PRESIDENT'S COMPREHENSIVE RESPONSE PLAN

FOR HIV/AIDS IN NIGERIA

FOREWORD

The HIV/AIDS epidemic in Nigeria has had far reaching social and economic impacts on the citizenry which raises concerns for my administration. The impact of the Global economic recession in recent times on all aspects of National development particularly the health sector cannot be overstated. My administration from the onset has always placed health on its priority list and the transformation agenda of my government aptly speaks to this. However, the systemic challenges facing the national HIV response and the slow pace of progress towards attaining set national and global targets have not gone unnoticed. There is no better a time in our history than in this period of our centenary celebrations to make significant impact on the national HIV response through a conscious effort to mitigate the noted challenges preventing our beloved country from halting and beginning the reversal of the epidemic.

Achievement of the Millennium Development Goals 4, 5 and 6; the elimination of Mother to Child Transmission of HIV and attainment of 50% domestic financing of the HIV response is a renewed commitment of this administration.

This comprehensive response plan provides an opportunity for all stakeholders to join hands and march towards the end of AIDS. I use this medium to call on the political class to see the achievement of an AIDS free generation in Nigeria as a befitting legacy we can leave behind for the citizens of this great nation.

God bless our great country and I wish all Nigerians happy centenary celebrations.

Dr Goodluck Ebele Jonathan GCON GCFR
PRESIDENT
FEDERAL REPUBLIC OF NIGERIA

PREFACE

The last five years has seen significant progress in the national response to HIV. The National prevalence has levelled out and started a decline and Nigeria is currently classified as having a stable change in the incidence rate of HIV infection among adults. Many more people are having access to antiretroviral drugs when compared to five years ago and impact of behavioural interventions are beginning to become manifest. In spite of the progress made, Nigeria remains one of the most burdened countries globally with over 3 million people living with HIV, significant gaps in treatment and limited domestic financing of the HIV response. The first bold step has been taken in identifying the challenges and the support of the president has injected the necessary momentum towards addressing them.

Our common goal remains to halt and reverse the spread of HIV by 2015 and in so doing contribute to the attainment of the MDGs and the national developmental goals including the President's vision and agenda.

To achieve this, we need to accelerate our efforts towards providing universal access to comprehensive HIV prevention, treatment, care and support services.

The President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP) could not have come at a better time. The Global effort to prioritize interventions; seek more cost-effective approaches to scale up service delivery and increase the multi-stakeholder involvement in the response to HIV remain practicable and will help halt and reverse the epidemic. The PCRP incorporates these tenets and provides a unique opportunity to achieve greater ownership of the response at sub-national levels and by this guarantee improved access and sustainability. It is anticipated that this will inject the required momentum into the HIV response and attainment of our national commitments.

The role of the PCRP is to galvanize the national response to attain the targets set in the National HIV/AIDS strategic plan (2010-2015), focus and strengthen the national response to HIV/AIDS. This initial two year plan is the first phase of the longer term sustainability strategy of the Nigerian Government. A longer term HIV investment case for 2015-2025 is being developed.

I call on our stakeholders, partners and the private sector to embrace this plan and join us in this renewed fervour in the national HIV response.

Prof. C.O. Onyebuchi Chukwu, FWACS, FICS
Honourable Minister of Health,
July 2013

ACKNOWLEDGEMENTS

The National Agency for the Control of AIDS (NACA), wishes to appreciate His Excellency, the President of the Federal Republic of Nigeria, Dr Goodluck Ebele Jonathan, GCON GCFR, for the Leadership and vision in challenging all of us to develop this very important document called the President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP).

The enthusiasm and robust support for the vision of Mr President by the State Governors is acknowledged. This support was demonstrated first during the select Presidential interaction in January 2013 and subsequent delegation of their Honourable Commissioners of Health and the Chief Executives of the various State AIDS Control Agencies (SACAs) to participate in the Technical deliberations of 13th June 2013 in Abuja on the draft PCRP .

The Leadership and supportive role of the Secretary to the Government of the Federation, Senator Anyim Pius ANYIM, GCON, and the Honourable Minister of Health, Prof. C.O. Onyebuchi Chukwu in transforming the vision of the President into an Action Plan that is implementable is highly appreciated.

The development of the document has been an all-inclusive process with contributions from key sectors of the National HIV/AIDS response. The support from our partners, the Expanded Theme Group on HIV/AIDS (ETG), Development Partners Group on HIV and AIDS (DPG) and particularly USAID, CDC, UNAIDS, UNICEF, WHO, World Bank and UNFPA is acknowledged and appreciated.

