal Capital Territory (FCT); Government Ministries, Departments and Agencies (MDAs); and the constituent coordinating entities of Civil Society Organization (CSOs) Networks. The NSF II, unlike the NSF 2005-2009 (NSF I), is linked to Universal and MDG targets and Vision 20:2020 and has an overriding emphasis on HIV prevention. The NSFII recently underwent a mid-term review, and the report is currently available. The findings of the MTR of the NSPII show that Nigeria is making some progress with respect to achieving a number of the UN general assembly targets. In particular, the country reports being on course to achieve targets 1, 5, 6, and 8.

The Response Analysis of the preceding NSF 2005-2009, together with input from over 250 stakeholders from public, private and civil society sectors and Development Partners provided the evidence for findings and recommendations that guided the NSF II. Although approximately 1,555,780 PLHIV require ARV drugs, about one third of this group are currently on treatment. The gender dynamics in the profile of infections and the growing burden of the 2.2 million HIV orphans in the country has made it necessary for the revised policy to critically address the following:

- The rising HIV prevalence among women
- The expansion in number of orphans and vulnerable children
- The stigmatization of PLHIV and violation of their rights as well as their roles and responsibilities.
- The differences in communication messages on abstinence, condom use etc in post – primary educational institutions.
- The issues associated with increased access to treatment and care.

The NSF II builds on the National HIV Policy and provides a broad structural framework for the implementation of this policy. Considerations that informed the development of this framework include the burden of HIV/AIDS in the country, the public health challenge of HIV/AIDS, comprehensive HIV/AIDS services, feminization of the epidemic and strategy for gender streaming, young people, MARPs, modes of HIV transmission, drivers of the epidemic, stigma and discrimination, cultures, traditions and religion, human rights and multisectoral partnership.

C. Other policy documents that the national response to HIV draws from are: the National Action Plan on Orphans and Vulnerable Children and the National HIV/AIDS Prevention Plan.

In spite of the numerous policies, minimal progress has been made in addressing the human rights and legal issues surrounding HIV/AIDS. This is mainly due to the fact that, in Nigeria, official policy documents do not constitute law and cannot be enforced in the

courts of law. They constitute merely administrative tools and guidelines that provide direction for governmental action. However, these policy documents can and may elaborate and specify the goals, values, and standards to which existing laws aspire and may be useful in interpreting the latter as well as guiding programmatic interventions by the government. The problem is that, at the moment, there are no HIV/AIDS specific laws on the statutes. Due to the delay in the progress of legal reforms and the absence of the backing of the law, government policy documents can only serve to inspire an effective national HIV/AIDS response that respects the rights of PLHIV and PABA.

Currently, the 1999 Nigerian constitution and international treaties ratified by the country have provided the major sources of human rights for PLHIV and PABA in the country. However, as none of these treaties or the constitution specifically addresses the situation of PLHIV and PABA, the case of their applicability often has to be made through advocacy and lobbying. One outcome of this advocacy agenda has been the efforts made by civil society networks in spearheading the pressure for the passage of the anti-discriminatory bill. Anti- stigma and discrimination bill has passed through Senate and House of Representatives. The bill is waiting to be sign into law by the president. Four (4) states have passed the bill into law. Efforts by civil society networks like CiSHAN, NYNETHA and NEPWHAN have recently included advocacy for increased government investment in the HIV response, facilitation of the use of available policies and guidelines and promotion of the establishment of the legal framework for protection of prospective employees and intending couples.

For most-at-risk and other vulnerable population groups like sex workers, men who have sex with men (MSMs) and injecting drug users (IDUs), there remains a clear absence of non- discrimination laws or regulations specifying protection for these groups. The National Assembly, has passed a bill to prohibit same sex marriage. Tagged Same-Sex Prohibition Law, the law proposed up to 14 years imprisonment each for gay couples who decided to solemnize their union while witnesses to the marriage or anyone who assisted the couples to marry could be sentenced to 10 years behind bars. Also proscribed by the new Bill is "public show of same-sex amorous relationships directly or indirectly" with 10 years' imprisonment stipulated as punishment. The bill has since been signed into law by The President of the Federal Republic of Nigeria. This Law now criminalizes gay groups and organizations and promotes the discrimination and persecution of persons on the basis of their sexual orientation and gender identity. However, according to the Director-General of NACA:

"Nothing in the same sex Marriage (Prohibition) Act 2013 refers to or prohibits programs targeted at prevention, treatment, care and support for people living with HIV or affected by AIDS in Nigeria. No provision of this law will deny anybody in Nigeria access to HIV treatment and other medical services.''

The Government of Nigeria remains fully committed to improving the health of Nigerians and preventing all AIDS related deaths, and therefore will continue to ensure that Nigerians have access to the requisite services that they may require as guaranteed by the constitution''

In the 12 northern states that have adopted Shari'a law, anal intercourse is punished with 100 lashes (for unmarried Muslim men) and one year's imprisonment and death by stoning for married or divorced Muslim men. As of March 2006, press reports say that more

than a dozen people have been sentenced to death by stoning since 2000, but the sentences had not been carried out.

Programmatic Response

Based on commitments to secure significantly increased resources (human, material, financial and technical) for the national HIV/AIDS response from both domestic and international sources, Nigeria set ambitious country specific targets to monitor progress towards Universal Access to HIV/AIDS Interventions. A number of large scale interventions were identified as critical to the success of progress towards the universal access goal. These interventions included gender mainstreaming, advocacy at all levels, capacity building including training and skills development, increased access to material goods, technical assistance and sustainable funding addressed in all six defined thematic areas for the national response, outlined below:

1. Promotion of Behaviour Change and Prevention of New Infections
2. Treatment of HIV/AIDS and related Health Complications
3. Care and Support of PLHIV, PABA and OVC
4. Policy, Advocacy, Human Rights and Legal Issues
5. Institutional Architecture, Systems, Coordination and Resourcing
6. Monitoring and Evaluation, Research and Knowledge Management

Indicator Overview Table

Table 2 - Global AIDS Response Program Indicators

TARGET / INDICATOR	UNGASS 2007	UNGASS 2010	GARPR 2012	GARPR2013
Target 1: Reduce Sexual Transmission of HIV by 50%				
General Population				
Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	22.5% NARHS 2005	24.2% NARHS 2007	24.2% NARHS 2007	24% NARHS 2012
Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	9.8% NARHS 2005	11.9% NARHS 2007	11.9% NARHS 2007	15.5% NARHS 2012
Percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	10.4% NARHS 2005	11.4% NARHS 2007	11.4% NARHS 2007	16.3% NARHS 2012
Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months and who report the use of a condom during their last intercourse	56.1% NARHS 2005	52.5% NARHS 2007	52.5% NARHS 2007	NARHS 2012 [pg127]?
Percentage of women and men aged 15-49 who received an HIV test in the past	8.60% (NARHS 2005)	11.7% (NARHS 2007)	11.7% (NARHS 2007)	17.1% NARHS 2012

12 months and know their results				
Percentage of young people aged 15-24 who are living with HIV	4.3% (ANC 2005)	4.2% (ANC 2008)	4.2% (ANC 2010)	4.2% (ANC 2010)
Sex workers				
Percentage of sex workers reached with HIV prevention programmes	34.30% (IBBSS 2007)	34.30% (IBBSS 2007)	18.2% (IBBSS 2010)	18.2% (IBBSS 2010)
Percentage of sex workers reporting the use of a condom with their most recent client	91.97% (IBBSS 2007)	98% (FSW only)	88.6% (MSW & FSW) 54.7% (MSW) 92.9% (FSW) (IBBSS 2010)	88.6% (MSW & FSW) 54.7% (MSW) 92.9% (FSW) (IBBSS 2010)
Percentage of sex workers who have received an HIV test in the past 12 months and know their results	38.2% (Female Sex Workers Only) (IBBSS 2007)	38.2% (Female Sex Workers Only) (IBBSS 2007)	41.8% (Male & Female Sex Workers) 17.5% (Male Sex Workers) 44.8% (Female Sex Workers)	41.8% (Male & Female Sex Workers) 17.5% (Male Sex Workers) 44.8% (Female
Percentage of sex workers who are living with HIV	32.7% (Female Sex workers only) (IBBSS 2007)	32.7% (Female Sex workers only) (IBBSS 2007)	24.5%(Male & Female Sex Workers) 18.6% (Male sex workers) 25.2% (Female Sex Workers) (IBBSS 2007)	24.5%(Male & Female Sex Workers) 18.6% (Male sex workers) 25.2% (Female Sex Workers)
Men who have sex with men				
Percentage of men who have sex with men reached with HIV prevention programmes	54.38% (IBBSS 2007)	54.38% (IBBSS 2007)	17.99% (IBBSS 2010)	17.99% (IBBSS 2010)
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	52.79% (IBBSS 2007)	52.79% (IBBSS 2007)	50.97% (IBBSS 2010)	50.97% (IBBSS 2010)

Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	30.15% (IBBSS 2007)	30.15% (IBBSS 2007)	24.92% (IBBSS 2010)	24.92% (IBBSS 2010)
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015				
Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	Not Available	Not Available	Not Available	Not available
Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	66.1% (IBBSS 2007)	66.2% (IBBSS 2007)	52.5% (IBBSS 2010)	52.5% (IBBSS 2010)
Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	89.2% (IBBSS 2007)	89.2% (IBBSS 2007)	70.89% (IBBSS 2010)	70.89% (IBBSS 2010)
Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	23.19% (IBBSS 2007)	23.19% (IBBSS 2007)	19.42% (IBBSS 2010)	19.42% (IBBSS 2010)
Percentage of people who inject drugs who are living with HIV	5.6% (IBBSS 2007)	5.6% (IBBSS 2007)	4.2% (IBBSS 2010)	4.2% (IBBSS 2010)
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths				

Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	5.25% (NNRIMS Data Base)	21.6% (FMOH 2009)	15.9% (FMOH 2011)	30.1% (FMOH 2013)
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Not Available	Not Available	4.0% (FMOH 2011)	3.9% (FMOH 2013)
Mother-to-child transmission of HIV (modelled)	--	29.1% (2010 Spectrum Modelling)	19.8% (2011 Spectrum Modelling)	27.3% (2014 Spectrum Modelling)
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015				
Percentage of eligible adults and children currently receiving antiretroviral therapy	16.67% (NNRIMS Data Base)	34.4% (FMOH 2009)	29.8% (FMOH 2011)	19.8% (FMOH 2013)
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	94.56% (ICAP Programme Record)	70% (FMOH 2009)	73.4% (FMOH 2011)	81.0% (FMOH 2013)
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015				
Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	55.95% (NTBLCP-Programme Data)	69.1% (FMOH 2009)	----------	28.1% NTBLCP(2013)
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries				
Domestic and international AIDS spending by categories and financing Sources	US$42,275,977.57 (NASA)	US$ 394,963,881 (NASA 2008)	US$497,817,471 (NASA 2010)	US$574,310,062 (NASA 2012 expenditure)
Target 7: Critical Enablers and Synergies with Development Sectors				
National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Refer to CRIS	Refer to Online UNGASS Reporting Template	Refer to Online GARP Reporting Template	Refer to Online GARP Reporting Template

Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	----------	----------	17.5% (NDHS 2008)	17.5% (NDHS 2008)
Current school attendance among orphans and non-orphans aged 10–14*	Orphans:75%, Non-Orphans:87% (CRS 2006 OVC Situational Analysis)	OVC: 83.9% Non-OVC:71.7% (NDHS 2008)	OVC: 83.9% Non-OVC:71.7% (NDHS 2008)	OVC: 83.9% Non OVC:71.7% (NDHS 2008)
Proportion of the poorest households who received external economic support in the last 3 months	Not available	Not available	Not available	Not available

Section Two: Overview of the Epidemic

HIV Prevalence

The first case of AIDS in Nigeria was reported in 1986 thus establishing the presence of the epidemic in the country. Consequently, and in line with WHO guidelines, the government adopted ANC sentinel surveillance as the system for assessing the epidemic. Between 1991 and 2001, Nigeria witnessed an increase in the prevalence of HIV in the country. The first HIV Sentinel Survey in 1991 showed a prevalence of 1.8%. Subsequent sentinel surveys produced prevalence of 3.8% (1993), 4.5% (1996), 5.4% (1999), 5.8% (2001), 5.0% (2003), 4.4% (2005), 4.6% (2008) and 4.1 %(2010). The National HIV/AIDS and Reproductive Health Survey (NARHS) was adopted in 2003 to provide information on key HIV/AIDS and Reproductive Health knowledge and behaviour-related issues. In 2007, the scope was expanded to include estimation of HIV prevalence in the country. A more comprehensive survey was conducted in 2012, (NARHS plus II 2012) which showed a decline to 3.4% in HIV prevalence, indicating a reversal of the epidemic in the country, compared to the 2007 figure of 3.6%.

Nigeria's epidemic is generalized, with wide variation in prevalence within the country. An analysis of the 2012 NARHS prevalence data in the country's six geopolitical zones shows that the prevalence is highest in the South South Zone (5.5%) while the lowest prevalence is in the South East Zone at 1.8%. There are also differences between urban and rural areas with prevalence figures in urban 3% and 4% in rural area. The pattern of distribution of HIV prevalence by sex showed that irrespective of sex disaggregation, the HIV prevalence pattern is the same across all selected background characteristics.

Socio-demographic differences in the HIV prevalence are also observable with women, youths, and people with low level of formal education being worst affected by the epidemic. NARHS plus 2012 showed an increase from 1.7% in 2007 to 2.9% in 2012 in the 15-19 years age group while the prevalence for the age category (20-24) for both years remain the same with a value of 3.2%.

Nigeria is the most populated country in sub- Saharan Africa, a region which carries the globe's heaviest burden of HIV/AIDS. In estimated numbers this represents about 3,229,757 still keeping Nigeria as the country with the second highest burden of HIV in the world, only after South Africa. The number of persons requiring ART stands at 1, 476, 741 in 2013 out of which 639,397 are currently receiving treatment.

Based on spectrum estimates for 2013, the number of new infections, annual AIDS death stands at 210,031.

