



National Agency for the
Control of AIDS (NACA)



Federal Republic of NIGERIA

**GLOBAL AIDS
RESPONSE
Country Progress Report**

Nigeria GARPR 2015

ABUJA, NIGERIA

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ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Ante-Natal Clinics
ART	-	Anti-Retroviral Therapy
ARV	-	Anti-Retroviral
BSS	-	Behavioral 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 Behavioral 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 2014, donors, partners and the Nigerian government have continued to wage sustained effort towards halting the epidemic and reversing the epidemic. Our collective effort has contributed to stabilizing the epidemic and we have begun to reverse it. Similarly, available data shows that we have continued to make steady strides towards achieving universal access to HIV/AIDS prevention, treatment and control. Efforts aimed at ensuring greater ownership and sustainability of the HIV/AIDS response were also put in place especially with the launch of the Nigerian President's Comprehensive Response Plan (PCRP) for HIV/AIDS 2013-2015. The PCRP was developed as an advocacy tool to mobilize internal or domestic resources for the HIV response at both state and national levels.

Nigeria still has the second highest HIV/AIDS burden in the world with an estimated 3,391,546 PLHIVs. However, estimates show that new infections have declined from an estimated 316,733 in 2003 to 239,155 a decade later in 2013. A total of 174,253 died from AIDS related cases in 2014 which is lower than 210,031 people in 2013. In 2014, the estimated number of persons in need of ART using the eligibility criteria of CD4 of 350/mm³ was 1,665,403 (1,454,565 adults and 210,838 children).

Progress has been made towards achieving universal access to HIV/AIDS services. The number of facilities providing HCT has increased eight fold and multiple strategies are used to increase access to HCT including community outreaches that were adopted. As a result, a total of 6,716,482 persons age 15 years and above were counselled, tested and received their results in 2014 compared to 4,077,668 in 2013. Health facilities providing ART have also increased. The number of adults and children currently receiving ART in 2014 has also increased to 748, 846 representing coverage of 44.3% based on the eligibility criteria of CD4 of 350 cells/mm³. Additionally, decentralization of PMTCT services has contributed to increasing the number of sites providing PMTCT services to 6,548 in 2014. The number of pregnant women who were counseled, tested and received results doubled from 1,706,524 in 2013 to 3,067,514 in 2014. This represents 46% of all pregnant women in the country. A total of 63,350 pregnant women received ARV prophylaxis to prevent MTCT in 2014 compared to 57,871 in 2013.

No doubt there are still challenges. The proportion of health facilities in the country offering HCT, ART and PMTCT services is still low with more access in urban than rural areas. Also, the proportion of the general population that has ever been tested for HIV is low at 26%. ART coverage for children less than 15 years has witnessed some improvement but remains low at less than 12%. PMTCT coverage has also improved but is still low at 30%. There are still challenges with mobilizing adequate resources as well as infrastructure, human and technical capacity gaps at all levels of the health system particularly at the subnational levels.

Some progress has been achieved but more can be done in the response to HIV/AIDS. I wish to on behalf of the President and Commander-in-Chief of the Federal Republic of Nigeria thank all our partners and stakeholders in the HIV/AIDS response. It is my earnest hope that together with all our international donor partners and government at all levels we can sustain these achievements highlighted in the 2015 GARP report as well as forge ahead

with effective strategies to address identified challenges and achieve even more in the fight against HIV/AIDS.

Professor John Idoko
Director General,
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Similarly, NACA appreciates the contributions of all the members of the Nigeria 2015 Report Steering committee for their technical 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 2015 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 Dr. Evelyn Ngige, Mr. Emma Abatta and Mrs. Mercy Morka of National AIDS/STI Control Program (NASCP) of the Federal Ministry of Health for their technical and leadership support. Special thanks also to Mr. Francis Agbo of the Strategic Knowledge Management Department of NACA for his leadership, Dr. Adedayo Adeyemi who was the lead consultant for 2015 GARP report and Mr. Mark Ojukwu who was the co-consultant. The diligent efforts of all members of the core team including: Mrs. Doris Ogbang (UNAIDS), Miss. Oluchi Obi (NACA), Mr. Festus Idepefo (NACA), Mr. Kenneth Alau (NACA), Mr. Akintomide Akinrogunde (NACA), Mr. Olutosin Adebajo (NACA) and Dr. Bodunde Onifade (FMOH) were well appreciated.

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1.1 Nigeria Country Profile

Figure 1.1: Geographical Map of Nigeria



Nigeria is a Sub-Saharan African country located in latitudes $4^{\circ} 1'$ and $13^{\circ} 9'$ North and longitudes $2^{\circ} 2'$ and $14^{\circ} 30'$ East of the west coast of Africa. The country with an approximately 923,768 square kilometers and 800km of coast line 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 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 namely: 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 country in Africa with an estimated population of 177,188,352 as at December 2014 with total fertility rate (TFR) of 5.5. Nigeria's annual growth rate was estimated to

be 2.54%. The net attendance ratio in primary education was 59.1; literacy rate of 15-24years was 71.5; percentage of births attended by skilled health personnel was 38.1%; contraceptive prevalence rate was 15.1%; antenatal care coverage for at least one visit 60.6%; and antenatal care coverage for four or more visits was 51.1% and unmet need for family planning was 16.1%. 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 1.1: Nigeria Basic Indicators¹

Basic Indicators	
Under-5 mortality rate, 2013	128
Infant mortality rate, 2013	69
Neonatal mortality rate, 2013	46
Annual number of under- 5 deaths (thousands), 2013	861
Maternal mortality ratio	576
Total population, 2014 estimates	177,188,352
Annual number of births (thousands), 2013	31828
Antenatal care coverage ((At least one visit)	60.6
Percentage of births attended by skilled health personnel	38.1
GNI per capita (US\$), 2011	1280
Life expectancy at birth (years), 2011	52
Literacy rate of 15-24years old	71.5
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

1.2 Inclusiveness of Stakeholders in the Report Writing Process

GARP 2015 report was led by National Agency for the Control of AIDS in collaboration with HIV/AIDS Division of the Federal Ministry of Health, and other stakeholders such as HIV/AIDS Division of the Federal Ministry of Health, UNAIDS, UNICEF, WHO and Implementing Partners. The reporting process started in January 2015 with the collation of data at the state level for the national indicators, and was validated at zonal meetings. This reporting process involved active engagement of state M&E officers towards building the capacity of state officers in the areas of routine HIV program data review and validation.

The report writing process commenced with the formation of the Global AIDS Response Program Report (GARPR) Steering Committee by the National Agency for the Control of AIDS in January 2015. The Steering committee was led by NACA and had membership from a broad spectrum of stakeholders including development partners, donors and civil society groups. The Steering Committee was tasked with the responsibility of approving the GARPR reporting work plan and responsible for ensuring that the report was submitted on time.

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: provide technical support for data collection, collation, analysis, interpretation and reporting, and guide the online entry of country data. Essentially, the team reviewed epidemiological, programmatic and financial data to describe the national HIV response.

NACA recruited two consultants to work with the GARP core team/stakeholders to generate data estimates using the Estimated Projection Package (EPP)/Spectrum, collate, analyze and validate data on the GARP indicators, perform online data entry, respond to queries where necessary and write the narrative report. The work of the core team was however monitored for quality and adherence to standards by the steering committee.

The core 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 the required routine service coverage. Since the last reporting period, the national reporting system has improved. As a result, ART and PMTCT program data were obtained directly at the level of the facility. 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 were of good 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
- b. Population based survey reports: Nigeria Demographic and Health Survey (NDHS) 2003 and 2008; National HIV/AIDS and Reproductive Health Survey (NARHS) 2007 and 2012.
- c. Sub-population survey reports; Antenatal HIV sentinel surveillance 2008 and 2010. Integrated Biological and Behavioral Surveillance Survey (IBBSS) 2007 and 2010.
- d. Specialized surveys in specific population groups, patient tracking systems, programmatic data, National AIDS Spending Assessment reports of 2007/2008, 2009/2010 and 2011/2012.
- e. Program Reviews: the National Commitment and Policy Instrument (NCPI), Nigeria Country UNGASS Report, 2003, 2005, 2007 and 2010, Nigeria Global AIDS Response Progress Report 2012 and 2013, Joint Annual Review of the National Response to HIV/AIDS 2011 and the combined NSF Mid-Term Review Report 2013.
- f. National HIV/AIDS Epidemiology Impact Assessment 2014, program data and other relevant data sources.
- g. Modes of HIV Transmission report 2009
- h. Universal Access report 2010

Additionally, part of GARPR activities was the completion of the National Composite and Policy Index (NCPI).

Also, a four day stakeholders' meeting was held to review and validate the country data, and to make online data entry and 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. After which a five day HIV/AIDS estimates workshop was held to revise the HIV/AIDS estimates for the country for both state and national level data. UNAIDS Geneva and UNAIDS country office provided technical support. The workshop was led

by the Federal Ministry of Health (HIV/AIDS Division) with participants from national, states, UNICEF and World Health Organization.

After the estimates workshop, the participants were involved in development of national and state level factsheet and reports.

Lastly, the GARP narrative document was circulated among key decision makers for comments and inputs before final submission to UNAIDS Gevena.

1.3 Status of the Epidemic

Monitoring of HIV epidemic in Nigeria has been done with the use of program data, surveys and special studies. The program data involves knowing the number of individuals (male and female) who were reactive during facility-based HIV testing among individuals that were counselled, tested and received results.

Surveys used to monitor HIV epidemic in Nigeria include Antenatal Care (ANC) Sentinel Survey, National HIV/AIDS and Reproductive Health Survey (NARHS), and the Integrated Biological Behavioral Surveillance Survey (IBBSS). These are periodic data collection targeting facility-based pregnant women, general population and key population respectively.