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Special commendation is given to the team of consultants led by Dr Alozie Ananaba and including Mrs. Christiana Laniyan, Dr Tuoyo Okorosobo and Emeka Nsofor for their subject matter expertise, commitment and professionalism in developing this document.

The effective coordination by Alex Ogundipe, Director Policy and Strategy, NACA and Cyril Ojeonu, Assistant Director Policy and Strategy NACA is highly appreciated.

The financial and technical support from UNAIDS is acknowledged and we hope to continue in this highly collaborative spirit until we successfully halt and reverse the HIV epidemic in Nigeria.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Care
BCC	Behaviour Change Communication
CBOs	Community Based Organizations
CPT	Co-trimoxazole Preventive Therapy
CSOs	Civil Society Organizations
CTX	Co-trimoxazole
DFID	Department for International Development
DHIS	District Health Information System
FCT	Federal Capital Territory
FGoN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
GFATM	Global Fund to fight HIV/AIDS, TB and Malaria
GoN	Government of Nigeria
HAD	HIV/AIDS Division
HAF	HIV/AIDS Fund
HAPSAT	HIV/AIDS Program Sustainability Analysis Tool
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IBBSS	Integrated Biological and Behavioural Surveillance Survey
IDPs	International Development Partners
IDU	Injecting Drug Users
IEC	Information, Education, and Communication
IMNCH	Integrated Maternal, New-born, and Child Health
IPs	Implementing Partners
JAR	Joint Annual Review
LACAs	Local Government Action Committee on AIDS
M&E	Monitoring and Evaluation
MAP	Multi-Country AIDS Program
MARPs	Most-at-Risk Populations
MDGs	Millennium Development Goals

MSM	Men who have Sex with Men
NACA	National Agency for the Control of AIDS
NARHS	National AIDS and Reproductive Health Surveys
NASA	National AIDS Spending Assessment
NASCP	National AIDS and STI Control Program
NDHS	Nigeria Demographic and Health Survey
SMT	State Management Team
TWGs	Technical Working Groups

Nigeria has pursued a vision to halt and reverse the HIV and AIDS epidemic in the country in line with global commitments. With the valuable support of local and international partners, the country has seen the epidemic profile change significantly from a HIV prevalence rate of 5.8% (in 2001) to 4.1% in 2010. Attaining the status of a country with stable change in the incidence rate of HIV infection among adults 15–49 years old between 2001 and 2011 is a significant achievement but the overall gaps in access to HIV/AIDS service remains a great challenge. This becomes all the more important with wider implications when put within the context that Nigeria has the second highest HIV burden in the world with 3.4 million people estimated to be living with HIV in 2012. At the end of December 2012, only 491,021 HIV positive persons out of an eligible population of 1.6 million were accessing ART (30% of national need). This exemplifies the scale of the service gaps and the urgent need to address them. Systemic reviews of the national response have identified key challenges which revolve around limited domestic financing of the response, weak coordination at national and state levels, inadequate state government contribution to resourcing the response; challenges with human resources for health, weak supply chain management systems; limited service delivery capacity and limited access to HIV services.

The urgency of the situation caught the attention of His Excellency Dr. Goodluck Ebele Jonathan *GCON GCFR*, the President of the Federal Republic of Nigeria, who in demonstrating high level of commitment to the national response to HIV, requested the development of a comprehensive response plan to bridge existing gaps and establish the framework for achieving global targets by 2015.

The President's Comprehensive Response Plan for HIV/AIDS in Nigeria (PCRP) is a response tool to the challenges facing the national response. It is designed with the mission of addressing priority system and service delivery challenges to the HIV and AIDS response in Nigeria.

The goal of the PCRP is to accelerate the implementation of key interventions over a two year period to bridge existing service access gaps, address key financial, health systems and coordination challenges and promote greater responsibility for the HIV response at Federal and State levels. Specifically, the plan aims to avail 80 million men and women aged 15 and older knowledge of their HIV status; enrol an additional 600,000 eligible adults and children on ART; provide ART for 244,000 HIV pregnant women for PMTCT, provide access to combination prevention services for 500,000 MARPS and 4 million young person's and activate 2,000 new PMTCT and 2000 ART service delivery points across the country.