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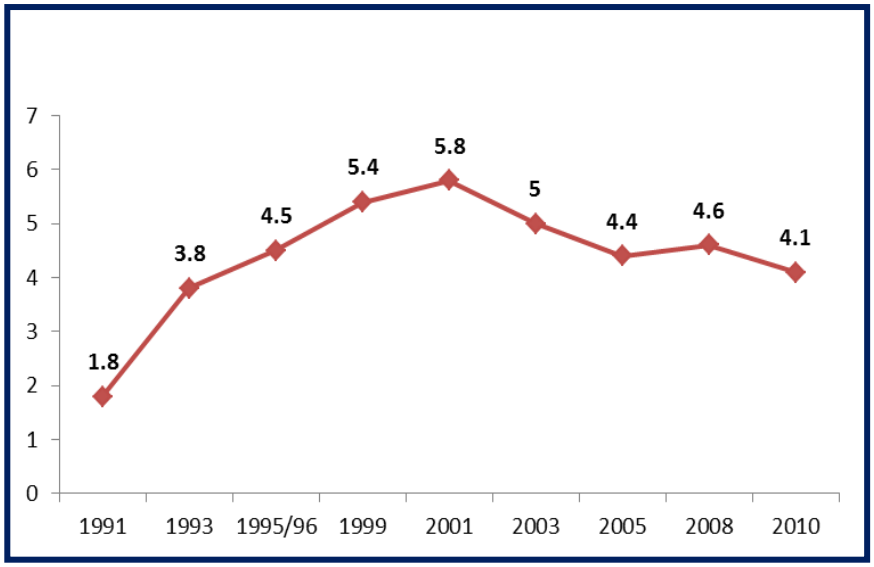
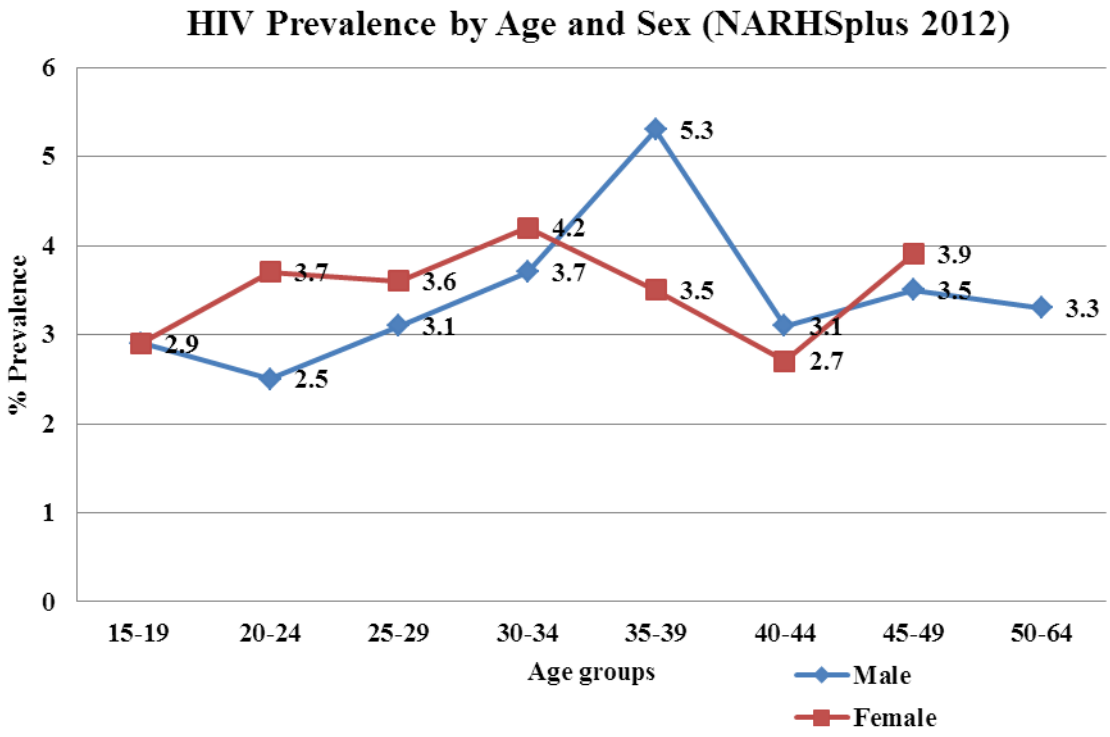
Figure 1- National median HIV prevalence trend in ANC 1991-2010



HIV Prevalence by Age

According to the NARHS 2012 data, the HIV prevalence was highest among 35-39 age group with a prevalence of 4.4 while 40-44 and 15-19 age groups had the lowest prevalence of 2.9%.

Figure 2: HIV Prevalence by age and sex

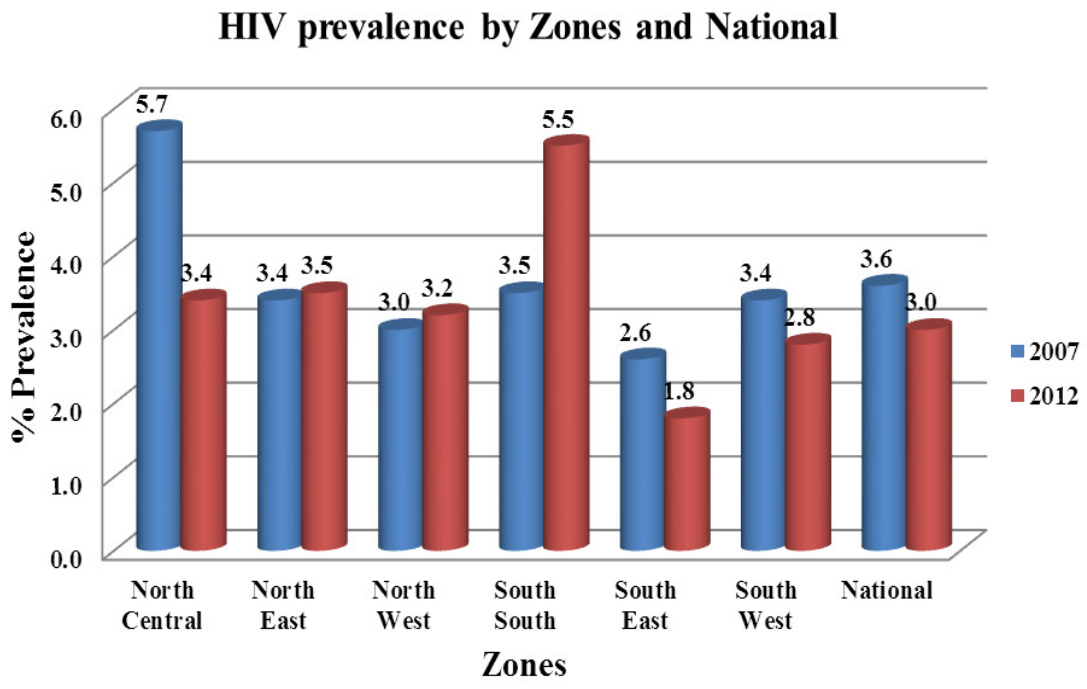


Patterns observed in the previous population based survey (NARHS 2007) shows that gender inequality is an important driver for the HIV/AIDS epidemic. Prevalence rates were generally higher among females (4.0%) than males (3.2%) in 2007. In 2012 even though there was a drop in prevalence it was still higher among females (3.5%) than males (3.3%). Findings also showed higher early vulnerability and infections for girls and women relative to boys and men.

HIV Prevalence by Geopolitical Zones and States

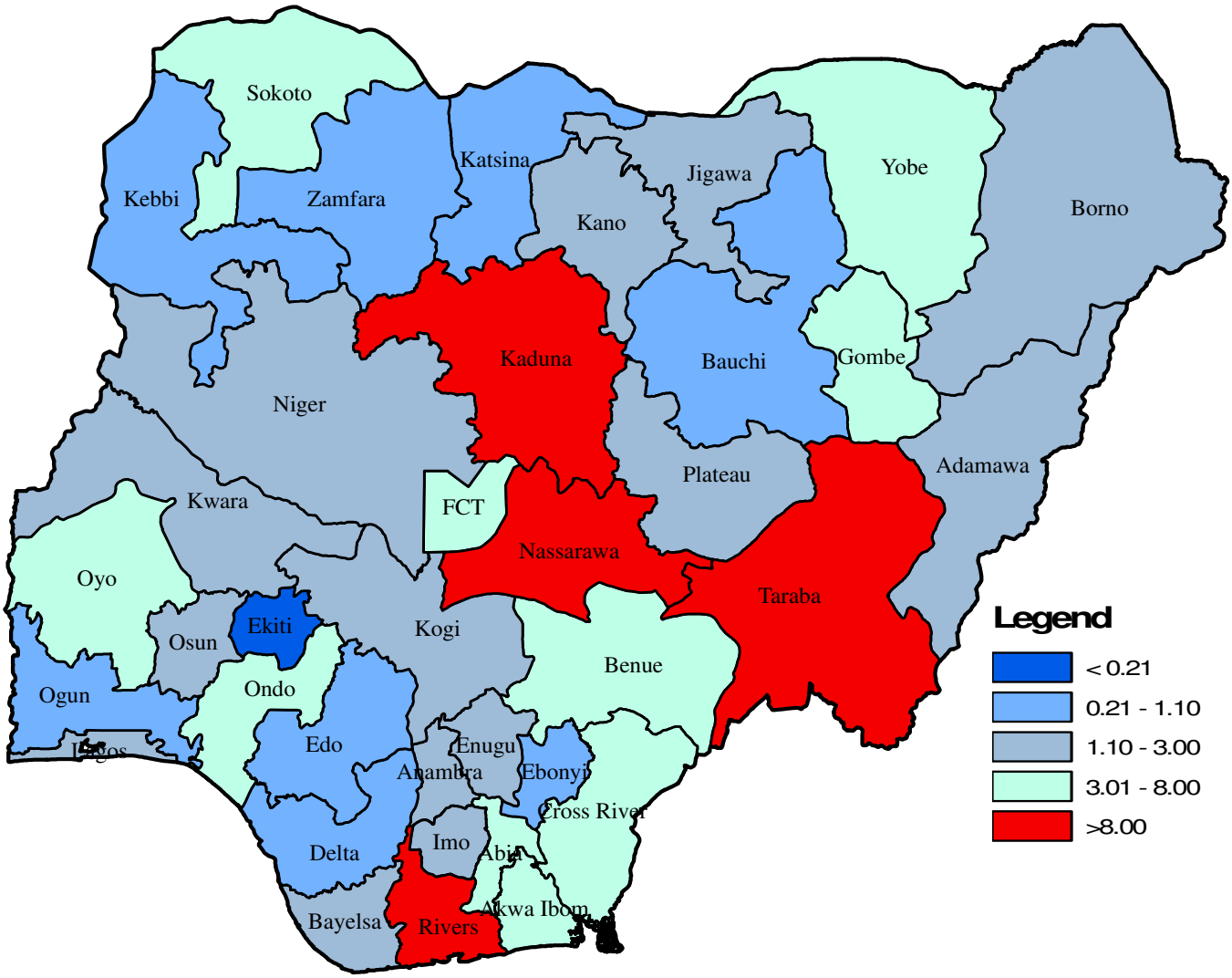
When 2007 data was compared with 2012 it was observed that while the HIV prevalence decreased in the North-Central, South-East and South-West Zones respectively it increased in the three other zones: South-South, North-East and North-West.

Figure 3: HIV Prevalence by zones and national



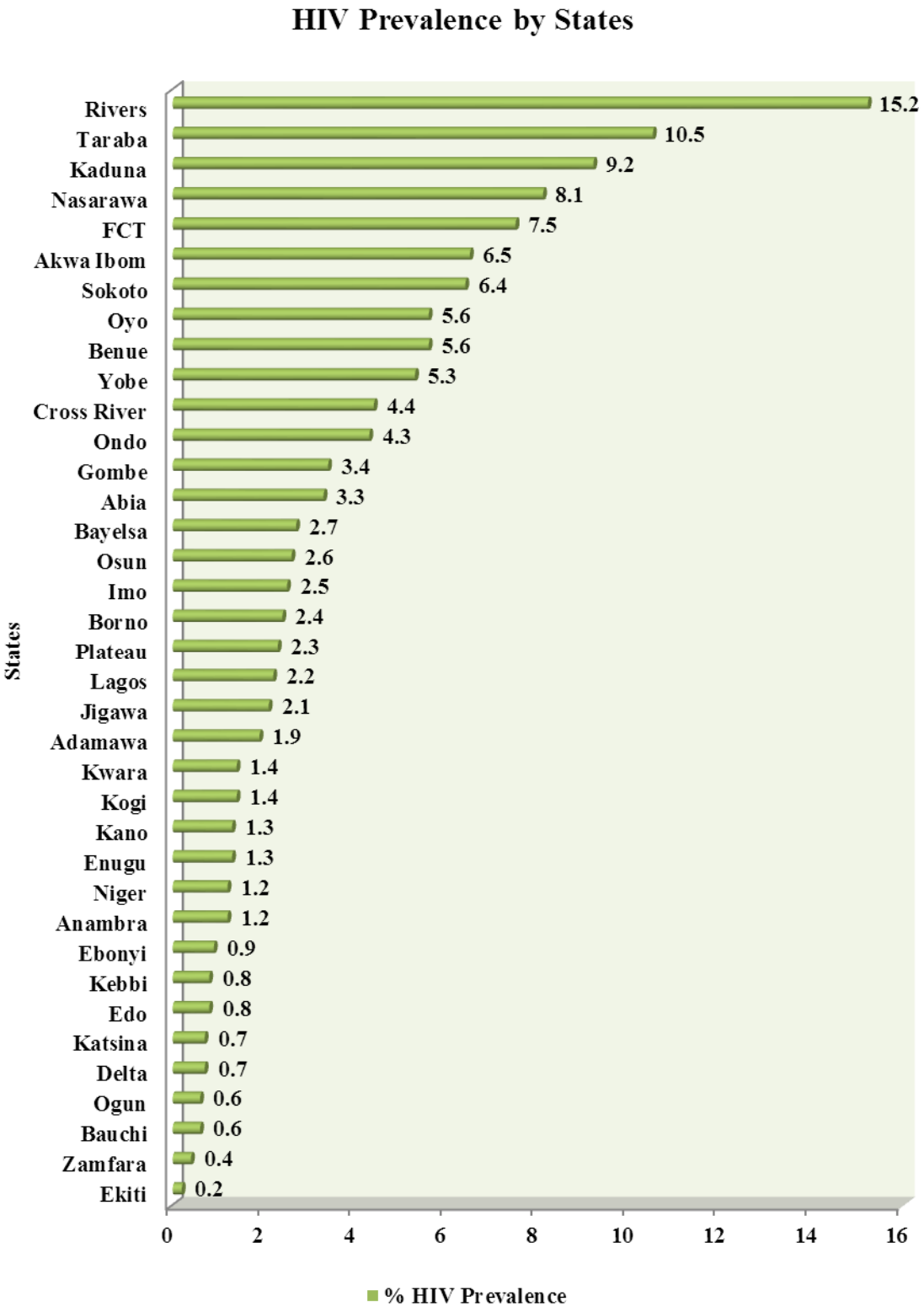
Fourteen states reported a prevalence that was higher than the national prevalence of 3.0% while nine other states had a low prevalence ranging 0.2 to 0.9%. The four states with the highest prevalence were Rivers (15.2%), Taraba (10.5%), Kaduna (9.2%) and Nassarawa (8.1%) respectively. Ten States have prevalence ranging from 3.3% - 6.5%. Ekiti state has the lowest prevalence among the states in the country.