Consequently, in line with guidelines from the World Health Organization (WHO), Nigeria adopted ANC sentinel surveillance as the system for assessing the epidemic. Sentinel survey data showed that the HIV prevalence increased from 1.8% 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. However, the result from the 2010 sentinel survey shows that ANC national prevalence was 4.1% (FMOH, 2010) with variability across states and local government areas. The results of 2013 ANC Sentinel Survey are being awaited. 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 for 2014, about 3,391,546 are living with HIV in Nigeria while it is estimated that 227,518 new HIV infections occurred in 2014 (male 103,917 and female 123,601). A total of 174,253 died from AIDS related cases in 2014 which is lower than 210,031 people in 2013. It is also estimated that a total of 1,665,403 (1,454,565 adults and 210,838 children) required anti-retroviral drugs (ARV) in 2014.²

Although most at risk populations or key 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 of HIV and transfusion of infected blood and blood products, on the other hand, account for the other notable modes of transmission.

The most recent 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 variations in Nigeria's epidemic at the sub-national (state) levels and among different 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 39 years 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 quality healthcare services.

1.4 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 past achievements 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 to ensure that the impact of HIV is reduced.

- 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, this includes:
 - 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 Program 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 its review in 2013; and the United Nations General Assembly Special Session on HIV/AIDS (UNGASS)

- Nigeria's Commitment to Universal Access, and to comprehensive HIV prevention, treatment, care and support issues 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 multi-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. Importantly, the targets of the NSP are population-based, and 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) was linked to Universal and MDG targets and Vision 20:2020 and has an overriding emphasis on HIV prevention. The NSFII underwent a mid-term review (MTR). 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. Additionally, the gender dynamics in the profile of infections and the growing burden of the 2.2 million HIV orphans in the country 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 in post – primary educational institutions.
- The issues associated with increased access to treatment, care and prevention.

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, substantial progress is needed 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 or guidance for governmental action. The problem is that, at the moment, there are no HIV/AIDS specific laws in the country. 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. Importantly, Anti-stigma and Discrimination bill has passed by both Senate and House of Representatives, and have been signed into by the President. Advocacies are ongoing by the civil society groups ensure the bill is passed and signed to law in all the states in Nigeria. This is important towards facilitating 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 is a need to prevent HIV risks among them. 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 of the 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. 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 Behavior 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

1.5 Indicator Overview Table

Table 1.2: Global AIDS Response Program Indicators

TARGET / INDICATOR	UNGASS 2007	UNGASS 2010	GARPR 2012	GARPR2013	GARPR 2014
Target 1: Reduce Sexual Transmission of HIV by 50%					
<i>General Population</i>					
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	22.5% NARHS 2005	24.2% NARHS 2007	24.2% NARHS 2007	24% NARHS 2012	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	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	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	64.5% NARHS 2012	64.5% NARHS 2012
Percentage of women and men aged 15- 49 who received an HIV test in the past 12 months and know their results	8.60% (NARHS 2005)	11.7% (NARHS 2007)	11.7% (NARHS 2007)	17.1% NARHS 2012	17.1% NARHS 2012

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)	4.2% (ANC 2010)
<i>Sex workers</i>					
Percentage of sex workers reached with HIV prevention programs	34.30% (IBBSS 2007)	34.30% (IBBSS 2007)	18.2% (IBBSS 2010)	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)	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 Sex Workers)	41.8% (Male & Female Sex Workers) 17.5% (Male Sex Workers) 44.8% (Female Sex Workers)

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) (IBBSS 2007)	24.5%(Male & Female Sex Workers) 18.6% (Male sex workers) 25.2% (Female Sex Workers) (IBBSS 2007)
<i>Men who have sex with men</i>					
Percentage of men who have sex with men reached with HIV prevention programs	54.38% (IBBSS 2007)	54.38% (IBBSS 2007)	17.99% (IBBSS 2010)	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)	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	30.15% (IBBSS 2007)	30.15% (IBBSS 2007)	24.92% (IBBSS 2010)	24.92% (IBBSS 2010)	24.92% (IBBSS 2010)
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by					
Number of syringes distributed per person who injects drugs per year by needle and syringe	Not Available	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)	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)	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)	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)	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)	29.2% (FMOH 2014)
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)	6.3% (FMOH 2014)
Mother-to-child transmission of HIV (modelled)	--	29.1% (2010 Spectrum Modelling)	19.8% (2011 Spectrum Modelling)	27.3% (2014 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)	44.9%* (FMOH 2014)
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	94.56% (ICAP Program Record)	70% (FMOH 2009)	73.4% (FMOH 2011)	81.0% (FMOH 2013)	N/A
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-Program Data)	69.1% (FMOH 2009)	-----	28.1% NTBLCP(2013)	N/A
Target 6: Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-					
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)	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 programs, 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	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)	17.5% (NDHS 2008)

Current school attendance among orphans and non-orphans aged 10–14*	Orphans:75%, Non-Orphans:87% (CRS 2006) OVC Situational	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)	OVC: 82.5% Non OVC:72.9% (NDHS 2013)
Proportion of the poorest households who received external economic support in the last 3 months	Not available	Not available	Not available	Not available	

*This was based on CD4 count of 350cells/mm³.

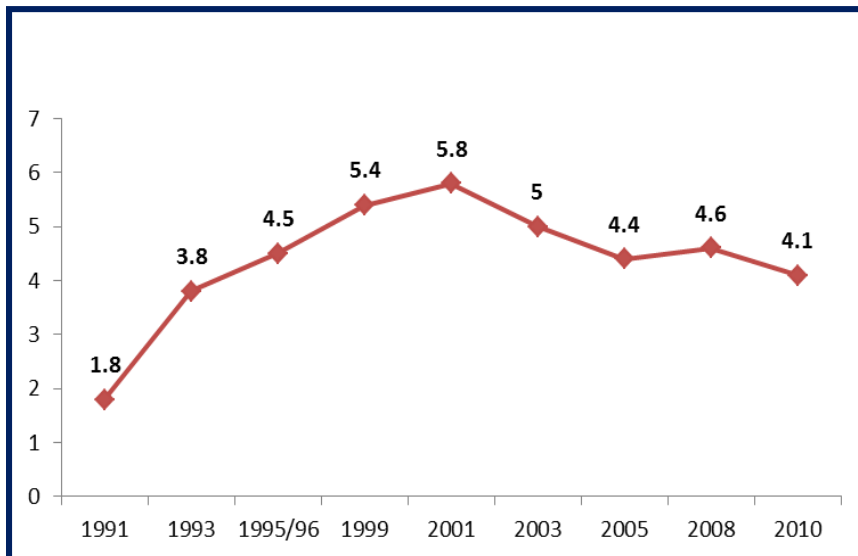
2.1 HIV Prevalence

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%.

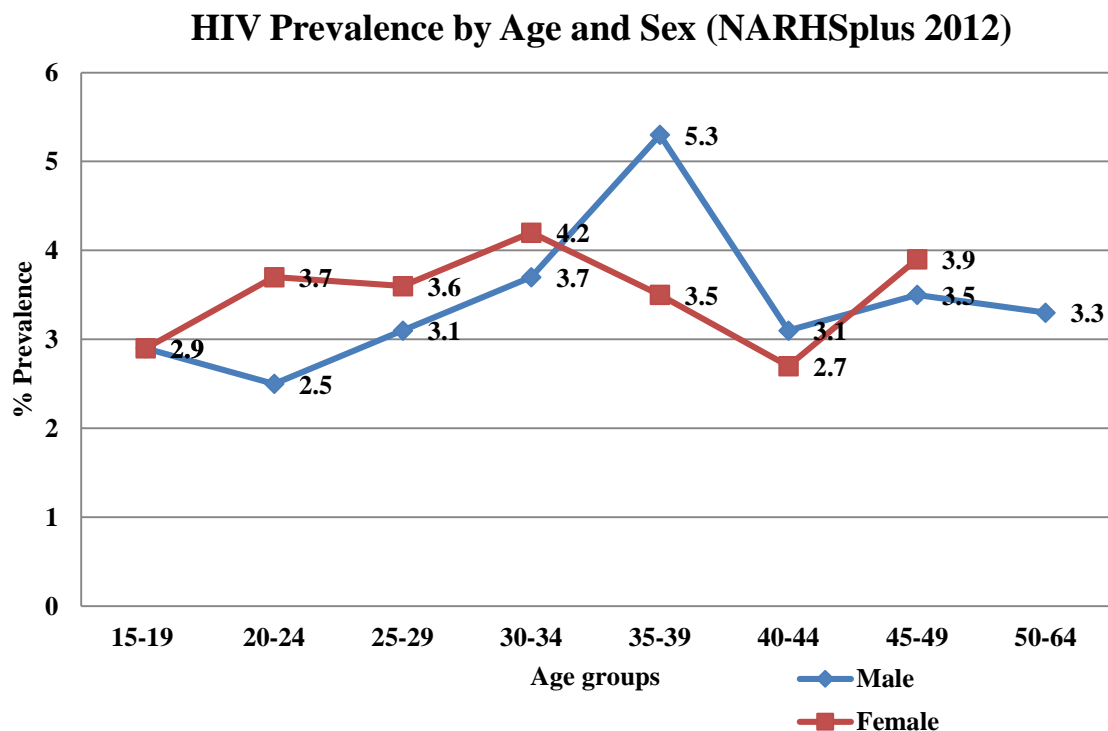
Figure 2.1: National median HIV prevalence trend in ANC 1991-2010



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 2.2: HIV prevalence by age and sex