This document presents a unique opportunity to put Nigeria back on track towards achieving global commitments, targets and expectations particularly that of halting and reversing the HIV epidemic by 2015. Its full implementation and the support of all stakeholders remain critical for achieving the desired impact and are highly solicited.

SECTION 1

1. BACKGROUND AND CONTEXT

1.1 RATIONALE FOR THE PRESIDENT'S COMPREHENSIVE RESPONSE PLAN

Nigeria has the second highest burden of HIV in Africa. With effective treatment, AIDS related morbidity and by extension mortality is reducing. Nigeria falls within the categories of countries classified as having a stable change in the incidence rate of HIV infection among adults 15–49 years old, 2001–2011[1]. Obstacles to scaling up HIV treatment persist in some countries, and these are partly due to inadequate funding, inadequate human resources, and weak procurement and supply management systems for HIV drugs and diagnostics and other health systems bottlenecks[2]. Nigeria has had its fair share of bottlenecks and the national response has shown similar characteristics as those described in the Universal Access Report.

Recognizing the genuine opportunity to plan for the end of AIDS, Nigeria joined other countries to pledge in the 2011 United Nations Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS to take specific steps to achieve ambitious goals by 2015[3]. This pledge amongst others identified the urgent need to significantly scale up efforts towards the goal of universal access to comprehensive prevention programmes, treatment, care and support. It also committed countries to redouble efforts to achieve universal access to HIV prevention, treatment, care and support by 2015. This is a critical step towards ending the global HIV pandemic, with a view to achieving Millennium Development Goal 6, in particular and to halt and begin to reverse the spread of HIV by 2015.

It is on the premise of this global declaration, the continuing challenges to universal access to HIV/AIDS services in Nigeria and the high political commitment by the President of the Federal Republic of Nigeria His Excellency President Goodluck Ebele Jonathan, that this President's Comprehensive Response Plan for HIV/AIDS in Nigeria (2010-2015), PCRP, becomes critical to jumpstart the acceleration process and bridging existing gaps in the national response both at funding and coordination levels.

> *"Domestic financial resources from the public sector and private out-of-pocket spending have been supplemented substantially by external funders including the U.S. President's Comprehensive Plan for AIDS Relief (PEPFAR), the GFATM, the World Bank Multi-country AIDS Program (MAP), and the U.K.-Department for International Development (DFID).*
>
> *Excluding private out-of-pocket expenditures, about US$600 million will be available for HIV programs in each of the next five years (2010-2014), with approximately 85 per cent coming from donors.*
>
> *This level of funding falls far short of the resources needed to reach universal coverage in all programmatic areas. The scarcity of resources and the current reliance on external donors compel prudent allocation across programmatic areas to ensure that strategic policy goals can be sustainably achieved"*.....HAPSAT Nigeria, 2009: Policy Modelling to Support Strategic Planning for Sustainable HIV/AIDS Services

1.2 THE DEVELOPMENT PROCESS OF THE COMPREHENSIVE RESPONSE PLAN

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

[1] Global AIDS report 2012
[2] UNAIDS, 2011 Universal access report
[3] UN General Assembly: Political Declaration on HIV and AIDS: July 2011

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

A team of consultants supported by representation 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 Analysis (NASA 2010), The Global Fund Financial Gap Analysis 2012 and the Global Fund Programme Performance Review of 2012). Also are view 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 & ownership, and sustainability beyond the two years life span of the plan.

It is important to point out that the PCRP is a tool for accelerating the national response and is designed to fast track on-going efforts at implementing the NSP2010-2015 and the wider national response to HIV/AIDS.

1.3 RELATED POLICY, PLANNING AND IMPLEMENTATION ENVIRONMENT

1.3.1 ***Policy***: Over the years the Nigerian response to HIV and AIDS has increased in scope and quality, encompassing many sectors and stakeholders. The coordination and standardization challenges posed by this were addressed through policies and guidelines which have guided Nigeria's response to HIV/AIDS. Whilst the policies have provided enabling environment for coordination and planning, the guidelines ensured effective and quality implementation in line with global best practices. These have contributed immensely to the achievements recorded thus far in the response in the areas of policy, planning and implementation.