Figure 4 - Geographic Distribution of HIV Prevalence by States



Across the country, urban prevalence is higher than rural in all six geopolitical zones. Similarly, urban prevalence was found to be higher in twenty eight states and FCT with the remaining eight states having higher rural prevalence.

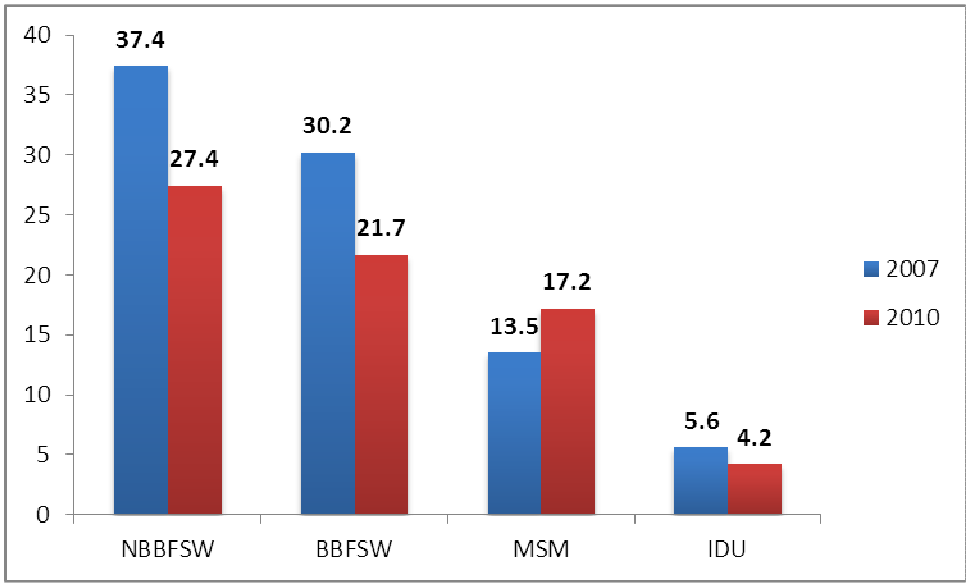
Figure 5: HIV Prevalence by states (NARHS 2012)



HIV Prevalence among Most-at-Risk-Populations

Based on comparison between IBBSS 2010 data for high risk groups and NARHS 2012 data for the general population, it is observed that key target populations or MARPS have a significantly higher prevalence than the general population. At the top of this group are the brothel-based female sex workers (BBFSW), with a current estimated prevalence of 27.4%. Non-brothel based female sex workers (NBBFSW) rank next with an estimated prevalence of 21.7%, followed by men who have sex with men with an estimated prevalence of 17.2%. While the HIV prevalence among FSW and transport workers is reducing, the prevalence is increasing among MSM: from 13.5% (2007) to 17.4% (2010).

Figure 6 - HIV Prevalence trend among MARPS (IBBSS 2007 & 2010)



HIV Incidence

New Infections

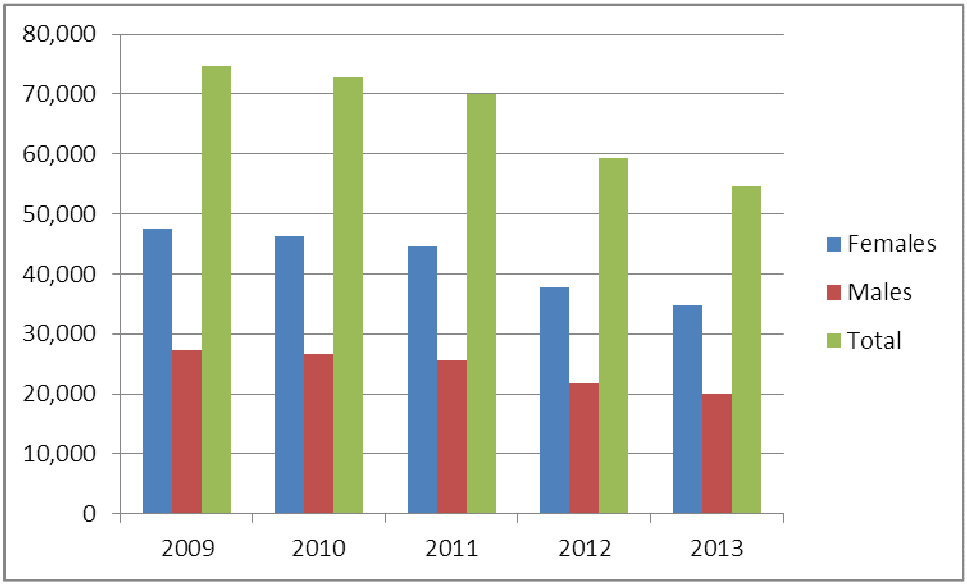
Recent estimates indicate that the annual number of new infections in the country has been on a steady decline, decreasing from 288,870 in 2009 to 283,589 in 2010 and then slightly again to 274,367 in 2011. Similarly, it decreased to 239,706 in 2012 and eventually 220,394 in 2013. The total number of new infections in females continued to surpass that of the males.

Table 3 - Trends in estimated new HIV infections 2009 to 2013

	Female	Male	Total
2009	157,976	130,893	288,869
2010	154,973	128,616	283,589
2011	149,864	124,504	274,368
2012	130,497	109,209	239,706
2013	120,003	100,390	220,393

Among young people age 15-24 the estimated number of new HIV infections showed similar trends. The number of new HIV infections dropped from 74,783 in 2009 to 72,814 in 2010 and 70, 0992 in 2011. A further drop occurred with new infections estimated at 59,739 in 2012 and 54662 in 2013 respectively. Similarly the estimates showed that more of the new infections occurred among young women age 15-24 than their male counterparts.

Figure 7: Trends in estimated number of new HIV infections among young people age 15-24 years



Transmission of HIV Infection

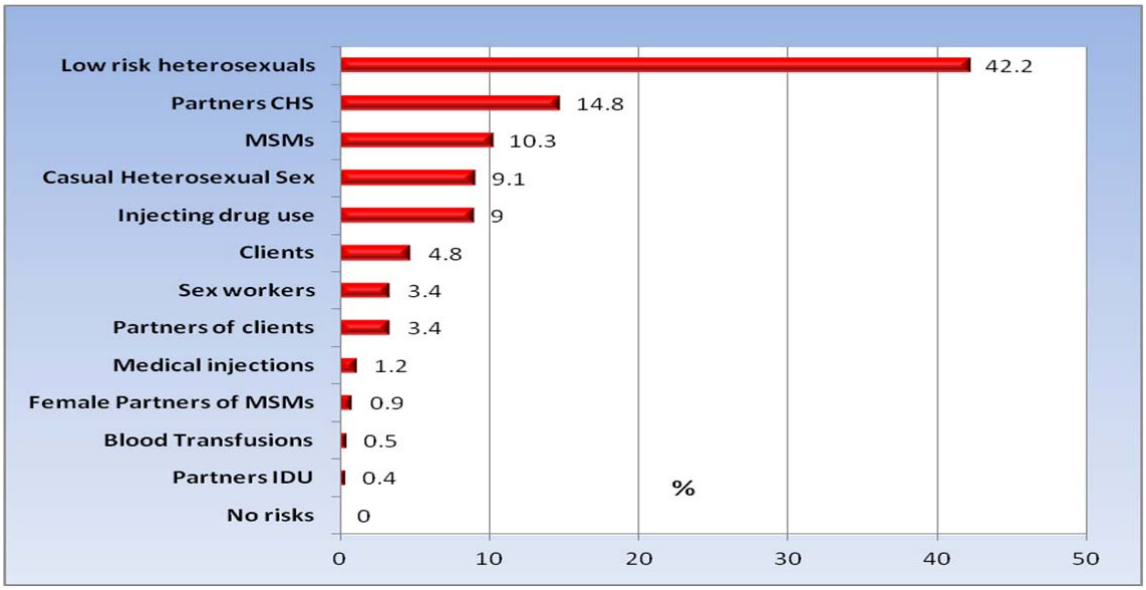
According to the mode of transmission studies conducted in 2008, majority of the infections occurring in Nigeria are due to HIV transmission within the general population. The bulk of the new infections occur in persons who are not engaging in high risk sex, a sub-population that includes cohabiting or married sexual partners. Two-fifths (42%) of the infections occur amongst persons practicing 'low-risk' sex. Because condom use in this group tends to be particularly low, infection acquired as a result of the previous / present high risk behaviors or relationships by one of the sex partners is easily transmitted to the unsuspecting partner.

However, the high risk groups still contribute a significant proportion of the new infections. Directly, Female Sex Workers, IDUs and MSMs alone, who constitute about

1% of the adult population, contribute as much as almost 23% of new HIV infections. These most-at-risk- population groups and their partners contribute as much as 40% of new infections, a population that makes up only about 3.4% of the adult population. Half of the infections contributed by MARPs and their partners are attributed to female sex workers, their clients and clients' partners alone, highlighting a profound need for programmatic response focus on this sub-population group.

MSMs and IDUs and their partners contribute about 10% and 9% respectively of the annual new infections. Targeting these groups will be significantly beneficial to reversing the spread of the epidemic in Nigeria. Notwithstanding the clarity of this need, there still remain enormous hurdles to mounting an effective response targeted at slowing down the transmission of HIV through these groups. These include the presence of policy and regulatory barriers that prevent engagement and recognition of these groups, increasing stigma and discrimination and threatening all efforts made at providing effective prevention, treatment, care and support for them.

Figure 8 - Distribution of New Infections by mode of exposure



Impact of HIV/AIDS on Children

Children are affected by HIV/AIDS through mother to child transmission infection or through the loss of one or both parents from AIDS. The 2008 National Situation Assessment and Analysis (SAA) on OVC showed that HIV/AIDS has been a major cause of death of parents (especially in households where both parents have died). Also, loss of parents may lead to social and economic vulnerability. When parents fall chronically ill from AIDS, children migrate between households. Many of the households taking on these children find it difficult to afford their support. Of 17.5 million vulnerable children, an estimated 7.3 million have lost one or both parents due to various causes. Of these, 2.23 million were orphaned by HIV/AIDS, while about 260,000 children are living with HIV/AIDS. About 20.3% OVC are not regular school attendant, and 18% have been victims of sexual abuse.

Section Three: National Response to the Epidemic

A. Policy and Framework

The first case of AIDS was reported in 1986 in Nigeria. This necessitated the creation of the National Expert Advisory Committee on AIDS (NEACA), Nigeria's first national response to HIV/AIDS Epidemic in 1987. This was soon followed with the establishment of the National AIDS and STI Control Program (NASCP) in the Federal Ministry of Health in 1988. Though it was an improvement, NASCP was essentially a health sector response.

Following the advent of democratic rule in 1999, a Presidential Committee on AIDS (PCA) and the National Action Committee on AIDS (NACA) were established in 2001 to coordinate the multi-sectoral response at the federal level. This represented the crucial point that domestic political acknowledgement of the diseases begun in earnest. Six years later, NACA was transformed into an agency - the National Agency for the Control of AIDS (NACA) to further strengthen its coordinating role and ensure a multisectoral response to the epidemic established and sustained. NACA oversees the activities of the State Action Committee on AIDS (SACA) and Local Government Action Committee on AIDS (LACA) that coordinate response at the sub-national levels.

As a mechanism to enhance harmonization and effectiveness of the national HIV/AIDS response, the "three ones" principle was adopted in 2005. NACA being the coordinating body for HIV National response utilizes one National Strategic Framework (NSF), and one Monitoring and Evaluation system - Nigeria National Response Information Management System (NNRIMS). All these are operationally in line with the three ones principle.

The first National Strategic Framework (NSF) for action tagged NSF 2005-2009 was implemented following the review and expiration of the HIV/AIDS Emergency Action Plan (HEAP) 2001-2013 in 2004/2005. The expiration of NSF 2005-2009 provided yet another opportunity to review the national response with a view to deploying new strategies to ensure the attainment of the national development goals and objectives. This is designed to reposition the prevention of new HIV infections as the major focus of the national HIV/AIDS response, for the National HIV/AIDS Strategic Plan (NSP) 2010-2015.

The NSP 2010-2015 aligns with key priorities outlined in the poverty reduction strategy for Nigeria (Nigeria Vision 20:2020) and the National HIV Policy. As a resource mobilization tool for the national response, it will help achieve universal access to HIV prevention, treatment, care and support and the Millennium Development Goal six on HIV in Nigeria.

The key HIV/AIDS priorities of the NSP 2010-2015 are related to the thematic areas identified by the National HIV/AIDS Policy 2010-2015. These areas are:

- Promotion of Behavior Change and Prevention of New HIV Infections
- Treatment of HIV/AIDS and Related Health Conditions
- Care and Support of PLHIV, PABA, and OVC
- Policy, Advocacy, Human Rights, and Legal Issues
- Institutional Architecture, Systems, Coordination, and Resources

- Monitoring and Evaluation Systems (comprising M&E, Research, and Knowledge Management)

A number of broad interventions were identified as crucial to the success of the national response and ambitious targets have been set to achieve universal access to HIV prevention, treatment, care and support. These interventions include gender-mainstreaming, advocacy at all levels, capacity building for training and skills development, and increased access to material goods, technical assistance, and sustainable funding.

Following the development of the NSP, NACA, in collaboration with her partners, supported the development of State Strategic Plans for the 36+1 states over same period (2010-2015). These state plans are also aligned with national priorities and thematic areas. Since the beginning of 2010, all activities in response to HIV and AIDS have been guided by these national and state strategic plans.

A mid-term review (MTR) of the NSP2010-2015 was conducted in 2013. The goal of the MTR was to review the progress so far made towards achieving the goals and objectives of the multi-sectoral response, as stipulated in the plan. It was also used to review institutional arrangement, coordination platforms and collaboration at various levels with the purpose of identifying critical implementation bottlenecks in programme management. A number of recommendations that could improve the efficiency of the intervention programs were made.