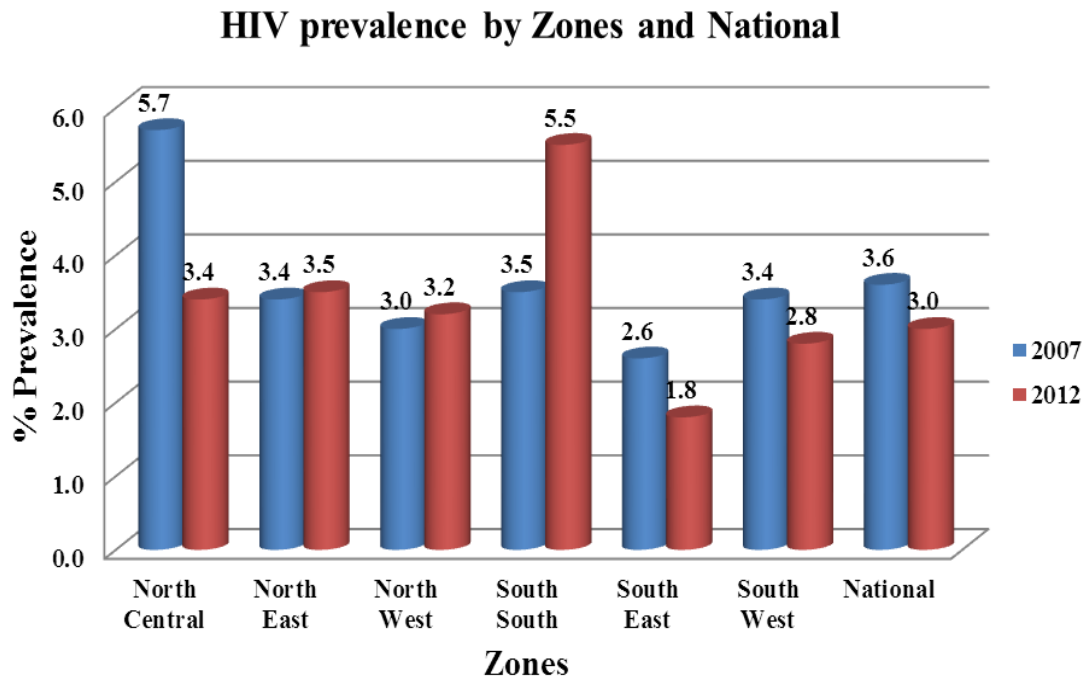


Patterns observed in the previous population based survey (NARHS 2007) shows that gender inequality is an important driver for the HIV/AIDS epidemic. Prevalence rates were generally higher among females (4.0%) than males (3.2%) in 2007. In 2012 even though there was a drop in prevalence it was still 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

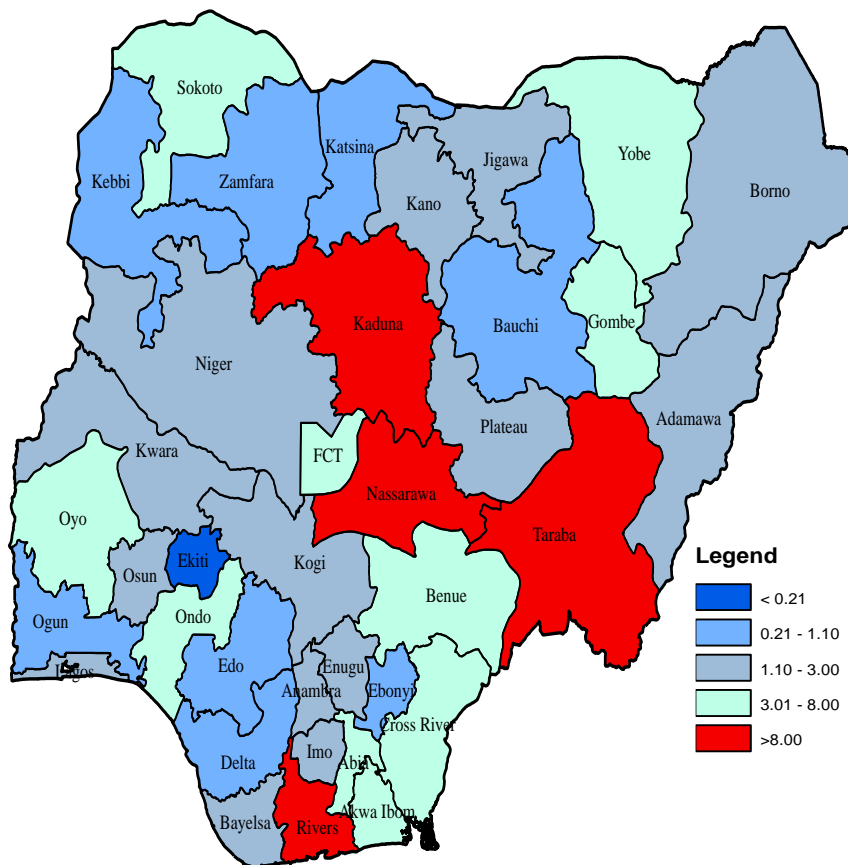
When 2007 data was compared with 2012 it was observed that while the HIV prevalence decreased in the North-Central, South-East and South-West Zones respectively it increased in the three other zones: South-South, North-East and North-West.

Figure 2.3: HIV Prevalence by zones and national



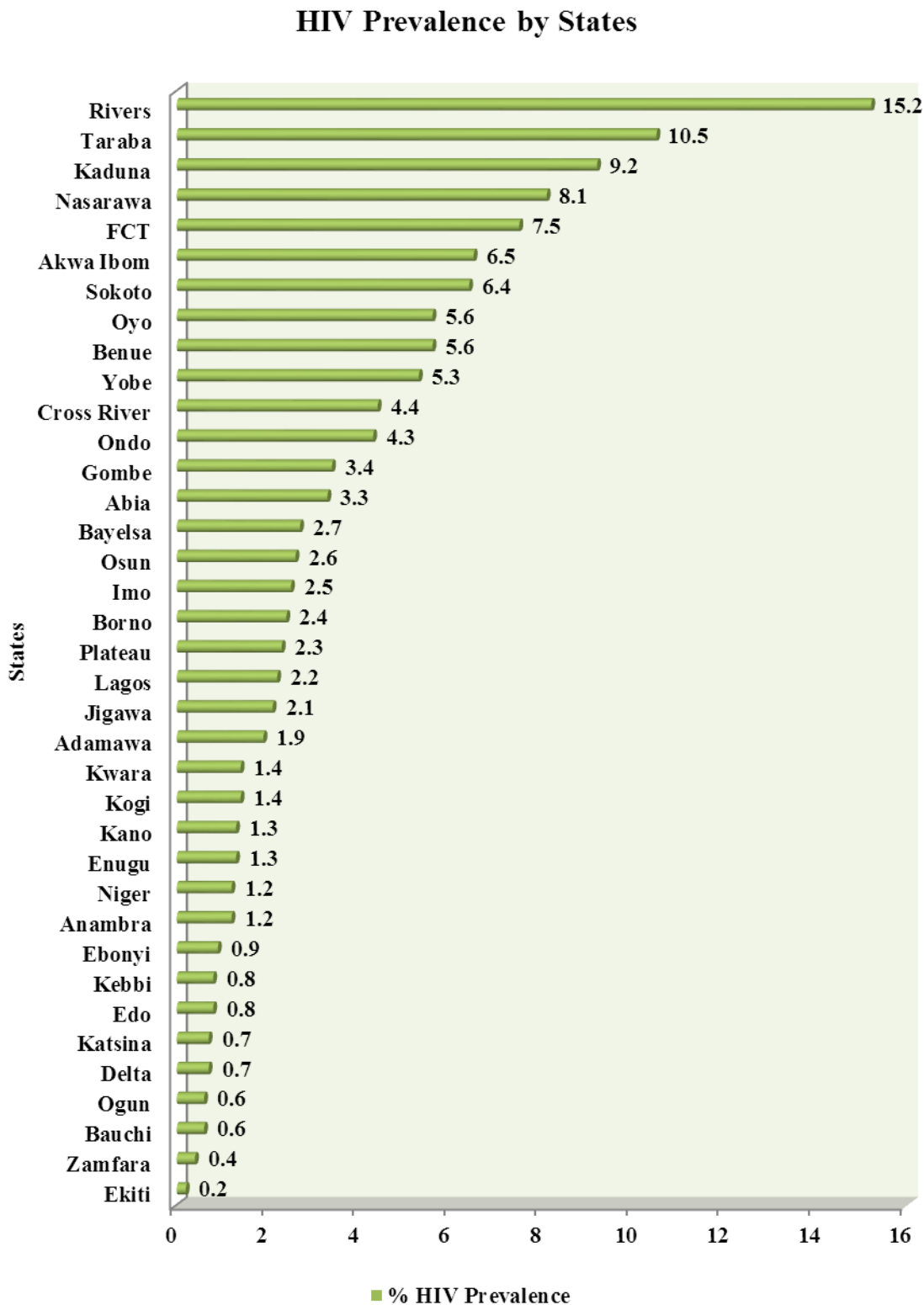
Fourteen states reported a prevalence that was higher than the national prevalence of 3.0% while nine other states had a low prevalence ranging 0.2 to 0.9%. The four states with the highest prevalence were Rivers (15.2%), Taraba (10.5%), Kaduna (9.2%) and Nassarawa (8.1%) respectively. Ten States have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

Figure 2.4: Geographic Distribution of HIV Prevalence by States (NARHS 2012)³



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.