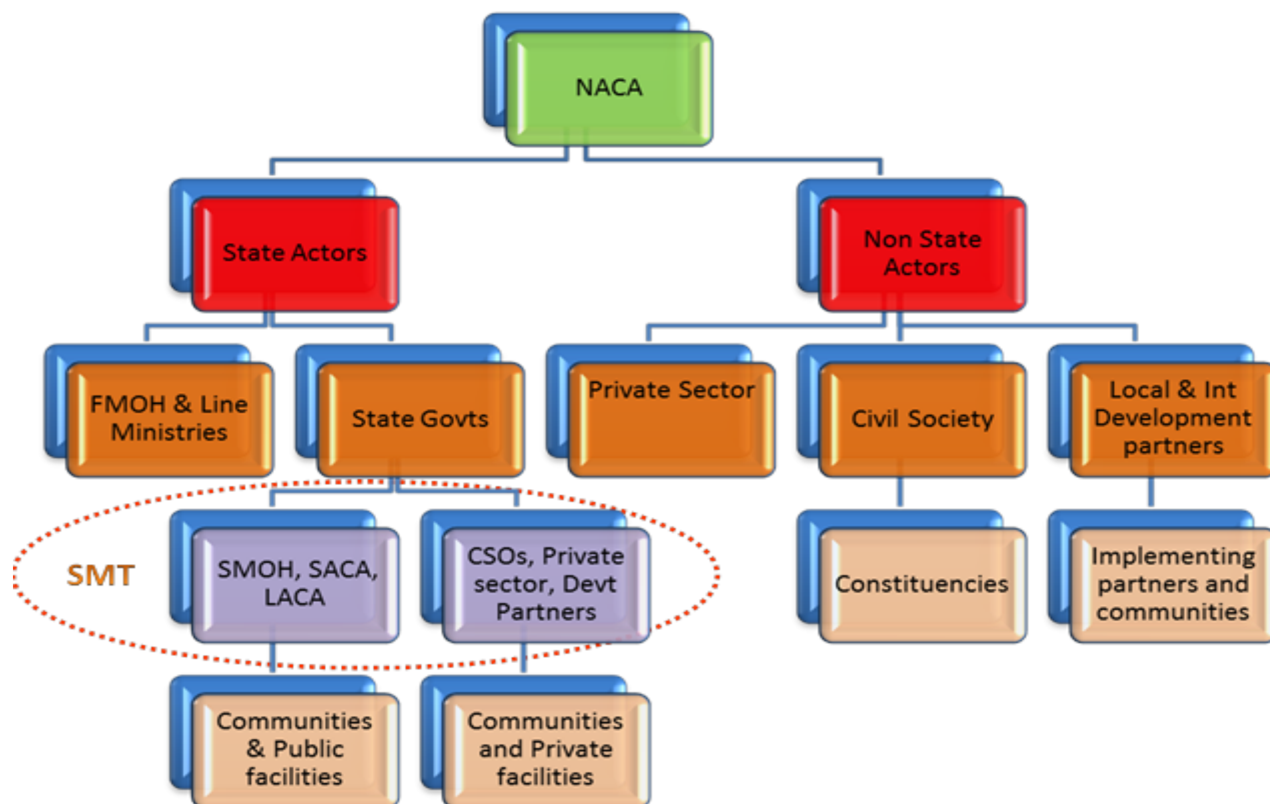
The country's HIV policy and programming frameworks have witnessed remarkable development in the last decade. Key outputs in this regard include: National HIV/AIDS Policy (2005 and 2010); National Strategic Framework (2005-2009 & 2010–2015); National HIV/AIDS Strategic Plan (2010-2015); National HIV/AIDS Workplace Policy; National HIV/AIDS Prevention Plan (2007-2009 & 2010-2012); and the National Behaviour Change Communication Strategy etc. Drawing from these, several sub-national and sectoral policies and plans have been developed and are currently being implemented across sectors and at all levels. All the States, FCT and line ministries currently have developed their 4 year strategic plans and 2 year operational plans. In addition, a monitoring and evaluation plan known as the NNRIMS Operational Plan II (NOP2 2011-2016) was developed to support effective tracking of the national response as well as inform future policies and programmes development and reviews.

The PCRP and implementation elements will be in accordance with existing national systems. The PCRP will explore innovate linkages to other existing national endeavours to ensure cost-effectiveness and sustain harmonization. The Federal Ministry of Health (FMoH) has the responsibility of developing national health policy and guidelines for its implementation. In line with the recommendations of the JAR 2011[4], dissemination of these policies and guidance documents will be a key accompanying strategy within the PCRP

1.3.2 ***Coordination:*** The national response in Nigeria is coordinated through a system involving state and non-state actors. NACA leads the coordination at national level, with the FMoH is 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 (CSOs), NACA-private sector, NACA-public sector and NACA-development partner and NACA-TWG interactions. In line with the tenets of the PCRP, this coordination mechanism while being utilized for implementation of the PCRP will be strengthened with the introduction of a management and funding model that encourages greater state level involvement, transparency and accountability.