B. Strategy

National Strategic Plan 2010-2015

The main thrust of the NSP 2010-2015 is behavior change and the prevention of new infections while sustaining the momentum in HIV treatment, care and support for adults and children infected and affected by the epidemic. In addition, the plan aims to address gender inequality, knowledge, management and research in a bid to ensure that interventions are evidence driven. The strategic plan has formal program goals, clear targets, detailed costs for each programmatic area and a monitoring and evaluation framework. It has since been endorsed by the relevant development partners who have all aligned and harmonized their HIV related programs to the national plan.

The NSP 2010-2015 is a multi-sectoral strategy covering sectors such as health, education, military, police, labor, transport, women and youth; with specific earmarked HIV budgets for their activities. The strategy also covers key and vulnerable populations, and settings such as prisons, schools and the workplace.

Though the strategy planning efforts have yielded key achievements such as collaboration with a broad range of stakeholders, review of policies, integration of services, GAP analysis and conduct of sustainability studies; challenges still remain. These include insufficient use of evidence, the annual operational plan not

being based on the strategic plan, implementation of plans that are not human right sensitive, inadequate results based management and gender based approaches.

The introduction of the Minimum Package for Prevention Interventions (MPPI) in 2013 has assisted the national response in the efficient and effective use of available resources through prioritizing, partnership, and engagement of affected communities. This strategic and simultaneous use of different classes of prevention activities (biomedical, behavioural, structural) in multiple-level operations (individual, community and societal/structural), helps in responding to the specific needs of particular audiences and modes of HIV transmission.

The Presidential Comprehensive Response Plan (PCRP)

The Nigeria Presidential Comprehensive Response Plan (PCRP) was developed in response to an evident concern within the HIV/AIDS stakeholder community about the existing gap towards achieving global targets for service uptake in the national response. Of specific concern is the slow pace of progress towards actualizing the 2011 United Nations Political Declaration on HIV and AIDS commitment which, amongst others, sought to intensify global efforts to eliminate HIV and AIDS and to take specific steps to achieve ambitious goals by 2015.

The Executive President of the Federal Republic of Nigeria, Dr. Goodluck Ebele Jonathan, convened a HIV/AIDS stakeholder parley during which the state of the National response was presented, including the related challenges. It was decided that the National response would require compliance with two key elements to the political declaration including bridging the funding resource gap and accelerating the implementation of key interventions. To this end, the President requested the development of a comprehensive response plan that provides a platform through which increased government contribution to the national response will be channeled, whilst ensuring key interventions are accelerated to provide quick wins within the two year life span of the plan.

A team of consultants and with support from the broader HIV-Stakeholder community were assembled and tasked with producing a 2 year costed comprehensive response plan that incorporates the tenets of innovation, use of evidence, cost effectiveness, high impact and lends itself to performance measurement.

Methods applied in developing the plan included desk reviews of existing reports including financial and programmatic gap analyses (including the 2011 Joint Annual Review, the National AIDS spending assessment (NASA, 2010), the Global Fund financial gap analysis 2012 and the Global Fund programme performance review of 2012. Also a review of evidence (local and international) that provide opportunities for scalability of interventions, broad consultations around issues of improved governance, greater involvement of other tiers of government, community participation and ownership, and sustainability beyond the two years life span of the plan.

However, the PCRP does not replace the NSP 2010-2015. Rather it is designed as a tool for accelerating the national response and to fast track on-going efforts at implementing the NSP 2010-2015 and the wider national response to HIV/AIDS.

The goal of the President's Comprehensive Response Plan for HIV/AIDS in Nigeria is to accelerate the implementation of key interventions over a two year period and bridge existing service access gaps. Specifically, the plan aims to avail 80 million men and women

aged 15 and older knowledge of their HIV status; enroll an additional 600,000 eligible adults and children on ART; provide ART for 244,000 HIV pregnant women for the prevention of mother to child transmission of HIV (PMTCT); provide access to combination prevention services for 500,000 MARPS and 4 million young person's and activate 2,000 new PMTCT and ART service delivery points across the country.

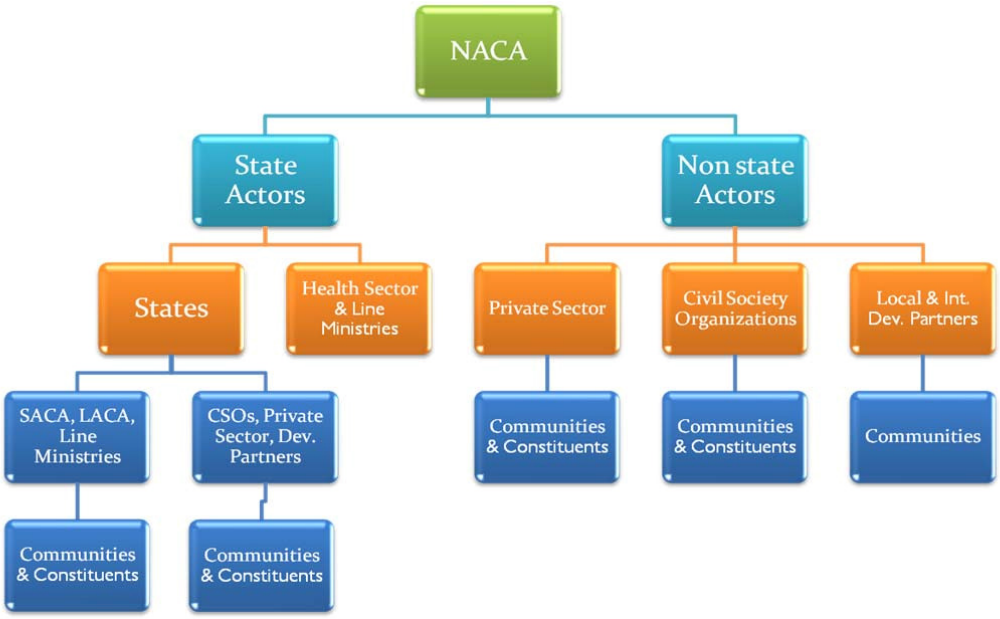
C. Coordinating Structures

The national response in Nigeria is coordinated through a system involving state and non-state sectors. NACA leads the coordination at national level, with the FMoH responsible for coordinating the health sector component of the response while other line ministries are responsible for coordinating other inter-related thematic areas.

Non-state actors are involved in key aspects of the response including resource mobilization, advocacy, demand creation and equity. NACA interfaces with representation from key stakeholders to broaden the coordination reach and effectiveness. These include NACA-SACA, NACA-Civil Society organizations (CSO's), NACA-private sector, NACA-public sector and NACA-development partner and NACA-TWG interactions. In line with the tenets of the PCRP, this coordination mechanism while being utilized for implementation of the PCRP will be strengthened with the introduction of a management and funding model that encourages greater state level involvement, transparency and accountability.

Technical working groups were established to plan and provide technical advice on thematic areas. Civil society coordination arrangements were also established. These took the form of Constituency Coordinating Entities (CCEs). Line Ministries also established HIV/AIDS responses and the private for profit business sector were organized into a response entity called the Nigeria Business Coalition against AIDS (NIBUCCA). The coordinating units are responsible for reporting on what other stakeholders are implementing to NACA. The response is accountable to the National AIDS Council that meets annually with all SACAs, Sectors, and Country Coordination Entities in line with the mandate in 2007 Act that set up NACA. There is also the HIV/AIDS Committee in the National Assembly and the AIDS Tuberculosis and Malaria Committee of the House of Representatives. These bodies all play roles as coordination and accountability structures for the response.

Figure 9 - Coordinating Structures of the National HIV/AIDS Response



National Level Coordination and Interface

NACA is mandated to provide overall coordination of the national response while SACAs and LACAs ensure the same in states and LGAs respectively. This responsibility entails establishing and sustaining relationships with diverse state and non-state actors at multiple levels. The definition, maintenance and sustenance of relationships between NACA and stakeholders remain a critical challenge. Currently NACA interfaces in five domains: SACA, CSO, private sector, and public sector and development partners.

NACA has also established interactive platforms with SACAs such as the biennial NACA-SACA forum, the NACA-SACA Resolution Workshops on state issues, NACA Technical Assistance (2009-2010) funded by DFID to support capacity building in SACAs; and lessons learned dissemination workshops of Enhanced National Response (ENR) Project. NACA also conducted advocacy visits to various arms of government to build support for the transformation of SACAs to agencies as well as provided technical, financial and managerial oversight for World Bank HIV/AIDS Funds (HAF) projects in several states. Technical Working Groups (TWGs) were established to coordinate joint planning and technical support for critical issues such as M&E and Gender.

Vision of NACA

- To be a cutting edge organization in the coordination, policy research, monitoring and facilitating of HIV&AIDS interventions in Africa.

Mission of NACA

- To continuously undertake and facilitate the coordination of programmes to contain the HIV/AIDS pandemic in Nigeria through planning, M & E, advocacy and resource mobilization.

Mandate of NACA

- Coordinate and plan identified multi sectoral HIV&AIDS activities of the National Response;
- Facilitate the engagement of all tiers of government on issues of HIV&AIDS;
- Advocate for the mainstreaming of HIV&AIDS interventions into all sectors of the society;
- Develop and periodically update the Strategic Plan of the National Response Programme;
- Provide leadership in the formulation of policies and sector-specific guidelines on HIV&AIDS;
- Establish mechanisms to support HIV&AIDS research in the country;

- Mobilize resources (local and foreign) and coordinate its equitable application for HIV&AIDS activities;
- Develop its own capacity and facilitate the development of other stakeholders' capacity;
- Provide linkages with the global community on HIV&AIDS; and
- Monitor and evaluate all HIV&AIDS activities.

State level coordination and interface

At the state level, the State Agencies for the control of AIDS are responsible for the coordination of the multi sectoral response to HIV/AIDS. SACAs have similar structure as NACA. In the early stages of the HIV/AIDS response in the country the SACAs were established as adhoc committees then known as state action committees on AIDS. In an effort to make them more sustainable structures and to ensure better coordination at the state level all SACAs have been transformed into agencies as at 2013. NACA along with her donors and international partners provides technical support to the SACAs at the state level while the SACAs, SASCP (NASCP equivalent at the state level) and implementing partners working at the state level provide technical support to the LACAs and lower levels. SACAs also coordinate joint planning at the state level by all the relevant stakeholders.

At the LGA level the Local action committee on AIDS (LACA) have similar broad mandate as NACA and SACAs to coordinate the HIV/AIDS response. As at 2013, 538 of 774 (70%) LGAs in the country have established LACAs to coordinate the response at that level.

Civil Society Organizations Interface

NACA facilitated the formation, funding, and capacity building of CSOs into constituent coordinating entities. These CSOs have had active involvement in the development of the multi-sectoral strategy. Their involvement include the review of the national HIV/AIDS Policy, participation in the NSP development, work with the House Committee on HIV/AIDS Civil, and advocacy and subsequent participation in the review of the NSF II. They have also actively participated in the planning and budgeting process for the NSP on HIV both at the state and national level. Civil Society Network for HIV and AIDS in Nigeria (CiSHAN) and Network of People Living HIV/AIDS in Nigeria (NEPWHAN), and youth networks.

Furthermore, NACA created a platform for CSO interaction and partnerships with donors. CSO networks and constituent coordinating entities that NACA has facilitated their development have become viable platforms for program activities. These networks have become recognized as critical players in the national response. For example, CiSHAN has a membership of over 3000 affiliate CSOs with six large constituencies.

Throughout this network, CSOs have participated robustly in advocacy, program planning and implementation with national, state and development partners at all levels. Their activities in the areas of HIV prevention, treatment, support and care are included in the national HIV strategy, budget and reports; however, they still lack the capacity to source for domestic/international funds. Faith based interventions leveraged the wide network of faith based advocacy and care providing institutions in communities to provide prevention, care, treatment and impact mitigation interventions. In this regard, a National Faith-Based Advisory Committee comprising Christians and Muslims was established by NACA to facilitate coordination of Faith Based Response component of NSF.

Coordination of Private Sector Response

Private response in the national response is relatively recent and remains largely untapped. The Public-Private Partnership Forum was established to organize and leverage the vast pool of resources and competencies in this highly organized sector to strengthen the national response. Workplace programs including prevention and treatment have been initiated in about 39 multi-national companies through the Nigeria Business Coalition against HIV and AIDS (NIBUCCA).

In addition, companies supported outreach programs to the public embedded in Corporate Social Portfolios either directly or through partnerships with local organizations. Small and Medium Scale Enterprises Development Agency (SMEDAN), Trade Union Congress (TUC) and National Association of Traders also have some HIV/AIDS program particularly at the national level and have been engaging with NACA.

The private sector has supported the development of structures that NACA has identified as benefits to the national response. These include:

- The Airtel, Etisalat, Access Bank and Skye Bank and other partners' support for the hosting of National Call Centre on HIV/AIDS & Related Diseases (approximately N10million).
- Support for the provision of comprehensive HIV prevention treatment, care and support in five oil-producing states by Shell Petroleum Development Corporation through the NiDAR project (approximately $3 million).
- Capacity building for HIV prevention services in the six geopolitical zones of Nigeria through the Chevron SME Project (approximately N59.5 million).
- Provision of comprehensive HIV prevention, treatment and care services in the Bonny Island through the Ibanise HIV/AIDS Initiative, conducted through the collaboration of SPDC, Exxonmobil and NLNG (approximately $1.85 million).

Coordination of Non-Health Public Sector Response

Thirty-one Federal ministries, departments and agencies are implementing HIV/AIDS activities which are convergent with their mandates. Most states also have line ministries and agencies' response. NACA's Program coordination department provides oversight for public sector activities including allocation and disbursement of funds such as the disbursement of funds to selected line ministries between 2002 and 2007 from the World Bank Multi-country AIDS Program (MAP). These ministries, departments and agencies in line with standards developed by NACA established HIV/AIDS critical mass teams to coordinate the HIV/AIDS response activities of the MDAs.

NACA supports the critical mass teams in planning, implementation as well as monitoring and evaluation of their HIV/AIDS response activities. Activities of the MDAs are tailored to suit their core competence or mandates and these activities target the internal domain i.e. staff of the MDA and the external domain targeting family, friends and other persons. For instance the target group for Ministry of Education would be their staff of the ministry and schools for which they coordinate the provision and supervision of educational services in line with the mandate establishing the ministry and dependents of these staff.