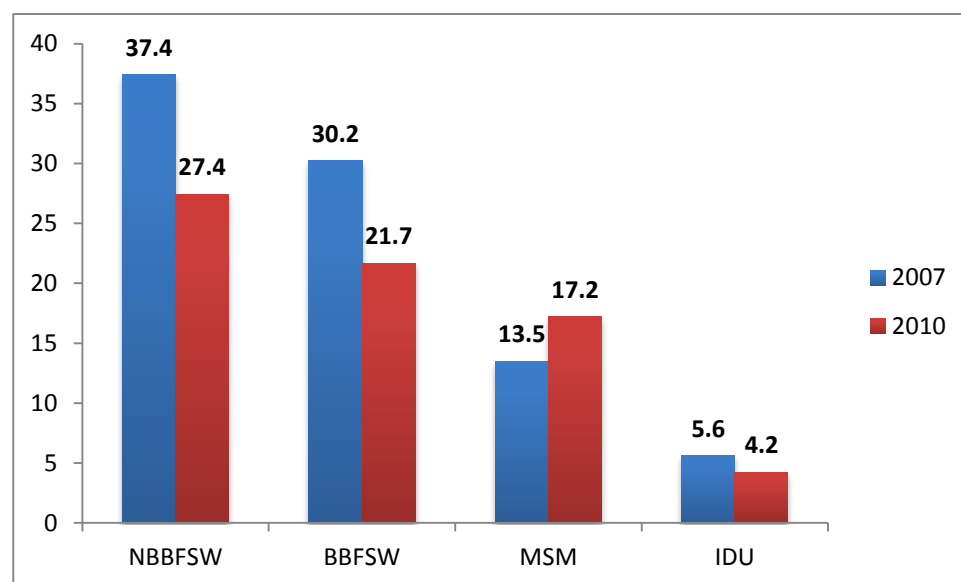
Figure 2.5: HIV Prevalence by states (NARHS 2012)



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 2.6: HIV Prevalence Trend among MARPS (IBBSS 2007 & 2010)



2.2 HIV Incidence

New Infections

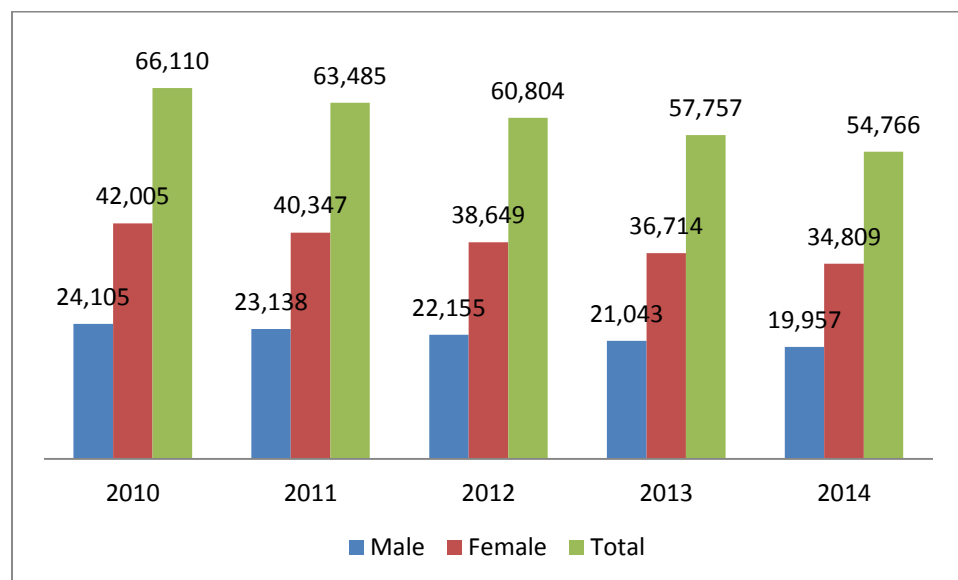
Recent estimates indicate that the annual number of new infections in the country has been on a steady decline, decreasing from 270,667 in 2010 to 253,506 in 2012 and to 227,518 in 2014. The total number of new infections in females continued to surpass that of the males. In 2014, the female made up of 54.3% of total new infections.

Table 2.1: Trends in Estimated New HIV Infections 2009 to 2014

	Female	Male	Total
2009	151,495	126,566	278,061
2010	147,245	123,422	270,667
2011	142,542	119,696	262,238
2012	137,671	115,835	253,506
2013	129,976	109,179	239,155
2014	123,601	103,917	227,518

Among young people age 15-24 the estimated number of new HIV infections showed similar trends. The number of new HIV infections dropped from 66,111 in 2010 to 63,485 in 2011 to 60,804 in 2012 to 57,758 in 2013 and 54,766 in 2014. Similarly, the estimates over the years showed that more of the new infections occurred among young women age 15-24 than their male counterparts. In 2014, the female made up about 64% of new infections.

Figure 2.7: Trends in Estimated Number of New HIV Infections among Young People Age 15-24 Years



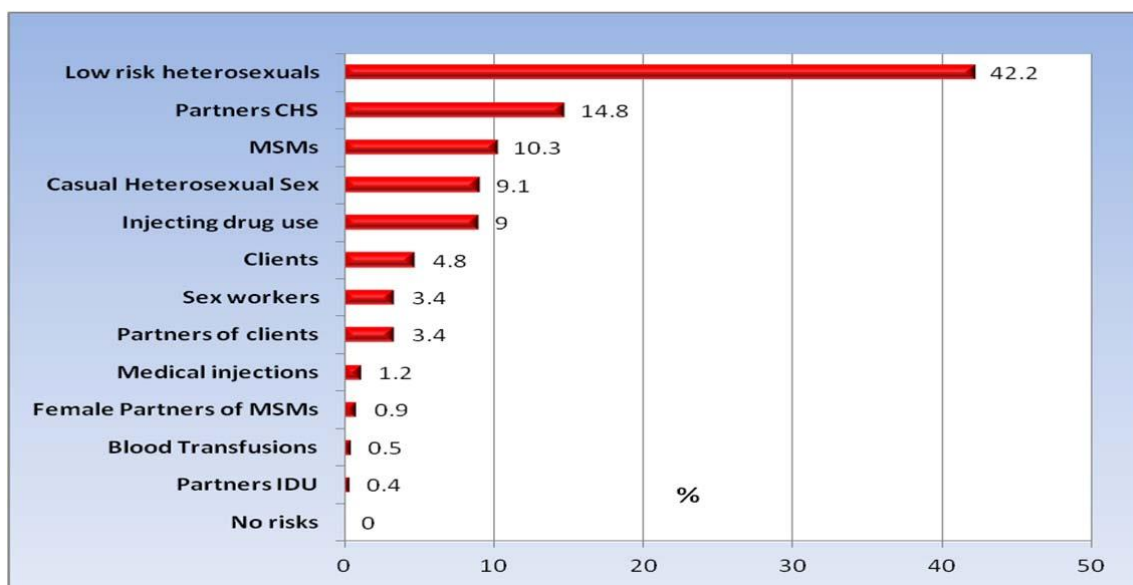
2.3 Transmission of HIV Infection

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 2.8: Distribution of New Infections by Mode of Exposure



2.4 Impact of HIV/AIDS on Children

Children are affected by HIV/AIDS through mother to child transmission of HIV 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.

Section Three: National Response to the Epidemic

3.1 Policy and Framework

Ever since the first case of AIDS was reported in 1986 in Nigeria, there has been development of different policies and frameworks. The need to control the spread of the virus 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 especially to cater for the 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 was as a result of Federal Government's commitment with political acknowledgement to reduce the burden of HIV and not deny the presence of the virus. 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 was 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, NACA 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 is helping to 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 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 program management. A number of recommendations that could improve the efficiency of the intervention programs were made.

Additionally, NACA has commenced the process for the revision of NSP2010-2015 in order to develop the third edition that will run from 2016 – 2020.

3.2 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 HIV/AIDS. In addition, the plan aims to address gender inequality, knowledge, management and research in a bid to ensure that interventions are evidence-based and driven by research findings. 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 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, engagement of affected communities and ensuring that the target communities receive sufficient amount of intervention. 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 the need of the HIV/AIDS stakeholder community about the existing gap towards achieving global targets for service uptake in the national response. Of specific concern was the slow pace of progress towards actualizing the 2011 United Nations Political Declaration on HIV and AIDS commitment which, among others, sought to intensify global efforts to eliminate HIV and AIDS and to take specific steps to achieve ambitious goals by 2015.

HIV/AIDS stakeholder parley meeting was convened and 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 Government of Nigeria through the President requested for the development of a comprehensive response plan that provides a platform through which increased government contribution to the national response will be channeled, while ensuring key interventions are accelerated to provide quick achievements 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 program performance review of 2012. Also, there was 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.

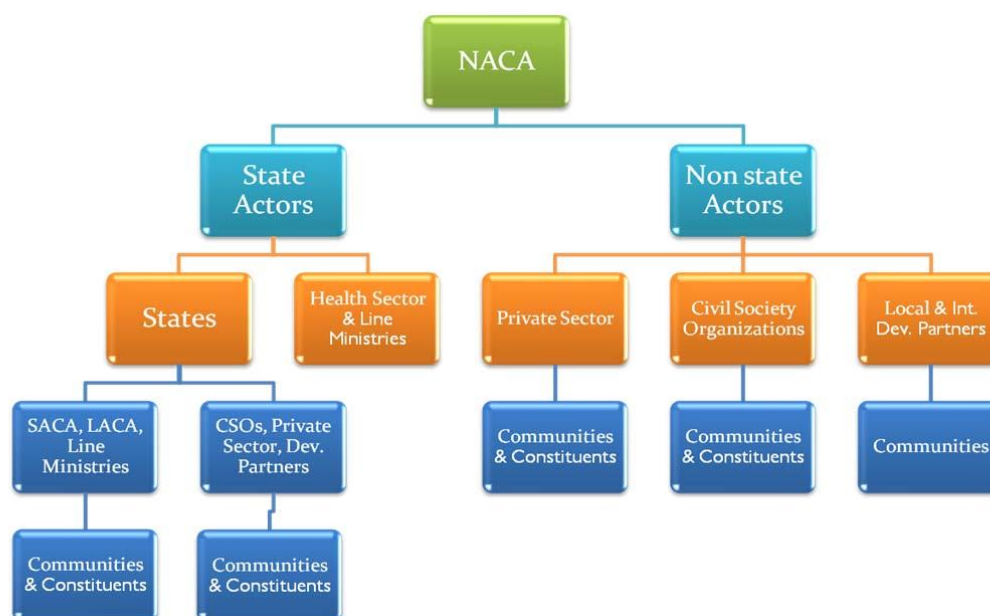
3.3 Coordinating Structures

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 PCRPP, this coordination mechanism while being utilized for implementation of the PCRPP 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 3.1: 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, 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, and NACA Technical Assistance (2009-2010). 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.

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 at the lower level. 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 their HIV/AIDS response. As at 2014, 603 of 774 (77.9%) 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, 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. These Civil Society Organizations include 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 on 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

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 their HIV/AIDS response activities.