[4] Joint Annual Review of the National Response to HIV/AIDS, 2011

FIGURE 1: NATIONAL HIV/AIDS RESPONSE COORDINATION ARCHITECTURE



1.3.3. ***Service delivery***: There are several challenges with service delivery: inadequate numbers of and mal-distribution of service delivery points, equity issues and quality of services. Universal access is hinged on radically increasing the demand and supply aspects of the HIV care continuum. Therefore, rapid investments towards increasing the number of service delivery points, the scope and quality of services and innovative approaches to increasing demand for HIV services are vital for achieving universal access; and retention within the service continuum, these are areas of focus of the PCRP. The PCRP targeted approach involves improving the capacity of existing facilities both human and infrastructural capacities; support to scale up activities to other levels of service delivery - PHCs and CHCs; and greater private sector involvement.

1.3.4 ***Monitoring and Evaluation:*** National HIV M&E systems require strong leadership and coordination mechanisms at the national and sub-national levels to generate the requisite information for decision making and tracking progress. From the 2011 JAR report[5], the current system is considered strong at the national level while those at the state, LGA and community levels need to be strengthened. The 2011 JAR report also recommends strengthening of coordination and advisory bodies such as the M&E TWG. The PCRP will strategically complement these on-going efforts. .

Operations research to generate evidence to inform, improve program design and cost-effectiveness of the national response is still rudimentary. The PCRP will exploit existing opportunities for generating evidence from local research to improve impact and sustainability of the effective interventions in the national response. Evidenced based interventions and 'good practices' will be widely disseminated for implementation.

[5]Joint Annual Review of the National Response to HIV/AIDS 2011

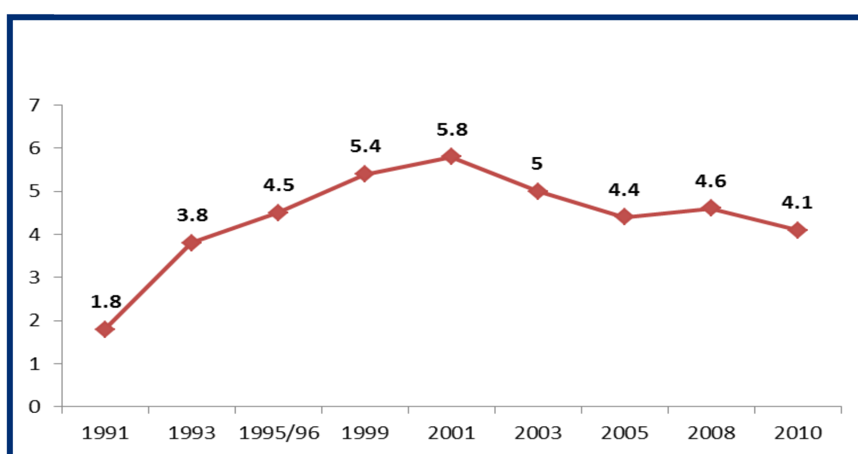
2. SITUATION AND RESPONSE ANALYSIS

2.1 THE HIV AND AIDS SITUATION IN NIGERIA

The first case of AIDS in Nigeria was reported in 1986 establishing the presence of the epidemic in the country. Nigeria carries the 2nd highest burden of HIV globally. The prevalence of HIV in Nigeria as at 2010 was 4.1%. Women and children constitute the largest percentage of those infected and affected in Nigeria. Analysis of the 2010 national HIV prevalence report shows that 58% of the PLHIV population is women.

The number of persons living with HIV (PLHIV) at the end of 2011 in Nigeria was about 3.4 million. An estimated 388,864 became newly infected by HIV in 2011 and an estimated 217,148 people died from AIDS related causes in 2011[6]. In addition, the number of persons requiring ART rose to about 1.66 million. Although the national median HIV prevalence has been reducing since 2002, other indices continue to worsen.

FIGURE 2: HIV PREVALENCE TREND IN NIGERIA 1991-2010



Source: 2010 Technical report on National HIV Sero-prevalence Sentinel Survey among Pregnant Women Attending Antenatal Clinics in Nigeria.