Under the World Bank HIV/AIDS Development Project (HPDP) II NACA and SACA plans to engage with and support the implementation of HIV/AIDS activities of some of these MDAs at the Federal and state level as well as LACAs at the state level.

Achievements in the non-health sector response include the development of National Orphans and Vulnerable Children (OVC) policy, the OVC Action Plan and the Standard Operation Procedures by the Ministry of Women's Affairs and Social Development; the development and distribution of Behaviour Change Communications (BCC) materials by the Ministry of Information and IEC materials targeting long-distance and transport fleet workers by the Ministry for Transport.

Significantly, the HIV/AIDS response in the security forces is ahead of other public sector responses. The Armed Forces Program on AIDS Control (AFPAC) and the Prison Services developed expanded HIV/AIDS responses for their respective services; AFPAC covers the entire armed forces Army, Navy, and Air Force. These activities are supported by the United States Department of Defence. In 2013, NACA, with support from implementing partners developed monitoring tools for Family Life HIV/AIDS Education (FLHE), Home-Based Care (HBC) and Orphan and Vulnerable Children (OVC).

Promotion of Behavior Change and Prevention of New Infections

The HIV Prevention response is coordinated at the national level by the National Prevention Technical Working Group (NPTWG), chaired by NACA and at the state level, by the state prevention technical working group hosted by SACA. Other TWGs reporting to the NPTWG are the BCC TWG, the HCT TWG. These groups met regularly in 2010 and 2011, developed the 2010-2012 National Prevention plan, and have produced an annual work plan since 2010. They developed a data capturing tool (PITT) for the national HIV prevention programme. These groups, with support from the Strategic Knowledge Management (SKM) TWG, in 2013 also developed standard National Prevention Monitoring tools for MARPs intervention programs.

Sub themes of this thematic area in the NSP include: HIV/AIDS counseling and testing, STI treatment, Prevention of mother to child transmission, behaviour change communication for MARPS and general population; condom programming; and post-exposure prophylaxis (PEP)

HIV Counseling and Testing

HCT is an important entry point for most forms of HIV and AIDS prevention and control interventions including PMTCT, treatment and care. It also constitutes a good platform for linkage between sexual and reproductive health services and HIV/AIDS related programs.

The percentage of persons that received an HIV test in the past 12 months is usually used as an indicator of the proportion of people who currently know their HIV status. Overall, the uptake of HCT is still low among the Nigerian population even though the proportion of people who had tested and received their results had doubled between 2003 and 2012.

According to the NARHS 2012, 23.5% of male and 29.2% of female reported ever tested for HIV. Out of this group, only 63% of female and 68% of males that tested for HIV received their results and know their status. Thirty-Six percent of respondents' aged 15 to 19 and 42.6% of those aged 20 -24 reported having an HIV test in the last 12 months. This shows that a lot more needs to be done to increase uptake of counseling and testing in order to achieve the access target for this objective.

Figure 10: Number of HCT sites in the country 2009-2013

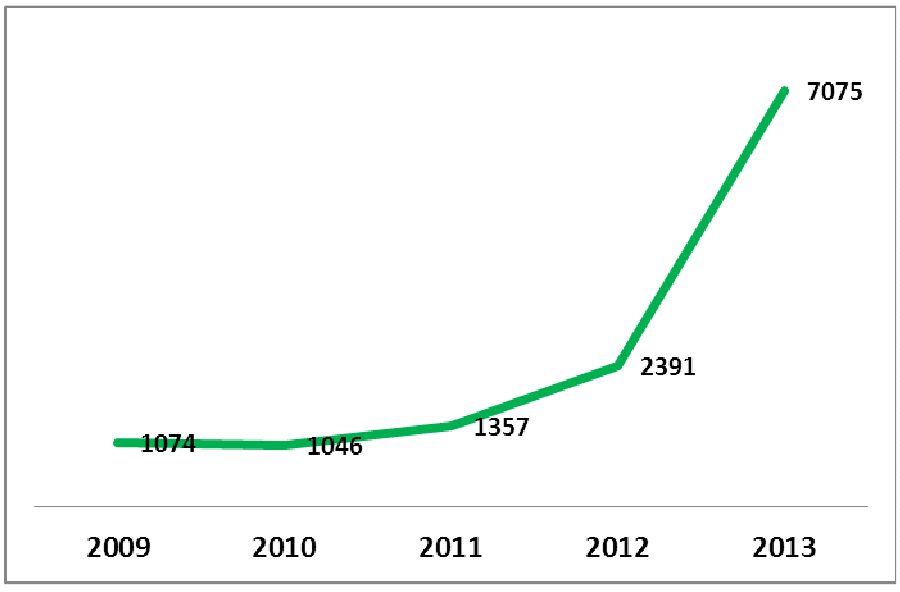
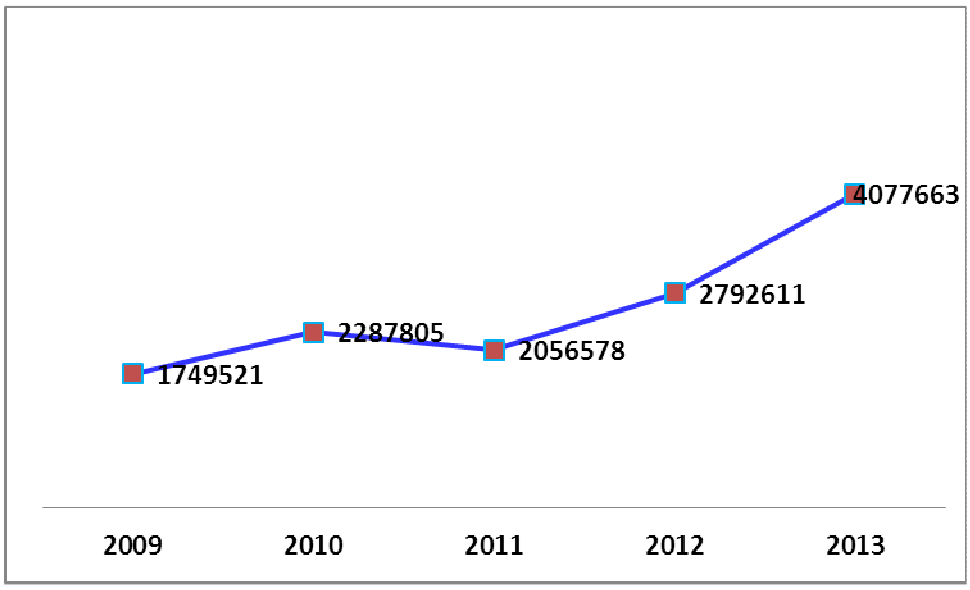


Figure 11: Number of Individuals Counseled, tested and Received Results 2009-2013



As at December 2013, the number of women and men aged 15 and older who received HIV testing and counseling in the past 12 months and know their results was 4,077,663. This demonstrated a more than fifty percent increase in the number of persons counseled, tested and received results in 2012.

Also in 2013, the number of HCT sites increased by 34% from 2391 in 2012 to 7075 in 2013. In spite of this increase, the proportion of the general population who has accessed HCT still remains low. Challenges faced by the HCT program in Nigeria include: Shortage of HIV test kits; weak supply chain and logistics management; wrong public perception that HCT is only useful for the diagnosis and management of HIV positive clients and low HIV risk perception and the stigma associated with HIV infection.

Some measures put in place to address these challenges and ensure access to and uptake of HCT services is scaled up include ensuring that the program offers several models of delivering HCT service and that the services are located as near to people and sub-populations as possible. Measures are also being put in place to strengthen logistic and supply chain systems to ensure steady flow of commodities especially HIV test kits.

Other strategies include the following:

- Support for DOTS/HCT integration by development partners are in progress with HCT integration into standalone DOTS centers across the country.

- Institutional efforts have been targeted at promoting the uptake of Couple Counseling and Testing (CCT). An assessment of two sample programmes showed that most couples accessed this service as a pre-condition for marriage rites and some because it is actively promoted as a component of their PMTCT services.

- The national HCT guidelines advocates for the promotion and use of Provider Initiated Counseling to increase HCT uptake. The FMoH issued a formal letter on PITC and the need for routine testing of patients based on an "opt-out" approach to facilities in 2009. While some health facilities implement PITC as a common practice and it remains directed by individual health care provider interest in others, there is still no known facility in the country that has instituted a policy on PITC.

Sexually Transmitted Infections

The poor management of STI is well recognized as a contributory factor to HIV infection, especially for men. Secondary data analysis of the 2010 IBBSS results shows a high association between reports of STI symptoms and HIV infection. Prior studies have established a relationship between STI and HIV infection with STIs being a well-recognized risk factor for HIV infection at the individual level. These data further heighten the need for public education about diagnosis and appropriate management of STI infections especially for men.

The 2007 – 2012 Ward Minimum Health Care Package strategy, developed by the National Primary Health Care Development Agency (NPHCDA) includes Control of Communicable Diseases (Malaria, STI/HIV/AIDS, and TB) as a component with 5.7% of all PHCs in the country providing all its components. The expectation is that a larger number of PHCs provide STI services even if they do not provide other components. It is also assumed that all tertiary care centres and some of the secondary care centers in the country will have the capacity to 'appropriately' diagnose and treat patients with STI.

Table 4: Percentage Distribution of Respondents According to Sources of Treatment during Last Episode of STI Symptoms According to Selected Characteristics; FMOH, Nigeria, 2012

Characteristics	Govt. health facility	Workplace Health facility	Faith-based Health facility	Private Health facility	Pharmacy	Traditional Healers	Patent Medicine Store
Sex							
Female	24.1	4.1	1.5	10.2	7.6	9.9	14.7
Male	16.5	5.1	2.9	9.4	8.3	13.4	14.8
Location							
Rural	20.7	3.8	1.6	8.2	8.1	12.9	14.3
Urban	23.3	5.9	2.8	13.6	7.4	7.1	16.0
Total	21.5	4.4	2.0	9.9	7.9	11.1	14.8

Source: NARHS+ 2012, FMoH

From table 3.1, 24% of female and 17% of male respondents preferred Government Health Facility to other sources of treatment of STI. With about 15% of respondents with STIs reporting use of patent medicine store for treatment and 8% reporting use of pharmacy for the same purpose, intervention to improve the management practice of the operators of these facilities is important particularly focusing on syndromic management, counselling and appropriate referral.

Behavioural Change Communication among Young People

The country's HIV prevention approach for adolescent and youths involves the use of Family Life and HIV Education (FLHE) training curriculum and peer education as a co-curricular strategy. With support from Global Round 9, the Federal Ministry of Education, in collaboration with State Ministries of Education and State Universal Basic Education Board (SUBEB) HIV&AIDS desk officers, 80 master trainers from 36 states were trained in 2011. These trainers in turn trained 5,432 teachers from 791 schools. About 250,973 students have since been reached. FLHE has since then been mainstreamed into the teachers training curriculum.

1n 2013, a total of 37 CBOs were reached and trained by NYNETHA, through support from the Global Fund round 9. NYNETHA also developed programmes to target out-of-school youths in 37 states and FCT through the engagement of the CBOs. About 1.8% of the total targets were reached with the MPPI approach. As at October 2013, 1110 youths have been reached with this programme.

In 2013, CISHAN and AONN trained 92 providers of OVC services across six states of the federation, including three CBOs per state. No records were kept on the number of out-of-school youths reached.

Interpersonal Communication (IPC) intervention approach was used to reach the general population with information on HIV. The Enhancing Nigeria's Response (ENR) to HIV programme funded by DFID reached a total of 1,947,737 males and 1,656,597 females in 2013 with behavioral change messages on HIV prevention in ENR supported states, across all the geopolitical zones in the country.

NACA, in collaboration with its partners, designed HIV education programmes that could impact on the behavior of community of persons who engage in high risk behaviors. This includes the development and production of prototype BCC messages and materials for prevention by the National Prevention TWG and airing of HIV prevention messages.

Behavior Change Communication among MARPs

The 2010-2015 National HIV Strategic Plan emphasizes behavior change communication for HIV prevention among MARPs. NACA and its partners have developed the PEP model for peer educator training among these populations. Part of this model is the Minimum Prevention Package Intervention, which uses social networking approaches to reach hidden and stigmatized groups and establishes referral systems to health services in MARP-friendly clinics. Specialized MARPs friendly training and capacity building are conducted for private and public sector healthcare service providers.

Prevention of Mother to Child Transmission (PMTCT) of HIV

The PMTCT program in Nigeria commenced in July 2002 in six tertiary facilities in the six geopolitical zones of the country. With the support of key development donors and partners such as UNICEF and the Center for Diseases Control (CDC) this was then scaled up to 11 by the end of 2003. With massive support from PEPFAR and the GFATM the number of sites has so far increased to 5767 as at December 2013. . Nigeria is committed to the goal of eliminating MTCT by 2015 and has consistently pursued this goal. In line with this goal the The Health Sector Plan and the 2010 National PMTCT guidelines articulate clear strategies to accelerate the expansion and strengthening of PMTCT services through decentralization and integrated service delivery at the PHCs. In 2012, a PMTCT scale-up plan was developed to support the acceleration of PMTCT programming at the state level starting with the 12+1 priority states: Abia, Akwa Ibom, Anambra, Bayelsa, Benue, Cross-Rivers, Kaduna, Kano, FCT, Lagos, Nassarawa, Plateau and Rivers, which together bear 70% of the burden of the epidemic and have consistently shown a high HIV prevalence.

Routine data in 2013 from PMTCT services in the country showed that, the number of pregnant women counseled, tested and received results, increased from 1,120,178 in 2011 to 1,706,524 in 2013. This represents an improvement from 2010 when only 907,387 pregnant women were counseled, tested and received their result. The number of HIV pregnant women who received ARV prophylaxis to prevent MTCT increased from 40,097 in 2012 to 57,871 in 2013. Also there has been a marked increase in the number of HIV positive pregnant women who received family planning counseling from 47,880 in 2012 to 54,867 in 2013, representing a 15% increase. Number of partners of HIV positive women who tested negative increased from 2,927 in 2012 to 4,828 in 2013.

However based on 2014 estimates the coverage for PMTCT still remains low at 30.1% even though it has increased from the previous coverage of 25.9% in 2012. Challenges being experienced with the PMTCT program in Nigeria include: inadequate uptake of PMTCT services by pregnant women; minimal male involvement and poor community participation in PMTCT and inadequate number of EID facilities in the country.

Efforts at strengthening the PMTCT programme in Nigeria include the following: Improved coordination of all relevant partners; accelerate implementation of the PMTCT

scale up plan; demand creation; promote greater community involvement and in particular integrate TBAs care for pregnant women as part of the national effort to address PMTCT.