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 the 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 support the implementation of HIV/AIDS activities of four MDAs (Ministries of Health, Youths, Education and Women Affairs) at the national level, and four at the state level in 35 states and FCT.

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 Behavior Change Communications (BCC) materials by the Ministry of Information and IEC materials targeting long-distance and transport fleet workers by the Ministry of Transport.

Significantly, the HIV/AIDS response among 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 Defense. 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).

3.4 National Targets and Program Responses

3.4.1 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 and 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 program. In 2013, these groups with support from the Strategic Knowledge Management (SKM) TWG, 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, behavior change communication for MARPS and general population; condom programming; and post-exposure prophylaxis (PEP)

3.4.2 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 increased from 2003 to 2014.

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 3.2: Number of HCT Sites in the Country 2009-2014

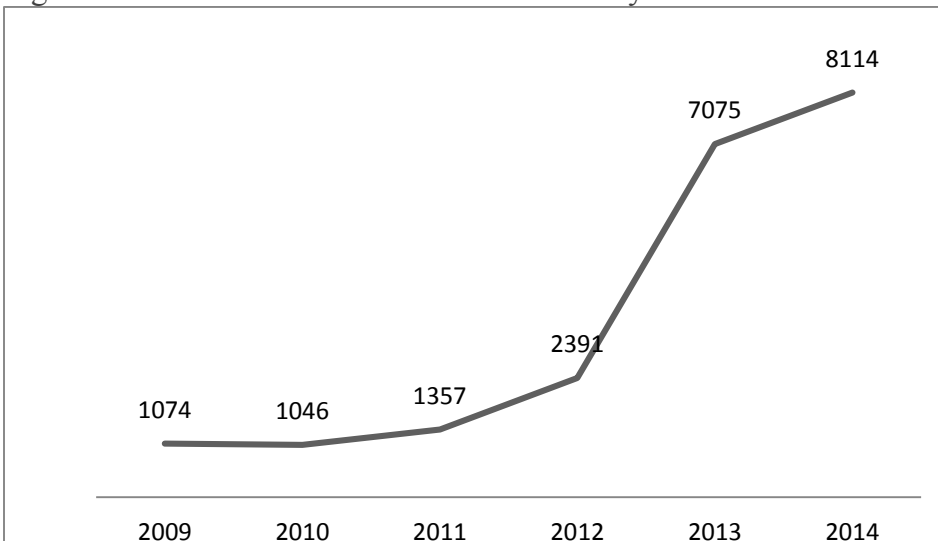
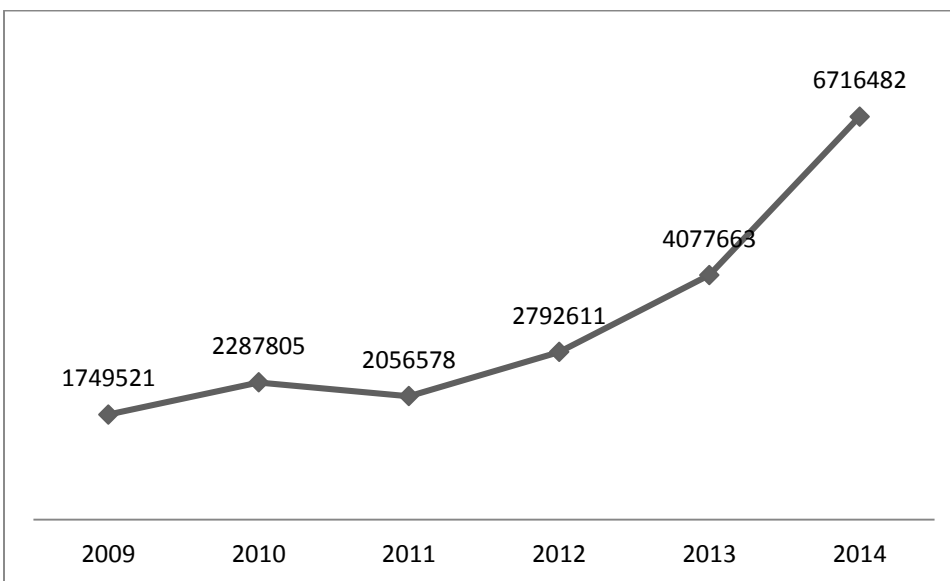


Figure 3.3: Number of Individuals Counseled, Tested and Received Results 2009-2014



In 2014, 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 6,716,482. This demonstrated about 64.7% increase in the number of persons counseled, tested and received results compared to that of 2013.

Also in 2014, the number of HCT sites increased by 14.7% from 7075 in 2013 to 8114 in 2014. 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 programs 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 Testing and Counseling (PITC) 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.

3.4.3 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 an 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 centers and some of the secondary care centers in the country will have the capacity to ‘appropriately’ diagnose and treat patients with STI.

Table 3.1: 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 Plus 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.

3.4.4 Behavioral 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. In 2014, the Federal Ministry of Education, in collaboration with the State Ministries of Education and State Universal Basic Education Board (SUBEB) HIV&AIDS desk officers was involved in the training of 13,852 teachers from 8,335 schools. About 949,396 students were reached in 2014. FLHE has since then been mainstreamed into the teachers training curriculum.

In 2014, the number of out of school youths reached with prevention education was 1,047,866 in all the states of Nigeria.

NACA, in collaboration with its partners, have designed HIV education programs 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.

3.4.5 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 key populations. Part of this model is the Minimum Prevention Package Intervention (MPPI), 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. In 2014, the following key populations were reached: Female sex workers 374,705; IDU 18,738; MSM 37,072; Armed Forces 21,353 and TW 52,383.

3.4.6 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 6,546 as at December 2014. Nigeria is committed to the goal of eliminating MTCT by 2015 and has consistently pursued this goal. In line with this goal 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 2014 from PMTCT services in the country showed that, the number of pregnant women counseled, tested and received results increased from 1,706,524 in 2013 to 3,067,514 in 2014 which was a 79.8% increase.

The number of HIV pregnant women who received ARV prophylaxis to prevent MTCT increased from 57,871 in 2013 to 63,350 in 2014 (an increase of about 9.5%). Also, there has been a marked increase in the number of HIV positive pregnant women who received family planning counseling from 54,867 in 2013 to 120,323 in 2014 (this was an increase of 119.3%). Number of partners of HIV positive women who tested negative increased from 4,828 in 2013 to 17,167 in 2014. However, based on the 2014 estimates, the coverage for PMTCT still remains low at 30.3%. 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 program 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 3.4: Number of PMTCT Sites in the Country 2009-2014

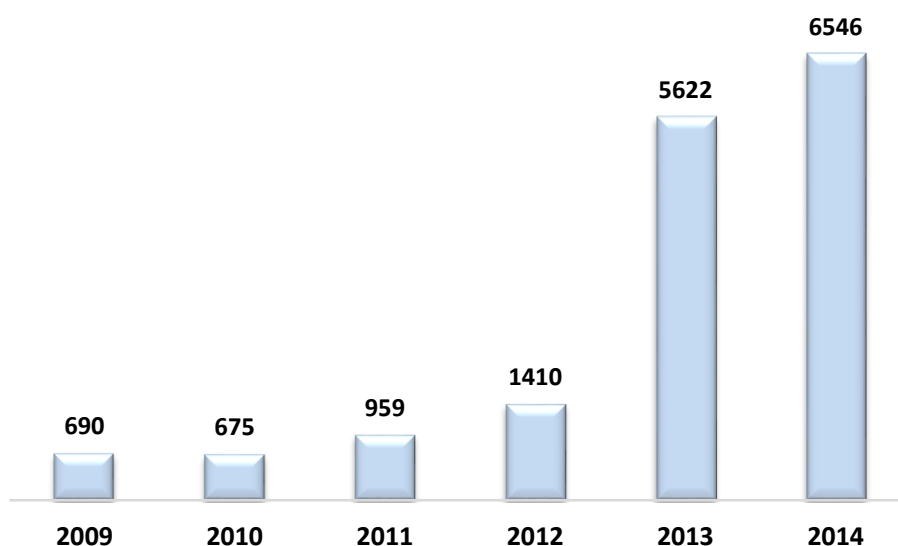
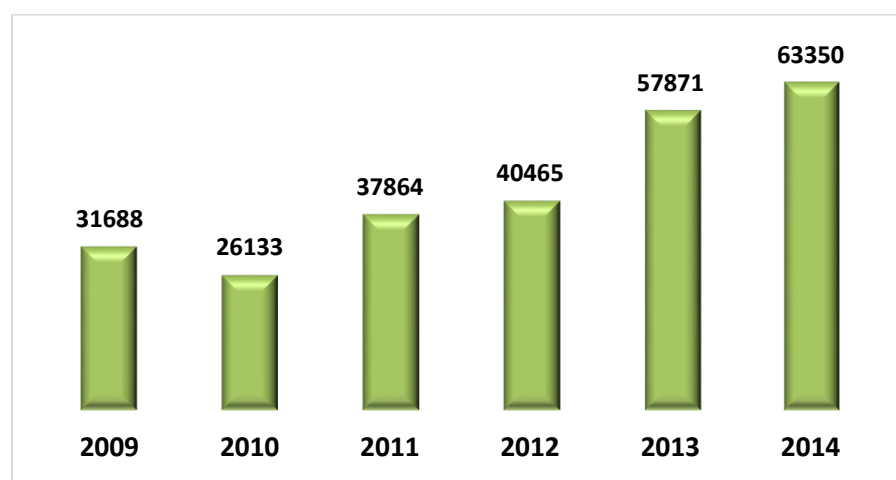


Figure 3.5: Number of HIV pregnant women received ARV prophylaxis in the country 2009-2014



3.4.7 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 this form of protection, have easy access to quality condoms and are able to use them consistently and correctly.

In 2014, 32,000,818 male condoms and 5,073,743 female condoms were distributed. 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 Brothel-based FSW (BBFSW) and 26.1% for Non Brothel-Based (NBBFSW) with their boyfriends.