Figure 12: Number of PMTCT sites in the country 2009-2013

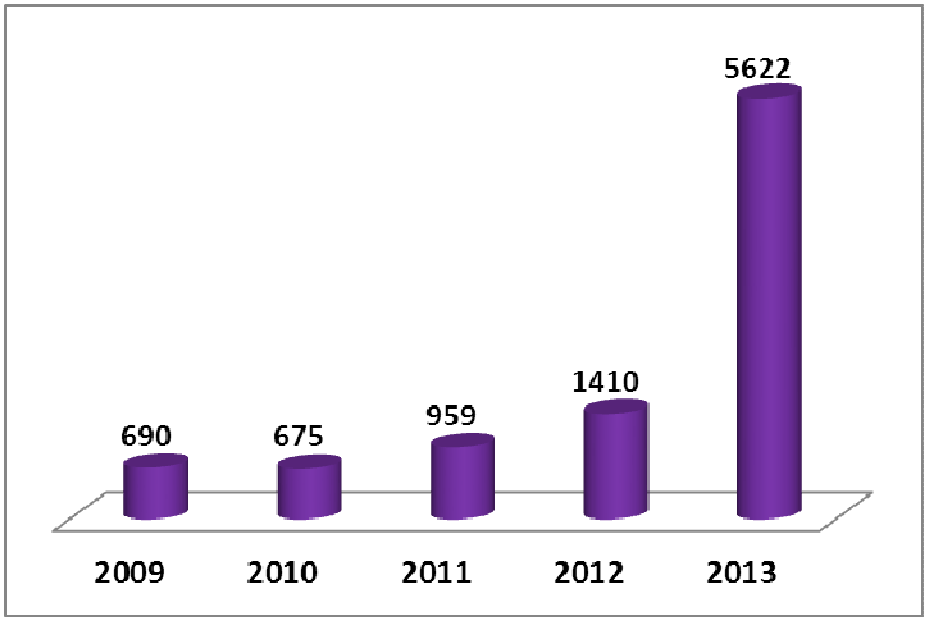
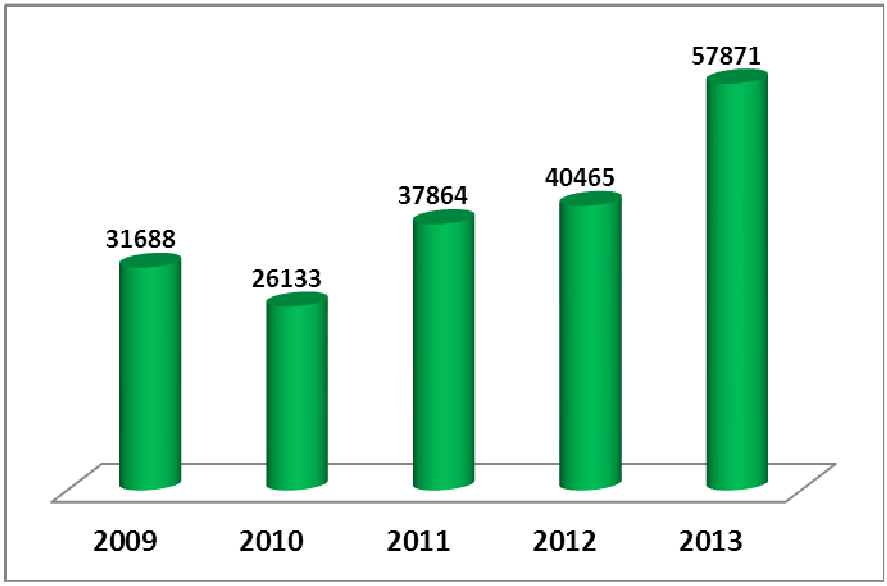


Figure 13: Number of HIV pregnant women received ARV prophylaxis in the country 2009-2013



Condom Programming

Condoms play a pivotal role in preventing HIV infection and other STIs. The goal of condom programming is to ensure that sexually active persons at risk of HIV and other

STIs are motivated to use condoms, have easy access to quality condoms and are able to use them consistently and correctly.

In 2013, 178,399,300 male condoms, 408,672 female condoms and 173,460 lubricants were distributed by Society for Family Health through the social marketing program. The Federal Ministry of Health and other NGOs also distributed some condoms. Key to the success of the distribution of female condoms was the effectiveness of its entry method and social marketing in raising awareness.

For sex workers, condom use has remained high among female sex workers (92.9% at last sex with client) and percentage of MSMs selling sex that used a condom the last time they had anal sex with a paying partner was 54.7%. Consistent condom use with clients remained high as well for female sex workers in 2010 and remained very low (20.7% for BBFSW; 26.1% for NBBFSW) with boyfriends.

Biomedical Transmission of HIV

Blood transfusion and unsafe medical injections are some of the means of HIV transmission. According to MOT 2010 report, blood transfusions and unsafe injection practices contributed to 0.5% and 1.2% of new HIV infections in 2010 respectively.

Blood transfusion services reported that 100% of blood collected in 2009 were screened for Transfusion transmissible infections (TTIs), state blood transfusion services do not use antigen tests to screen blood, so they do not guarantee 100% safety unlike their national counterparts.

Many health facilities operated inadequate environmentally acceptable healthcare waste management programmes, uptake of HBV vaccination among waste handlers was poor (39%), and hand washing with soap and running water was low (23%) prior to sustained intervention. Universal precautions are also poorly adhered too. There are current legislative frameworks and guidelines for safe blood practices. However, there are no guidelines on the clinical use of blood and blood products. There is also no system for collection of blood safety data from all the public and private facilities in Nigeria where organ transplant, and blood and blood product use occur. There are thus, existing challenges to ensuring biomedical transmission of HIV is completely eradicated.

The widespread availability of sterile needles/syringes at pharmacies and patent medicine stores makes needle sharing not a major route of HIV transmission in the IDU community in Nigeria (9). About 83% of IDUs use clean sterile needle. However, there is no active national HIV programme targeting IDUs.

There are no concrete public engagement programmes that promote post exposure prophylaxis (PEP) access by the general public. PEP provision is still limited to about 20% of health facilities. In 2011, all the 491 ART sites were able to provide PEP to those in need though very few have PEP programmes in place. There are no concrete programmes and guidelines on PEP, male circumcision and future microbicide and HIV vaccine access beyond its mention in the NPP 2010-2012. Since 2012, increased campaign has been mounted and programmes put in place by NACA towards addressing this gap. On the other hand, there have been significant

efforts in the field by CSOs to promote community understanding and involvement with NPT trial. These efforts have however, been concentrated in Southern Nigeria.

Treatment of HIV and related Health complications

Antiretroviral therapy prevents AIDS-related illness and death and has been shown to have the potential to significantly reduce the risk of HIV transmission and the spread of tuberculosis. Treatment is not limited to ART access. Management of opportunistic infections, screening of those with TB for HIV infection and vice versa, and the placement of PLHIV on co-trimoxazole and INH are efforts targeted at reducing the risk for opportunistic infections in PLHIV and all part of the overall treatment programme.

The ART program in Nigeria commenced in 2002 in 25 sites across 18 states in the country. In 2006 the Federal Government of Nigeria later introduced the free ARV treatment policy for all eligible persons in 2006 and since then the ART program has witnessed massive scale up in the number of sites providing ART services and in terms of the number currently receiving treatment. For instance the number of sites providing ART has increased from the 25 sites in 18 states in 2002 to 820 in 2013 and spanning all 36 states + FCT. Also the number of adults and children currently receiving ART has increased to 639,837 persons as at 2013. This increased availability and use of cost effective antiretroviral drugs has had significant impact on the public perception of the disease, access to prevention services, disease transmission and occurrence of OIs, quality of life and life expectancy of people living with HIV.

Figure 14: Number of ART sites in the country 2009-2013

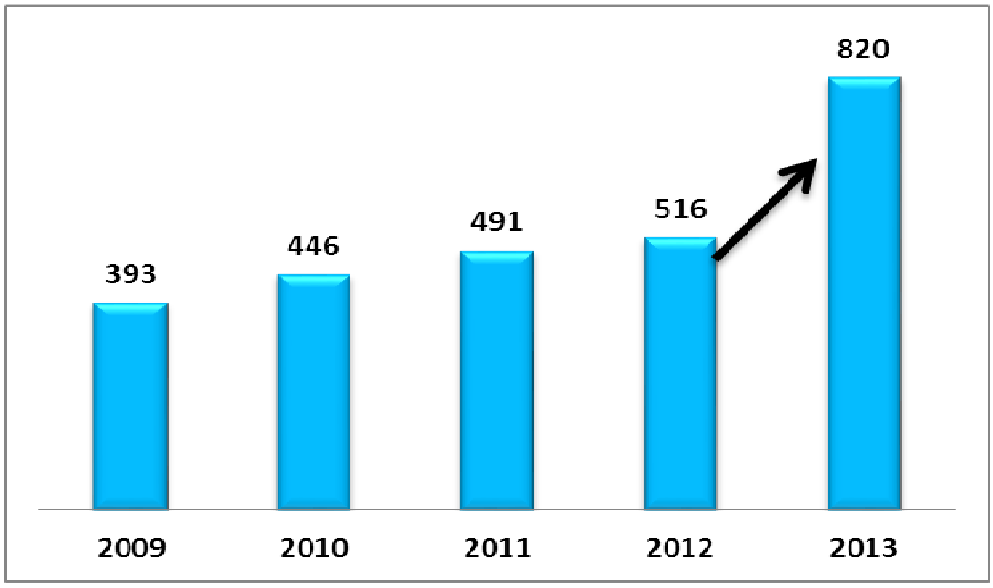
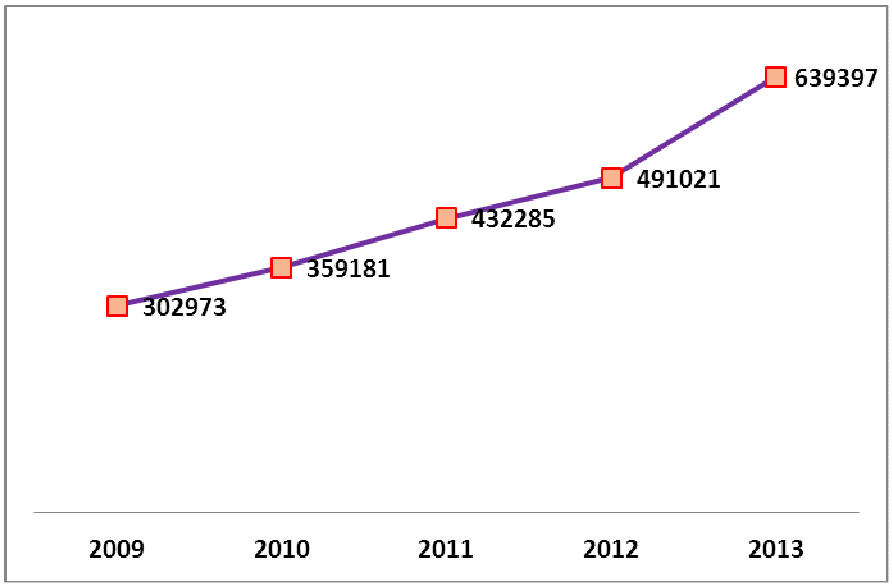


Figure 15: Number of adults and children currently receiving ART in the country 2009-2013



This scale up of ART has ensured that the provision of comprehensive ART services has moved from being mostly tertiary hospital based to secondary and even some primary health care facilities. Over the years the Government has initiated the decentralization of ART services to the primary health care level towards increasing access to ART for eligible persons. This decentralization process designates PHCs as ART refill centers and integrates the delivery of this service into the routines of healthcare workers already employed at the PHCs. Nurses and Community Health workers at these PHCs do not initiate patients on ART but they perform rapid HIV screening and are also able to provide support services for those already initiated on ART.

Co-Management of TB and HIV is fundamental in reducing the transmission of multi drug resistant TB forms and improving survival rates for PABA. Compliance with the 2010 national guidelines that requires that all HIV-infected individuals with active TB, irrespective of the CD4 count be initiated on ARV remains poor. As at the end of 2013, 11,153 of HIV positive individuals received treatment for both HIV and TB. There are a number of stand-alone DOTS sites that mean that intra-facility and inter-facility linkages are required for effective referrals.

In 2013, 4712 (2.5%) of the newly enrolled ART individuals (185,708) started IPT treatment using INH. This is a significant improvement from 2011, when only 969 (0.5%) of the newly enrolled PLHIV (183,866) started Isoniazid Preventive Therapy (IPT). Currently, most ART sites do not offer IPT. Many physicians are also reluctant to prescribe IPT due to difficulties with diagnosis of active TB and fear of INH resistance. As at December 2013, many Implementing Partners (IPs) were scaling up IPT delivery.

Despite these achievements in the ART program there are still gaps and some of which include: inadequate access to ART by children; weak referral between community and facilities providing ART services; weak procurement and supply chain management; insufficient number of human resources; Poor linkages of DOT sites with ART sites;

variation in quality of care and treatment services and low level of collaboration and engagement with the private sector.

The Federal Government of Nigeria and her donor partners in the HIV response are working together to further scale up ART services in the country; improve coordination of the ART programme; strengthen health systems in general; define and monitor standards of care and treatment; strengthen referral; encourage task shifting among health workers as well as improve collaboration with vertical programs.

Care and Support of people infected and affected by HIV/AIDS including OVC

Women and girls are more vulnerable to infection and bear the burden of care for infected family and community members. Though they provide care for other members of their immediate and extended families and many women living with HIV/AIDS themselves do not have access to adequate care and support. Similarly HIV/AIDS has been identified as one of the major causes of orphaning in Nigeria. The magnitude of the burden of caring for people infected by HIV/AIDS as well as those affected by it including orphans and vulnerable children (OVC) cannot be ignored. The NSP 20102015 recognizes this and as such people infected and affected by HIV/AIDS including OVC are a major group targeted for the HIV/AIDS response.

HIV/AIDS Care and support involves the provision of palliative care and support to PLHIV and their families and the provision of social protection to OVC. In Nigeria the Hub and Spoke Network Model (cluster system) enables a continuum of care to be provided for PLHIV and PABA in the communities. The model consists of one treatment center, two HCT centers and two support groups of PLHIV providing treatment adherence, stigma reduction and generating uptake for HCT services, five CBO providing HBC services, and one CBO providing OVC services. Outside the cluster model, CSOs, trained HBC officers, PHC officers, youth groups and PLWHA support groups help to mobilize PLHIV to receive care.

The 2003 Child Rights Act (CRA), in combination with the National Plan of Action for OVCs and the National Child Policy provides a legal framework for the implementation of services for orphans and vulnerable children in Nigeria. The Ministry of Women Affairs and Social Development at both the Federal and state level coordinates the OVC response. The Federal Ministry of Women and Social Development (FMWASD) also chair the coordination platforms for the National OVC response. These platforms include the National OVC Steering Committee and the National Technical Coordinating Group (NTCG). Implementation of OVC programmes have also been significantly supported by external support from PEPFAR and the Global Fund Rounds 5 and 9, with PEPFAR supported IPs providing legal assistance and protective care services to OVCs in 2012 /2013

A Child Protection Networks (CPN), funded by UNICEF, has been established in 23 States and the FCT. They serve to engage a diverse range of interested organizations in monitoring, reporting and responding to child protection abuses, as well as providing legal aid for children in conflict and in contact with the law..

There have also been various state level efforts at supporting OVCs, for example, the provision of food and nutrition services to OVCs and PLHIV in Kaduna state, the provision of food and nutrition services and skills acquisition to OVCs in Taraba state.

Organizations like AONN (Association for Orphans and Vulnerable Children in Nigeria), Pact-REACH, MSH to mention a few have all contributed in alleviating the growing population of OVC in Nigeria. For example **CUBS(community based orphans and vulnerable children)an MSH project** in partnership with Africare provides support for Federal and State Ministry of Women Affairs and Social Development and the Local government Area social welfare units and building capacity of community based organizations to provide service to vulnerable children.

CUBS worked in 38 CSO's to form the child protection committees (CPCs) tasked with protecting and improving the well-being of vulnerable children in their communities. Each CSO recruited 10 to 15 leaders from traditional ruling councils, Landlord associations, religious groups and market associations to form their committees. CUBS trained these leaders in advocacy leadership, community and resource mobilization, child protection and OVC needs.

By December 2013, CUBS have trained 14,000 caregivers and provided sub-grant to 38 CSOs to provide services to 50,000 vulnerable children. It has strengthened community based vulnerable children service delivery and supported the CSO's to initiate and or reactivate the child protection and vulnerable children intervention projects in 11 focal states (Akwa Ibom, Bayelsa, Delta, Rivers, Gombe, Taraba, Kebbi, Sokoto, Ekiti, Enugu, and Imo). It helped the CSO's to develop their operational policies and procedures and conduct an analysis of the challenges faced by vulnerable children. CUBS also implemented income generating activities to support female heads of household with vulnerable children.

Section Four: Best Practices

Nigeria has been steadfast in its commitments to strengthen its response to the HIV and AIDS epidemic through the implementation of multi-sectoral comprehensive intervention programs. The same commitment has been replicated in several NGOs and CSOs which have over time initiated programs that propagate grassroots and advocacy efforts aimed at curbing the spread of the epidemic; and may possibly evolve into best practices. The programs below have been identified as best practices by the organizations which implement them at various levels. Though varied they all present a consolidated and innovative effort in HIV prevention, treatment, care and support.

Coordination at National and Sub-National Levels

Response to HIV and AIDS in Nigeria has been through a growing and expanding coordination mechanism. The National Agency for the Control of AIDS and the State-level counterparts has continued to use this mechanism to carry out their functions effectively. At the national level, there are Technical Working Groups (TWGs) comprising relevant MDAs and partners in all intervention areas which are replicated at the state level. The TWGs provide advisory oversight to government implementing agencies. Activities of the TWGs are therefore coordinated through regular interactions and technical meetings. For example, at the national level, the M&E TWG was restructured for improved performance. During the period under review, all meetings of the national M&E TWG featured the presence of selected state level M&E TWG in order to be updated and to provide opportunities for shared experience which can in turn be implemented at their level.

Program Implementation through partnerships

Cooperative relationships among stakeholders in order to share responsibilities for implementation in different areas of interventions featured prominently during the period under review. For example, there exist government-government partnership, government-donor partnership, and government-implementing agencies partnership at national and sub-national levels. There also exist a great level of partnership among implementing partners leading to reduced cost of implementation, reduced duplication of efforts, synergistic accomplishments and overall successes in programme implementation.

The President's HIV/AIDS Comprehensive Response Plan

This is the first ever in the history of Nigeria. The Nigerian President in collaboration with the Health Minister and health professionals have established a two year comprehensive response plan targeting HIV/AIDs in Nigeria. The comprehensive plan

was developed in response to an evident concern within the HIV/AIDS stakeholders' community about the existing gap towards achieving global target for service uptake. The plan provides an opportunity for all stakeholders to join hands in the fight of HIV/AIDs.

This plan intends to prevent 105,000 infections and save 46,000 lives in 2 years by providing universal access to comprehensive HIV prevention, treatment and care and support services.

ESTABLISHMENT OF NATIONAL HIV/AIDS RESOURCE CENTRE (NHRC)

The National HIV/AIDS Resource Centre (NHRC) of Nigeria was established as a centralized platform to generate, share and use information strategically by all stakeholders within the HIV and AIDS National Response. It serves as a reference point for authentic, appropriate and viable information in different contents and categories for all HIV/AIDS research topics. The NHRC houses a comprehensive data base of information generated in Nigeria in the area of HIV/AIDS and allied areas to facilitate easy online access and use by the administrators, policy makers, research scholars, health care professionals, programme personnel and the general public. The centre comprises of a physical library and an online virtual network with automised search engines housing research outcomes, reports and training manuals.

The establishment of the NHRC in Nigeria has greatly enhanced access to strategic information and research findings in Nigeria. Between January and September 2013, a total of 1676 users were provided with vital resources and assisted in research activities by staff of the NHRC.

Shaping the Nigeria HIV Response programming landscape at sub-national level (States and LGAs) towards increased ownership and sustainability effort

Nigeria HIV Response programming landscape is fast evolving in terms of its effectiveness and efficiency in addressing equity, delivering highly efficacious interventions and establishing one M&E systems at sub-national level. This is due to increased political leadership on the part of the Government and her agencies as well as better technical coordination on the part of technical capacity building organizations (TCBOs) and donors at the national and sub-national level. This development is now leading towards increased sense of ownership and propensity for sustainability of those systems created by implementing partners to both plan, deliver and manage large scale comprehensive HIV and AIDS prevention, care and treatment programs.

Before 2012, coordination of technical support to HIV response at states and LGA-level in Nigeria is practically fragmented due to parallel funding mechanisms and pluralization of systems and process for planning, implementing and managing HIV response. This was characterized by huge HIV expenditures and little or no result to show for all the efforts.

With the advent of the Strengthening Integration of HIV and AIDS (SIDHAS) project in 2011 (a project managed by FHI360 and her consortium partner) with funding support from PEPFAR and USAID, Government's leadership and ownership effort in the cross sectional integration of HIV and AIDS services into the general healthcare system was

brought to the fore through the establishment of State Implementation Teams (SITs) and Local Government Area Implementation Teams (LITs) structures. In addition, structures and systems for transitioning technical capacities to these government entities begun with co-location and co-sitting of the TCBO staff with their government counterparts. Routine joint mentoring and integrated supportive supervision visits (ISS) to health facility and community-based efforts were institutionalized.

To further strengthen the cohesion of these technical programming landscape, USG system in Nigeria embarked on streamlining comprehensive HIV prevention, care and treatment implementing partners (IPs) to one IP working in each state so as to engender technical focus required to stimulate government involvement in HIV work, minimize overall HIV programming costs and elimination of duplicity of efforts (i.e. HR, Technical and Financial resources). With SIDHAS project acting as the lead IP in 13 states and co-lead in 2 states, saturation of 8 of the 12 priority states for massive PMTCT scale up was made possible in a well-coordinated manner and in close collaboration with the host governments at the States and LGAs. This has led to: a) the development and roll-out of state-wide evidenced-based eMTCT scale up plan (2012 -2015) for these 8 states, b) Increase in ANC coverage, c) PMTCT service coverage and d) population coverage in relation to estimated numbers of pregnant women in need of ANC and PMTCT services as at the end of 2013.

Due to cross cutting nature of the M&E system required for managing the wide range of public health interventions including HIV and AIDS programs within the health sector, SIDHAS project have engaged other stakeholders and government to commence Integrated Health Data Management Team (IHMDT) approach to collecting and managing routine health data in an integrated manner. The obvious benefits from this IHMDT approach includes: maximization of scarce HR available for M&E system strengthening at LGAs and State-level, cost minimization for the entire data management process and high chance for higher health data reporting rates. However, at the national level this has culminated in the establishment of a single database for all routine health data in the country – all in the spirit of the third-ones principle.

THE NATIONAL CALL CENTRE FOR HIV/AIDS

The National Call Centre on HIV/AIDS and Related Diseases was put together and commissioned by NACA (National Agency for the Control of AIDS) in August, 2012. In collaboration with AIRTEL the centre intends to reach . This is a collaborative project with support from Airtel Network Limited. The establishment of this National Call Centre will go a long way in strengthening our national response to HIV/AIDS, as is the case in other countries of the world, such as South Africa, the Philippines and India, who have used help lines and Call Centres successfully in the fight against the HIV/AIDS pandemic.

The project intends to make available information on HIV/AIDS and other related diseases to the masses by dialling 6222 from an AIRTEL or ETISALAT line.

Since conception till September 2013, 49113 people have accessed the centre in which 13389 were males and 7251 females. A total of 16429 accessed the centre for HIV/AIDS knowledge.

Men and PMTCT in Benue State

In Benue State, as in much of Nigeria, antenatal care is viewed as women's business and men are rarely found in clinics where such care is provided. But men are essential in the effective prevention of mother-to-child transmission (PMTCT) of HIV. In Benue State, PMTCT Site Coordinators wanted to get more men participating in PMTCT Clinics. They set up a rule that women who came to the Family Support Clinic (FSC) for antenatal care with their husbands would be moved up in line and attended to earlier, providing an incentive for women to bring their men to the clinic. This provides clinicians with an opportunity for couples counseling and testing. So far, men involved in the program have been cooperative and children born in the clinic under the programme have all been HIV negative.

Section Five: Major Challenges and Remedial Actions

Progress on Key Challenges from the 2012 GARP report

Several challenges were identified in the 2012 report that the country must work towards in improving the quality and access of HIV/AIDS interventions and services. Progress points on key challenges outlined in the GARPR 2012 are addressed as follows:

1. **Funding Gaps:** Funding gap challenges still exist since the last GARP report was submitted. However government, on the request of the President, recently launched the President's Comprehensive Response Plan on HIV/AIDS (PCRP). This plan, to most part, seeks to reinvigorate the national HIV/AIDS response in Nigeria and importantly to increase domestic spending on the same. The PCRP suggested a total domestic investment of US$1.7 billion for the two year period 2014-15. To which the government has committed the amount US$40 million, as federal contribution, for the first year. The state governments are also expected to match this contribution. The full commitment to the PCRP expenditure will result in over 50% domestic funding for the response.

   On full implementation, the PCRP will result in the following impacts:

   (i) A 40% reduction in new HIV infections (translating into 210,000 new infections averted annually);

   (ii) Increase, by a 100%, of number of persons receiving ART to more than 1 million;

   (iii) A 21% reduction in number of AIDS deaths, to 115,000 annually (translating into 92,000 deaths averted);

   (iv) A more than 80% reduction in mother to child transmission (PCRP proposes placing up to 244,000 women on PMTCT);

   (v) A saving of up to US$1.72 billion in treatment costs alone.

2. **Overdependence on Donor Support:** In 2008, only 7.6% of total funding for HIV/AIDS came from the public sector. The country has strengthened its commitments to funding the national response to the epidemic and in 2010 the proportion of funding for HIV/AIDS rose dramatically to 45.5% of total funding from all sources ($286,658,813), representing a 7-fold increase in funding. The findings of the recently conducted NASA show that the HIV response is still heavily dependent on external contributions (for example 2011 expenditure, Nigeria accounted for 17.8% and 21.4% in 2012).

   This situation is expected to change significantly with the full funding of the PCRP.

3. **Low PMTCT Coverage:** In 2013 PMTCT coverage stood at 57871 representing 30.1% coverage. While the 1,706,524 pregnant women counseled and tested for HIV in 2013 remains overall a distant achievement for targets set for 2012 and the goal of eliminating MTCT in 2015.

4. **Low uptake of HIV Counseling and Testing Services:** As at the end of 2013 only 4,077,663 persons were reported to have been tested for HIV, which falls far below the national access target for Nigeria. In mitigating low uptake of HCT, the PCRP proposes the provision of access and linkages to test as many as 80 million people over a two year period.

Challenges in the Current Reporting Period

Although the country has made substantial efforts and progress in improving the national response to HIV, some challenges still remain. A Joint Annual Review of the National Response to HIV commissioned by NACA in July 2011 identified many of these challenges. Some of the challenges summarized below are sourced from this report:

1. **National Commitment and Policy**
   - The anti- stigmatization and discrimination bill has been passed by the Senate and House of Representatives but remains yet to be signed into law by the president.
   - Although some states have passed the anti-discrimination bill into law in their states, some state law enforcement agencies (Judiciary and Police) are still not aware of the existence of the law.
   - Some of the guidelines in use have not been updated in line with the current scientific and global trends. For instance, the guidelines on syndromic management of STI were last reviewed in 2007.

2. **Institutional Architecture, Systems, Coordination and Resourcing**
   - Linkages of the national response to overall government structures and efforts in other sectors are not well defined in the NSPII e.g. National Economic Empowerment and Development Strategy (NEEDS) and the Millennium Development Goals (MDGs).
   - There is weak coordination structure at the subnational level. There is the need to strengthen the existing 37 coordination and management teams and their mechanisms at the subnational levels to effectively and efficiently manage the response.
   - Limited private sector participation in service delivery and the lack of clear mechanisms for integration of the sector has resulted in little or no information about the sector's contribution to the national response.
   - There is still a gap in the coordination of the national response owing to the differing perspectives and practice demonstrating ownership and clarity of process in implementing the national response. Although there are accountability arrangements between NACA and various implementing partners, the process of integrating the various reporting system is still on-going.

- The national procurement and supply chain management mechanism still faces significant challenges. This is particularly in respect to medical commodities, drugs and laboratory consumables/reagents.
- Maintenance of equipment such as laboratory equipment is an on-going challenge.