3.4.8 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 was 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 programs, 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 to. 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 program targeting IDUs.

There are no concrete public engagement programs that promote access to post exposure prophylaxis (PEP) 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 programs in place. There are no concrete programs and guidelines on PEP, male circumcision, future microbicide and HIV vaccine access which were mentioned in the NPP 2010-2012. Since 2012, increased campaign has been mounted and programs 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. However, these efforts have been concentrated in Southern Nigeria.

3.4.9 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 program.

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 1057 in 2014 and spanning all 36 states + FCT. Also, the number of adults and children currently receiving ART has increased to 747,382 persons as at 2014. 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 3.6: Number of ART Sites in the Country 2009-2014

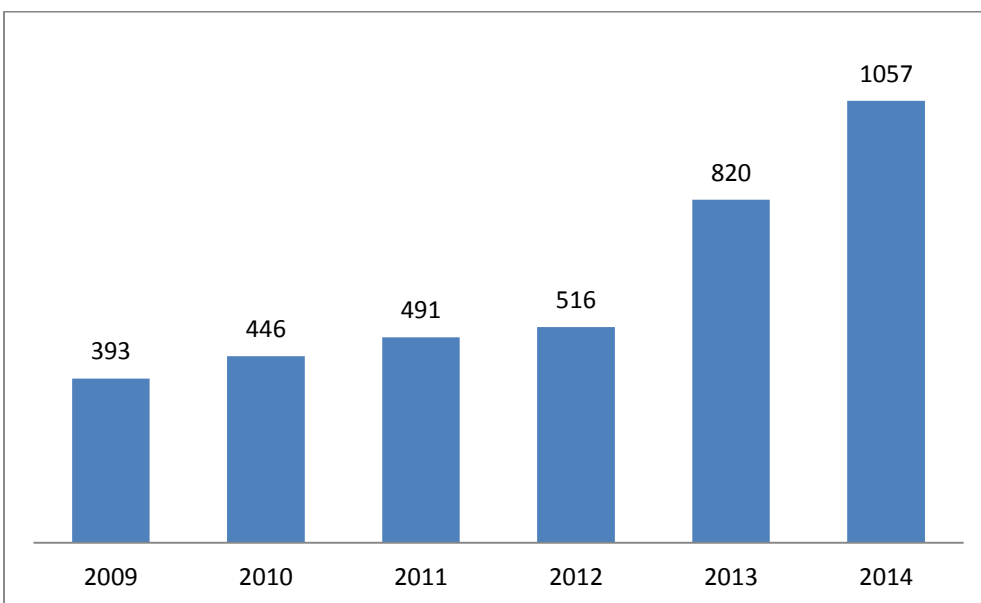


Figure 3.7: Number of Adults and Children Currently Receiving ART in the Country 2009-2014

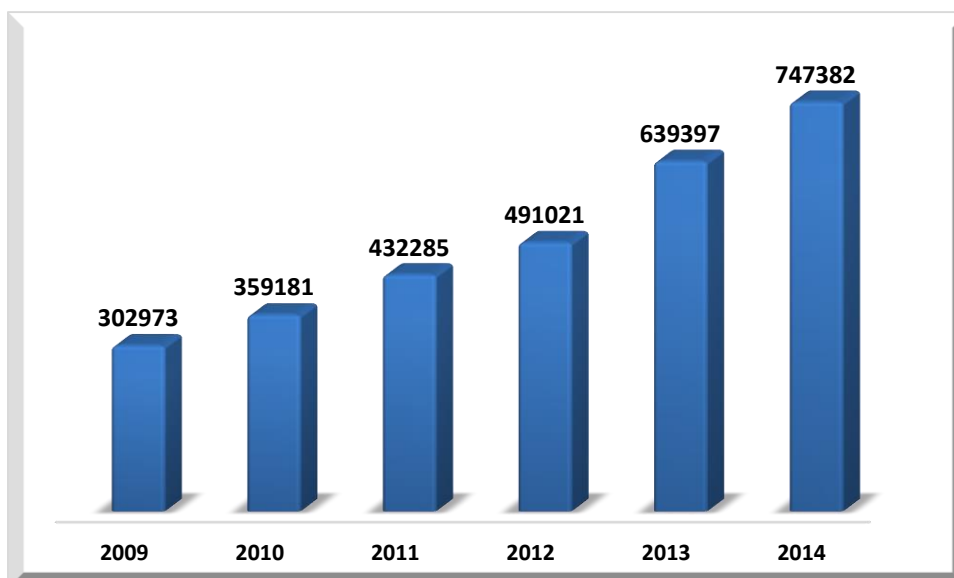
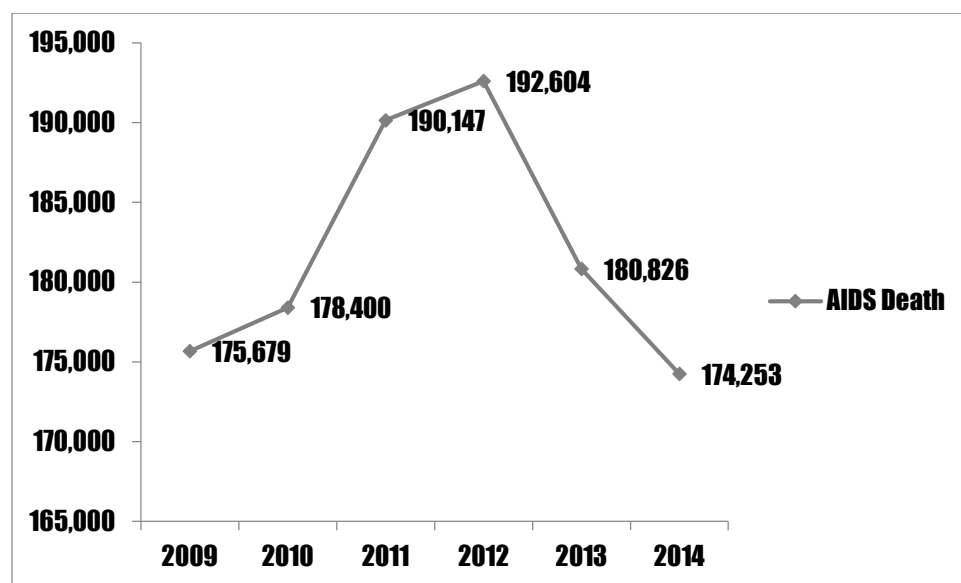


Figure 3.8: AIDS Related Deaths in Nigeria from 2009 – 2014



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 routine 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 2014, HIV positive individuals that received treatment for both HIV and TB were 17,102 which was higher than 11,153 in 2013. There are a number of stand-alone DOTS sites that mean that intra-facility and inter-facility linkages are required for effective referrals. In 2014, the number of persons enrolled for HIV care (PreART and ART) who were placed on Isoniazid (INH) prophylaxis were 22,899.

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 program; 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.

3.4.10 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. About 6% of under-18 children in Nigeria have one or both parents deceased. Evidence has shown that 9% of children are orphans or are vulnerable due to illnesses among adult household members. OVCs are more likely to be attending school compared to their non-OVC counterparts. About 95% of OVCs did not receive any type of medical, emotional, social, or material assistance or any school-related assistance.¹ The NSP 2010-2015 recognizes this programming need 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 levels coordinates the OVC response. The Federal Ministry of Women and Social Development (FMWASD) also chairs 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 programs 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.

Some organizations have been contributing to alleviating the growing population of OVC in Nigeria. For example CUBS (community based orphans and vulnerable children) which 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.

In 2014, the number of orphan and vulnerable children provided with social services health, nutrition, shelter, education and care, protection, psychosocial support, household and economic strengthening was 897,935. The number of OVC who have improved quality of life per standardized instrument as related to the service areas using CSI was 100,977. The number of OVC whose households received free basic external support in caring for the child was 86,307. The number of HIV positive people who received home-based care was 115,452.

Section Four: Best Practices

Nigeria's commitments to strengthening HIV/AIDS response through evidence-based approaches have been in line with the global best practices. This has necessitated the implementation of multi-sectoral comprehensive intervention programs. The same commitment has been replicated in several NGOs and CSOs which have over the years initiated programs that propagate grassroots and advocacy efforts aimed at limiting the spread of the epidemic. The programs below have been identified as best practices in the HIV national and state level responses.

4.1 Coordination at National and Sub-National Levels

Response to HIV and AIDS in Nigeria has been through a growing and expanding coordination mechanism. With coordination from NACA, the Agency has been collaborating with its State counterparts to ensure impact-oriented HIV programming to reduce new infections and improve quality of lives of people living with HIV/AIDS. 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 with the state TWGs. 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. In year 2014, national TWG meetings featured the presence of states within the geopolitical zones where the meeting was taking place. This was needed to update and provide opportunities for shared experience which could be implemented at the state level as a result of exposure to national TWG functioning.

4.2 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, reduction in the duplication of efforts, synergistic accomplishments and overall successes in program implementation.

a) Linking treatment coverage to prevention:

HCT and ARVs in key population groups were used to facilitate strategic and targeted coverage of treatment among HIV+ pregnant women (at first point of contact), HIV/TB, FSWs, their clients and communities who were not effectively reached. This also ensured focusing on ARV/TB treatment to facilitate high coverage by swiftly linking prevention to demand and providing support for greater prevention benefits. Thus, ARV/TB treatment coverage across all the states was improved strategically among key populations by strengthening and leveraging treatment and prevention including links for social mobilization and demand creation. These increased the number of people living with HIV/AIDS on national ART treatment program especially those eligible based on CD4 count less than 350.

b) ANC Platforms as leverage for PMTCT uptake and Impact

The ante-natal clinics (ANCs) as first point of contact for pregnant women was reinvigorated to increase PMTCT coverage and uptake by reducing missed opportunities for HIV testing, treatment and care. The ANCs service delivery pattern was re-engineered to address the challenges of low coverage and limited testing capacity by providing human capacity development, technical and material support for the ANCs to provide testing, treatment (where possible) and referrals for other continuum of care. The ANCs therefore were used as one-stop shop for comprehensive primary health care with priority for maternal and child health including early infant diagnosis.

c) Addressing key population transmission and key drivers of new infections

HIV and AIDS programming and policy on key population was strengthened through a conscious involvement of key populations in HIV and AIDS response. This enhanced the knowledge about extrapolation of size estimates using benchmarks and improved the national size estimates of key populations in the national response; thereby, strengthening MARPs intervention involvement from a human rights-based perspective.