3. Low PMTCT Coverage

- PMTCT coverage is still well below desired targets. Only 30.1 % of HIV positive pregnant women received ARV prophylaxis to reduce MTCT in 2013
- There are still very few facilities providing Early Infant Diagnosis (274). The Federal Ministry of Health will need to allocate funding to the establishment of more EID facilities in Nigeria if national targets of 80% of HIV exposed infants having access to EID services in 2015 are to be met.

4. Treatment of HIV/AIDS and Related Health Conditions

- There are still weaknesses in the referral system that contributes to the continual loss of clients between service points.

5. **Care and Support for PLHIV, PABA and OVC**

- The linkage between the FMWASD/SMWASD and basic service sectors (i.e. Health and Education) who are critical stakeholders for OVC response remain weak and a threat to effective response at both national and sub-national levels.

Section Six: Support from the Country's Development Partners

Key support received from development partners

In Nigeria various development partners are present and are equally active in the design, implementation and tracking the HIV response. These include, but are not limited to, the United States government, the World Bank, United Kingdom, the United Nations System, and the Global Fund to Fight AIDS, Tuberculosis and Malaria [GFATM]. The partners have, in collaboration with the government of Nigeria, identified several aspects of the national response that they have been supporting financially and technically. Some of these areas of support include health information management systems, procurement and supply chain management, logistics management, health systems and community systems strengthening, disease management and surveillance, orphan and vulnerable children interventions, data and strategic information management.

A recent expenditure assessment shows that Nigeria received a combined sum of US$861,901,975 over the period of two years (2011 – US$410,556,793 and 2012 – US$451,345,182).

Actions to be taken by development partners for achievement of targets

Beyond financial resources development partners also deploy a significant level of technical expertise at the sub-national and federal levels in Nigeria. These personnel work closely, with Nigerian counterparts, to design, implement and monitor and evaluate relevant components of the national HIV response. The recently launched President's Comprehensive Response Plan (PCRP), the commencement of the integration of National National Response Information Management System (NNRIMS) and the other Health Information Systems to a single platform using DHIS2, the harmonization of drugs and supplies procurement platform (including commodity and equipment purchase), state level HIV estimates, HIV epidemic appraisals on key populations, national HIV/AIDS surveys (e.g. NARHS, NDHS, MICS etc), special studies (e.g. HIV drug resistance) and analyses (ie. Bottleneck analysis on PMTCT services, Deep Dives study etc) are among the various and numerous areas and outputs from the support provided to Nigeria by development partners. Using the findings and the guidance from the above, the development partners and the GoN have proceeded to adjust and align HIV programming to ensure the attainment of national targets in a timely and well-coordinated fashion.

Section Seven: Monitoring &Evaluation

7.1 Overview of the National HIV/AIDS M&E System

Monitoring and Evaluation (M&E) is a key component of the multi-sectoral response to HIV/AIDS in Nigeria**.** Initially, it was done through HIV sentinel surveillance conducted among pregnant women accessing antenatal services in hospitals and clinics in line with global health standards from the World Health Organization. The adoption of the 'three ones' principle led to the development of the country's national HIV/AIDS M&E framework known as the Nigeria National Response Information Management System (NNRIMS) in 2004. NNRIMS is a simple, robust, standardized and unified monitoring and evaluation framework for the national HIV/AIDS response. The purpose of NNRIMS is to track progress in the implementation of the national HIV/AIDS response and use feedback information to improve policies, programs and service delivery in line with the principle of 'three ones'.

HIV/AIDS M&E stakeholders led by the National Agency for the Control of AIDS developed the country's first national M&E plan called the NNRIMS Operational Plan (NOP1) 2007-2010 to track progress of the National Strategic Framework 2005—2009. With the expiration of NOPI and in the face of a dynamic HIV/AIDS epidemic, Nigeria conducted an assessment of the national M&E Framework in 2009 using the 12 components framework of an effective M&E System. This also coincided with the development of a new National Strategic Plan 2010-2015. A new M&E plan called the NNRIMS operational plan (NOPII) 2011-2016 that will be responsive and useful to monitor the progress of the National Strategic Plan 2010-2015 was thus developed in a collaborative process involving all relevant stakeholders.

The goal of the NOPII 2011-2016 was to provide a simple and robust monitoring and evaluation system that will facilitate tracking of progress of the National HIV/AIDS response and the use of information to improve programs, policies and service delivery. This second edition of the M&E plan was therefore aimed at providing and improving the means for NACA to monitor the national response and provide effective leadership in the fight against the epidemic. Likewise, this M&E plan was aimed at strengthening the implementation of the NSP as well as strengthening the sub-national level M&E capacity to coordinate and monitor the activities under the various HIV/AIDS interventions. Data for monitoring and evaluating progress in the HIV/AIDS response was obtained from two main sources: routine data sources and non-routine data sources.

7.2 Routine Data Sources for the National Response

Routine data sources provide data that are collected on a continuous basis, such as information that clinics collect on the clients utilizing their services. Although these data are collected continuously with individual client encounters, the processing, aggregation and reporting on the data usually takes place on a monthly or quarterly basis. When NOP1 was developed standardized national program indicator sets, routine data collection and reporting tools and guidelines were also developed. The review of the national M&E system in 2009 later facilitated the review and harmonization of the existing national response indicators and their associated data collection and reporting tools. Approved national harmonized data collection and reporting tools include the following:

7.2.1 PMTCT data collection and reporting tools

In order to collect service coverage data and to monitor service delivery, a set of six PMTCT registers have been developed. These registers capture appropriate healthcare delivery data required at sites providing PMTCT services and include:

- General antenatal clinic register.
- The HIV/AIDS Counseling and Testing (HCT) Register.
- Partner register.
- The Labor and delivery register.
- Maternal follow-up register.
- Child follow-up register.
- Client Intake Form
- PMTCT Monthly Summary Form

7.2.2 ART Data Collection and Reporting Tools

These consist of a set of nationally approved forms, registers and summary forms that are used to collect data on ART service provision at ART sites. These include:

- HIV/AIDS Care Card
- PMM forms including: Adult initial clinical evaluation form; Pediatric initial clinical evaluation form; Laboratory request and result forms; Pharmacy tools (daily worksheet and monthly worksheets); and Adherence support tools
- Pre-ART register
- ART register
- ART monthly summary forms
- Cohort analysis forms

7.2.3 HCT Data Collection and Reporting tools

- Client Intake Form
- HCT Client Register
- HCT Client Register for Mobile Service

- HIV Request and Result Form
- Combined Report-Requisition and Issue Form - HIV Test Kits
- HIV Testing Worksheet
- HCT Monthly Summary Forms

7.2.4 OVC data collection and reporting tools

- OVC Register
- Initial OVC Assessment forms
- OVC Enrolment form
- Household Assessment form
- OVC Termination form

7.3 Non Routine data sources for the national response

Non-routine data sources provide data that are collected on a periodic basis, usually annually or biennially. Non routine data sources for the HIV response in Nigeria include the following:

7.3.1 Sentinel Surveillance among ANC and STI Clinic Attendees

Sentinel surveillance data is based on antenatal clinics attendees among women of child bearing age (15-49 years). It is conducted every 2-3 years and its purpose is to monitor the trends in HIV prevalence in the country. Data obtained from ANC sentinel surveys are used to generate estimates of HIV prevalence that are nationally representative. At the health centre, a rapid test is applied or in some cases, the blood sample is sent to a testing site. Positive rapid tests are then confirmed with ELISA method at a reference or state laboratory, if there is no referral laboratory in the state or zone, positive rapid test are confirmed at the National Public Health Laboratory. ANC survey generates data on two main indicators for the national M&E system and which include HIV prevalence among ANC attendees aged 15-24 years and HIV prevalence among 15-49 years.

7.3.2 National HIV/AIDS and Reproductive Health Survey (NARHS)

NARHS is a population-based survey that is conducted every 5 years. Since the last round of GARPR reporting, another NARHS survey was conducted in 2012. The target groups in NARHS are women of reproductive age (15-49 years) and men aged 15-64 years. The survey obtains information on the knowledge, behaviour and practices related to the prevention and transmission of HIV and other STIs. Serological testing to estimate HIV prevalence was incorporated into NARHS since 2007. Hence, it is now referred to as NARHS Plus.

The NARHS provides data on outcome indicators that focus on partner reduction, consistent use of condoms in regular and non-regular partnerships, delay of sexual activity among young persons, myths, stigma and discrimination and appropriate practices regarding STI/HIV/AIDS, knowledge and awareness of STI, and condom accessibility.

7.3.3 Integrated Biological and Behavioral Surveillance Survey (IBBSS)

IBBSS is conducted every two to three years and targets high risk groups such as IDUs, MSMs and FSWs. They focus on use of condoms with regular and non-regular partners, myths and appropriate practices with regards to STI/HIV/AIDS, exposure to interventions, and other high risk behaviors such as substance abuse. It also includes collection of serological samples for HIV testing to determine the prevalence amongst MARPS. The last round of IBBSS was conducted in 2010 and preparations for the conduct of another round of IBBSS commenced in 2013. .

7.4 Second Generation Surveillance System

HIV surveillance systems track HIV infection or other biological markers of risk such as STIs. Since HIV infection among adults must be preceded by one of a limited number of behaviors, such as unprotected sex with an infected partner or injection with contaminated needles, if these behaviours change, there will be a change in the spread of HIV. Second generation surveillance systems provide opportunity to monitor trend in high risk behaviours, using them as early warning signs and to explain dynamics of the epidemic. Thus, second generation surveillance uses data from behavioral surveillance and it can also help to generate hypotheses. Nigeria's second generation surveillance system needs to be tailored to the dynamics of the epidemic. There were some second generation surveillance opportunities in the country such as HIV data triangulation conducted in 2009 on sexual transmission prevention of HIV to provide decision makers with data on the trend and magnitude of the epidemic, and indications about the effectiveness of national response. Other second generation surveillance analyses conducted in Nigeria recently include Epidemiology, Response and Policy Synthesis (ERPS) and Mode of Transmission (MOT) analysis at national and state levels.

7.5 Achievements of M&E in 2013

- Conduct of local HIV epidemic appraisals for MARPS in 22 states. The epidemic appraisals provided information on venues or hotspots where these MARPS meet. Data from the appraisals were used to generate size estimates for FSWs, MSMS and IDUs. It also contributed information towards a better understanding of the drivers and dynamics of the epidemic among these target groups.
- Implementation and rollout of cloud based DHIS2 platform for electronic reporting and analysis of routine data. All 36 states and FCT have commenced the use of DHIS 2.0 for reporting HIV/AIDS routine data with 22 of the 36 states having so far rolled out to secondary and tertiary facilities as well as LGAs.
- In October 2013, NACA, DPRS (FMOH), USG, World Bank and the GFATM began the pilot of a DHIS mobile phone application for data reporting in 80 PHCs in 20 states. A comprehensive review of the DHIS mobile pilot is planned for March 2014 and the lessons learned will be used to scale up the DHIS mobile application to 520 PHCs in 2013 and 5000 by end of December 2015 respectively.

- Integration of all existing health DHIS2 databases towards strengthening the NHMIS in Nigeria commenced and is being led by the DPRS (FMOH) and with the

collaboration and support of all the relevant stakeholders. The integration process is expected to be completed in 2014.

- The country also conducted a multi stakeholder review of the nation's progress towards agreed targets in the UN political declaration and a joint mid-term review (MTR) of the implementation of the National HIV/AIDS strategic plan 2010-2015 respectively. Findings from the reviews will inform the development of a two year operational plan and strengthen efforts to reach universal access targets set for 2015.

- A mid-term review of the World Bank HPDP2 that provided evidence for a restructuring of the project towards ensuring that the goal, objectives and targets of the HPDP2 are reached by the end of the project was also held in 2013.

- Training for state HIV/AIDS teams from the 12+1 high burden states on the use of Estimates and projection package (EPP) and spectrum for generating and utilizing state specific HIV/AIDS estimates towards promoting data availability and use for planning and decision making at the subnational levels.

- The decentralization of routine data collection to state and facility has facilitated the ownership of the data set and its use at the state level.

- NACA also commissioned ten operational research studies towards identifying ways to address gaps involving the private health sector's engagement with the national response; identify drivers of the national epidemic in four high prevalence states; suggest how to effectively retain patients in HIV care; construct models for ART decentralization; and enhance the success of community-based referral systems for PLHIV

- Development of standard and harmonized national data collection tools for the non-health sector response including: HIV prevention for both MARPS and general Population; care and support, family life and HIV/AIDS education (FLHE)

- Conduct of a third National AIDS Spending Assessment in 2013 to analyze HIV/AIDS expenditure for the period 2011 and 2012. Data from NASA studies proved to be a useful advocacy tool that provided evidence and impetus for the Federal Government of Nigeria to launch and commit to funding the Presidential Comprehensive Response Plan (PCRP) towards ensuring that the country reaches the target set in the Nigeria-US Partnership Framework on HIV/AIDS of sourcing 50% of HIV/AIDS funds from domestic sources by 2015.

- More M&E professionals have been trained in Nigeria to improve the state and national responses through initiatives of MEASURE Evaluation working with Government of Nigeria in strengthening the HIV information system.

7.6 Challenges

- Weak infrastructural support (computers, internet facilities) for DHIS 2 electronic reporting at the LGA and facility level respectively.
- Another noticeable challenge of the M&E system is its failure to adequately capture the contributions of private sector to the HIV/AIDS response in Nigeria.
- Inadequate formal mechanisms for dissemination of research findings
- Evaluation of the impact and effectiveness of national HIV/AIDS programs and interventions have not taken place
- Absence of a harmonized national M&E calendar of activities

7.7 Remedial Actions

- Leverage resources from all sources, including government to empower the facility and LGAs with infrastructural support to enhance timely data collation and submission using DHIS2.
- Commission regular and periodic evaluations of the various HIV/AIDS programme needed to review the impact and effectiveness of the strategies and interventions.
- Strengthen collaboration and partnership with umbrella bodies for private sector such as NIBUCCAA.
- Conduct local epidemic appraisals for MARPS in the remaining states where it has not been conducted.
- Develop and continually used Geo-spatial data across the country
- Need to review existing directory of health facilities in the country and integrate it into the DHIS

Conclusion

This Nigeria 2014 GARPR report highlights the progress Nigeria made in HIV response in the year 2013. While the report shows that some progress has been made in the last 12 months since the last GARPR reporting round in 2013, it is also obvious that much needs to be done to ensure the country meets country targets for universal access by the end of 2015. The Federal Government of Nigeria, her donor and partners in the HIV/AIDS response and the Nigerian people remain committed to ensuring that we meet these targets.