In the same vein, recognizing the significant areas of risk behaviors and its gender dynamics including the declining use of condoms among FSW partners as the drivers of new infections in the national response conscious gender mainstreaming actions were initiated. Gender sensitive prevention actions were intensified to address high male risk behaviors and tackle the high level of new infections. Interestingly, the changing dynamics of transactional sex is being challenged through deepened and sustained prevention using BCC targeting bridges and link, girls and youths. Programming for condom use is also enhanced among FSWs and their communities including BCC among FSW partners.

d) Geographic focus of the national response based on a three-tier analysis

The national HIV/AIDS response and the roles of partners were differentiated according to a three geographic tiers by states based on an elaborate assessment of epidemiological data and modeling of new infections and disease burden. This provided a better division of focus between national program and state level roles, as well as among implementing partners by leveraging on comparative advantages. This way HIV/AIDS resources and financing are focused to achieve high coverage speedily, make meaningful impact and reduce new infections by 50%, while covering the full epidemic and targeting areas with possibilities of increasing new infections especially at the sub-national levels.

e) The President's HIV/AIDS Comprehensive Response Plan and National HIV Resource Mobilization Strategy - following the development of the Presidential Comprehensive Response Plan (PCRP) to the HIV/AIDS in the country, significant increase in the percentage of government spending to HIV/AIDS programming was witnessed especially through the active involvement of the Executive and Legislative arms of the government. In 2014 additional funding for the HIV response was recouped from the PCRP initiative through the assistance of NACA to the sub-national governments (States) for the development of focused and targeted State Unified Operational Plans (SUOP) involving multiple stakeholders. Furthermore, at the national level, a sum of Eight Billion Naira only (N8, 000, 000, 000. 00) was approved for appropriation through the Subsidy Reinvestment Empowerment Program (SURE-P) by the National Assembly.

Besides, there is somehow stabilization of external funding for HIV response by the international partners, while there is an improvement in state level funding mobilization and budget expenditure. The support for state level investment returns, implementation of state profiles including strengthening analytical capacity and investment cases, and adoption of

innovative state funding mechanism like result-based funding, funding linkages and integration helped boost State funding base.

f) Using Evidenced-based Research, Planning and Decision-making for Sustainable HIV/AIDS Management:

Innovative researches were pioneered to enable the country better understand the HIV/AIDS epidemic especially among out of school youth, persons with disability and male most-at-risk population. This is in addition to the IBBSS and Stigma Index Survey conducted to ascertain the level of stigma experienced by Persons Living with HIV (PLHIV). These researches and studies have led to the development of targeted, effective and efficient HIV/AIDS interventions at the national, sub-national and community levels. It has also immensely contributed to the emergence of a skilled-cadre of HIV response managers using evidence-based planning and decision-making tools for sustainable HIV/AIDS management using rigorous evaluations in a demand-driven and efficient way. For instance, this has facilitated the production of annual response reports at the sub-national levels with improved financial information. Key linkages for effective HIV response were established in the areas of HIV/TB, gender and social inclusion, public-private-partnership and private sector participation.

g) Harmonization of NHOCAT for capacity Assessment

The new organizational capacity assessment tool, the national Harmonized Organizational Capacity Assessment Tool (NHOCAT) is popularized and gradually being accepted, widely used to facilitate the harmonization of capacity building for line ministries, agencies and CSOs. Interestingly, NHOCAT is being adopted for use by the World Bank, USAID, DFID and others in Nigeria. MSH has also replicated the NHOCAT in a new “Progress” tool used for capacity assessment of CSOs and public sector bodies. This Nigerian organizational assessment capacity tool is in active use in Kenya and other developing countries.

Section Five: Major Challenges and Remedial Actions

CHALLENGES IDENTIFIED IN 2014 REPORT	ACTION(S) TAKEN
<p>National Commitment and Policy</p> <ul style="list-style-type: none"> • 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. 	<p>Concerted efforts by the stakeholders at the national and sub-national levels is being intensified for the President’s accent to the Anti-Stigmatization and Discrimination Bill, while sensitization and capacity building actions were conducted for law enforcement agencies at the sub-national levels where anti-discrimination laws exist.</p> <p>The HIV/AIDS Division of the Federal Ministry of Health championed the process for the development and/or updating of relevant HIV/AIDS guidelines with support from Implementing Partners and donors. Developed and/or updated guidelines were printed and distributed to the sub-national levels for distribution to the end-users.</p>
<p>Institutional Architecture, Systems, Coordination and Resourcing</p> <ul style="list-style-type: none"> • 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 	<p>A number steps has been taken to address these obvious lack of synergy across government structures and efforts. The reactivation of the various TWGs involving every relevant state and non-state actors (MDAs, private sectors, CSOs, NGOs, FBOs etc) under the coordination of NACA has enhanced linkages while reducing leakages.</p> <p>Various donor-funded projects have taken up these responsibilities of strengthening the coordination capacity of the sub-national coordinating bodies under the guidance or supervision of NACA using a common tool for capacity development.</p> <p>Various avenues for private in development are being explored as part of the wider post-MDG consultation. Through the GF support more private-sector participation in HIV/AIDS has been recorded while their contribution is equally being harvested.</p> <p>The recently developed PCRPs has substantially enhanced the national response coordination. There are accountability arrangements between NACA and various implementing partners, the process of integrating the various reporting system is still on-going</p> <p>The national storage facility is currently</p>

<p>demonstrating ownership and clarity of process in implementing the national response.</p> <ul style="list-style-type: none"> 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 	<p>under construction and once completed will enhance the national supply chain management mechanism and distribution. While the mechanism for the maintenance of laboratory equipment at the national and sub-national levels has been improved upon.</p>
<p>Low PMTCT Coverage</p> <ul style="list-style-type: none"> 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 	<p>The introduction of Option B+ regimen is improving access to ARVs for pregnant or breastfeeding females living with HIV. This has enhanced PMTCT uptake and reduced the over reliance on laboratory testing to determine eligibility for HIV treatment and care among pregnant or nursing women.</p> <p>As such more facilities are being equipped at the sub-national and community levels to provide EID services with support from development partners. Training of laboratory staff to support clinicians and health workers diagnose and treat HIV/AIDS related conditions are being prioritized.</p>
<p>Treatment of HIV/AIDS and Related Health Conditions</p> <ul style="list-style-type: none"> There are still weaknesses in the referral system that contributes to the continual loss of clients between service points. 	<p>National referral forms are being developed for adoption and/or adaption by implementing partners at the national, sub-national and community levels with strong link to the national reporting forms. In addition, innovative program actions including the use of ‘escorts’ for those referred.</p>
<p>Care and Support for PLHIV, PABA and OVC</p> <ul style="list-style-type: none"> 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 	<p>There has been an improved linkage between the FMWASD, SMWASD and implementing partners as shown in the various coordinating and reporting meetings facilitated at the national and sub-national levels.</p>

The increasing proportion of HIV exposed infants still unable to get Early Infant Diagnosis (EID) services presents the need for the scale-up of PCR laboratories in states with high HIV prevalence. This will require strengthening strategies for screening breastfeeding mothers and their children and facilitating easy access to testing centers. While logistics support

related to EID services also need to be integrated within the wider HIV response procurement and logistics mechanisms.

The decline in the number of clients receiving adherence support between 2011 and 2013 clearly indicates the need for an action towards incorporating adherence support for PLWHAs as part of the comprehensive ART program in the country. Of importance in this regard, is the need to strengthen community systems and social networks for proper follow-up of cohorts of adults and children on ART even as more PLWHAs switch to 2nd line regimens. More so, achieving geographical spread of ART sites in terms of location and quantity is a challenge to be addressed in national ART goal.

One of the main challenges confronting the national response was the decline in the volume of governments' spending and resources allocated to HIV/AIDS response. This is attributed to the contractions in the national economy due to the global oil market instability and economic uncertainties. The non-release of the national and sub-national governments' budgetary allocations on HIV/AIDS as at when required and in budgeted quantum has adversely delayed and/or derailed the national response. This remains a huge issue impeding the delivery of sustainable, efficient, and effective HIV/AIDS response. Conversely, the implication is that there has been a steady decline in the unmet needs of HIV/AIDS interventions in Nigeria. This is evidenced in the recorded unmet needs of adult ARV at 59% in 2013, the unmet needs for PMTCT services at 73% as at 2013, and the unmet needs of pediatric ART fluctuating from 87% to 80% between 2012 and 2013 based on Spectrum Outputs of 2014 (UNAIDS & NACA, 2014). The PCRPs however, which is intended to ensure proactive HIV/AIDS response is seemingly not adequately backed with the desired funding and political will as shown in the 2014 national budgets. Regrettably, development Partners and donor funds still represent the vast majority of HIV/AIDS funding in Nigeria. On the other hand, accountability in terms of sustaining inclusive planning, program and financial reporting in the absence of donor programs are likely to be struggled with among multi-sectoral coordinating agencies.

Although there has been improved coordinating relationship between NACA and NASCP, same cannot be said at the sub-national levels between the SACAs and SASCP for the delivery of an effective and well-coordinated multi-sectoral response. Misunderstanding of roles and responsibilities as well as misinterpretation of mandates still prevails at the sub-national level leading to missed opportunities, duplication and conflicts. There is therefore need for better understanding of mandates, responsibilities and roles clarification with a clear mechanism for the monitoring of compliance supervised by NACA.

An essential initiative is the strengthening of the institutional capacities of the entities on HIV/AIDS response at the national, state and local levels. At the state level, the SACAs have all transformed into agencies but not all the SACAs have an established board, functional Technical Working Groups (TWGs) and operational LACAs at the LGA levels. For instance, while TWGs on M&E, Prevention and Care and Support have been established and functional to some extent across all the states, TWGs on Policy and Advocacy, Gender, Resource Mobilization and PMTCT in most cases are non-existing and weak. Consequently, more proactive actions are required to establish and/or reactivate TWGs on Policy and Advocacy, Gender, Resource Mobilization and PMTCT.

A mix of public, private and international funding sources of HIV expenditure exist in the country, the international funding source accounts for majority of the national HIV expenditure. The contribution of the public funding source is far less than the international funding source, while the private source of funding is very low and unpredictable – this

keeps widening the HIV funding gap. The continuous decrease in public source of HIV spending is worrisome in the light of achieving national and universal targets and in the event of either partial or total withdrawal of international funding sources.

Although HIV/AIDS related policies and plans exist in the country at the national and sub-national levels, obnoxious practices, attitudes and behaviors permeates the HIV/AIDS landscape. Some of these policies and laws violates fundamental human rights, discriminates and stigmatizes citizens. For instance, the enforcement of stigmatizing and discriminatory policies has continued to limit access to the most-at-risk populations; and consequently, there are limited targeted behavior change prevention programs for such groups in the national response.

Concrete Remedial Actions Planned for the Achievement of Agreed Targets

Efforts will be geared towards lobbying the executive and legislative arms of governments at the national and sub-national levels for the implementation of the PCRPP through sustained funding. To this end, relevant institutional and organizational systems at the national and sub-national levels will be strengthened to mobilize additional domestic funds for HIV/AIDS response and utilize same in an inclusive and cost-effective manner. Consequently, advocacy and capacity development on public sector accountability will be prioritized at the national and sub-national levels for coordinating and implementing entities. Developing the institutional capacity, management and operating systems of the coordinating and implementing entities will also not be neglected so that they are able to play their envisaged roles.

The primary health facilities in the country will be upgraded and efforts made towards adequate resourcing with personnel and equipment for HIV/AIDS response particularly for the achievements of EID and PMTCT related results. Supporting the Ministries of Health at national and sub-national levels to champion and sustain the integrated supportive supervision processes will be explored.

There is an urgent need for concerted efforts and engagement towards increasing the HIV/AIDS public funding base to reduce and/or eliminate dependency on international sources from bi-lateral or multi-lateral agencies for HIV funding. Additional local resource mobilization options need to be explored for the expansion of the national HIV/AIDS resource base across public and private sectors. While some HIV/AIDS program areas have been given significant attention, others are barely given attention even in HIV resource allocation and utilization. Ensuring equity in HIV/AIDS funding across program areas needs to be prioritized. This means implementing all-inclusive response strategies across all HIV/AIDS program areas and among all targeted beneficiaries, while ensuring that interventions in priority states with highest disease burden are adequately financed.

The National HIV/AIDS Strategic Plan will require support for its review and subsequent development of a new plan for 2016 and beyond. Creative ways of harnessing stakeholders' capabilities for the new NSP development will be required.

6.1 Key Support Received From Development Partners

With regard to assistance from development partners – a number of partners have been active in Nigeria during the period under review, they include: the United States Government, the World Bank, United Kingdom, the United Nations System, and the Global Fund to Fight AIDS, Tuberculosis and Malaria [GFATM]. Some of the areas of support include health information management systems, procurement and supply chain management, treatment, care and support, logistics management, health systems and community systems strengthening, disease management and surveillance, orphan and vulnerable children interventions, data and strategic information management. Different aspects of the response are being supported by the partners. For instance, the World Bank funded HIV/AIDS Program Development Project (HPDP) is being used to support CSOs, private sector and public sector participation in the national response.

HAF3 has enormously supported the CSOs participation in the national response. DFID and USAID continued to be the most significant donors for the national response through assistance at the national and sub-national levels. The United Nations System in Nigeria provided support in the areas of gender mainstreaming and women's rights, advocacy and human rights, program management and coordination, as well as other areas of HIV response among key population groups. The GFATM has been a strong backing to the national response across all the implementation levels.

The technical expertise of the country's implementing partners and donors has substantially transferred skills to national and sub-national entities for the design, implementation, monitoring and evaluation of relevant components of the national HIV/AIDS response. This support has ensured the realignment of the national response based on empirical evidence.

USAID, PEPFAR and United States Government (USG) Partners

During the period under review, USAID, PEPFAR, CDC and the USG partners supported a broad range of interventions including efforts to improve pharmaceutical management of ARVs and other HIV-related drugs, supporting the integration of HIV and TB programs, strengthening and expanding access to HTC, improving TB detection and diagnosis, and improving treatment and monitoring of HIV/TB co-infected individuals. The USG partners also supported community-based OVC interventions, small grants for community-based HIV/AIDS activities, including support for adolescents and young people, capacity-building for HIV support groups, and locally-based interventions for OVC. The USG commitments for the year 2014, established clear priorities with expected outcomes to expand and improve the effectiveness of national prevention interventions, including SBCC, HTC, condom promotion and distribution, PMTCT and targeted interventions addressing key populations. Other areas supported include assistance for the universal ART coverage while strengthening and stabilizing the national ART program for the long-term impact by providing ongoing, relevant training for health care workers involved in HIV care at the hospital, health center and community level.

UN Systems in Nigeria

The UN agencies operating in Nigeria has supported different interventions, through their various agencies to enable national and sub-national governments and civil society to promote and protect the rights of women, girls and PLWHIVs. UNICEF has been unequivocal in its support for adolescent and youth oriented prevention interventions promoting the integrated adolescent and youth friendly health services in HIV/AIDS treatment and care, and the strengthening of social protection systems for OVCs. UNFPA supported PMTCT and Family Planning interventions, WHO provided technical assistance for programming in HIV and TB, as well as HIV/TB collaborative activities to the Ministry of Health, UNESCO continued its support of the educational sector response to HIV/AIDS and UNAIDS supported the multi-sectoral partners and coordinated the implementation of the multi-stakeholder intervention activities.

World Bank

The World Bank provided HIV/AIDS support to reduce the risk of HIV infections by scaling-up prevention interventions, increasing access to and utilization of HIV/AIDS care and support services. This support is broadly categorized into expanding public sector responses; strengthening mechanisms for HIV program coordination and management and expanding civil and private sector engagement and response through the HIV/AIDS Fund (HAF). Capacity-building and technical assistance for the national response focusing on building multi-sectoral capacity for HIV/AIDS management as well as addressing weakness in the health systems are some of the areas focused. Through the HAF, support was provided for the improvement of community-level program delivery capacity among State and the civil society actors – at the local government and local community-based organization levels. HAF has expanded and scaled-up the non-public sector response to HIV/AIDS and provided support for the private sector participation and/or involvement in HIV/AIDS service provision.

6.2 Actions to Be Taken by Development Partners for Achievement of Targets

Beyond financial resources development partners also deployed a significant level of technical expertise at the sub-national and federal levels in Nigeria. Their personnel worked 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 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 the PMTCT analysis (that is Bottleneck analysis on PMTCT services) 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 Federal Government of Nigeria have proceeded to adjust and align HIV programming to ensure the attainment of national targets in a timely and well-coordinated fashion. This is needed to improve coordination.

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 NOP1 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 (NOP2) 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 NOP2 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

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 obtained 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 among MARPS or key populations. The last round of IBBSS was conducted in 2014 and the findings will be released in 2015.

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 behaviors change, there will be a change in the spread of HIV. Second generation surveillance systems provide opportunity to monitor trend in high risk behaviors, 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 2014

- Implementation and rollout of cloud based DHIS2 platform for electronic reporting and analysis of routine data. All 36 states and FCT are using DHIS 2.0 for reporting HIV/AIDS routine data.
- Review of the pilot DHIS mobile phone application implemented by NACA, DPRS (FMOH), USG, World Bank and the GFATM was done in 2014. This is vital to massive scale-up of DHIS mobile application to 5000 PHCs by end of December 2015.
- 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 2015.
- The country through National Agency for the Control of AIDS also conducted a multi stakeholder review of the HIV/AIDS situation in the country known as the National HIV/AIDS Epidemiology and Impact Analysis (NHEIA). The findings of the review provided understanding of the distribution and drivers of HIV epidemic over years in Nigeria, and an assessment of the effectiveness of program implemented.
- 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.
- Development of standard and harmonized national data collection tools for the non-health sector or community response including: HIV prevention for both MARPS and general Population; care and support, family life and HIV/AIDS education (FLHE)
- More M&E professionals have been trained in Nigeria to improve the state and national responses which is in line with the commitment for human capacity building in the 12 components of functioning M&E system.

7.6 Challenges

- Weak infrastructural support (computers, internet facilities) for DHIS 2 electronic reporting at the LGA and facility level respectively.
- Lack of integration of DHIS instances run by different Agencies/Department

- 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.
- Weak collection system for data generated in non-health and private sectors
- 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
- Data dissemination and use are still weak in the areas of evidence-based HIV programming
- Absence of a harmonized national M&E calendar of activities
- Limited number of trained health personnel in the area of monitoring and evaluation or strategic information to support data collection and reporting
- Data reporting from community outreaches is still weak

7.7 Remedial Actions

- Leverage resources from all sources, including government to empower the facility, LGAs and communities with infrastructural support to enhance timely data collation and submission using DHIS2.
- Commission regular and periodic evaluations of the various HIV/AIDS program 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
- Need to develop a culture of data dissemination and use for evidence-based HIV programming
- Need to strengthen capacity building, mentorship and supportive supervision among facility and community health workers

7.8 Conclusion

This Nigeria 2015 GARPR report highlights the progress Nigeria made in HIV response in the year 2014. While the report shows that some progress has been made in the last 12 months since the last GARPR reporting round in 2014, 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 donors and partners in the HIV/AIDS response and the Nigerian people remain committed to ensuring that targets are met.

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