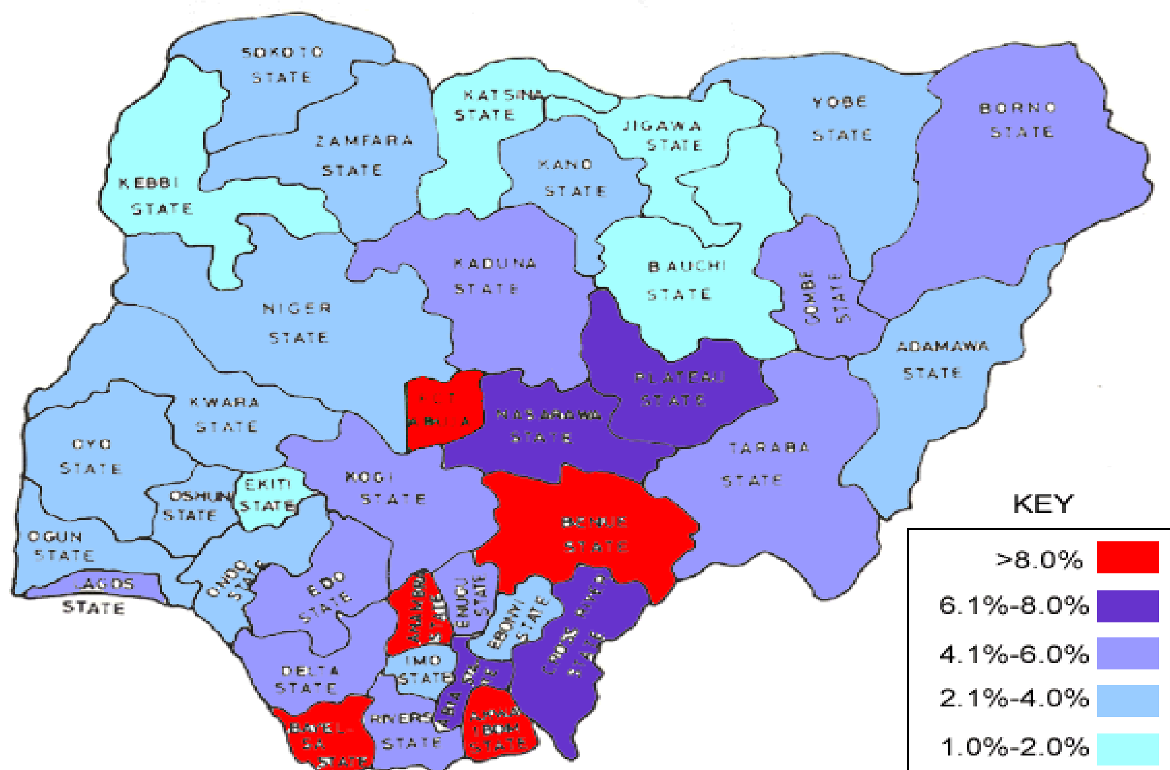
HIV prevalence by Geopolitical Zones and States

A comparison of HIV prevalence by geopolitical zone in Nigeria between 2008 and 2010 showed that prevalence in the North West and South-South zones reduced while it increased in the North Central, South East and South West zones. The HIV prevalence in the North-East zone has remained stable. Twelve (12) states and the Federal Capital Territory (FCT) that have high HIV prevalence have been shown to be responsible for about 70% of the HIV burden in Nigeria. These states which are referred to as the '12 plus one states' are: Benue, Akwa-Ibom, Bayelsa, Anambra, FCT, Plateau, Nasarawa, Abia, Cross-River, Rivers, Kano, and Kaduna.

The lowest prevalence of 0% was reported in four locations in the country: Kwamiin Gombe State, Rano in Kano State, Owhelogbo in Delta State and Ganawuri in Plateau State. The highest HIV prevalence of 21.3% was reported for Wannune in Benue State.

[6]Spectrum modeling 2011

FIGURE 3: HIV PREVALENCE MAP- NIGERIA



HIV Transmission

Heterosexual transmission accounts for the majority of HIV transmission. The 2010 Mode of Transmission Study[7]reported that 34.6% of new HIV infections occur among couples considered as engaging in 'low-risk' sex, while 23% occur among most at risk populations(MARPs). More than a third of all new infections were linked to female sex workers, their clients and partners, men who have sex with men and injecting drug users and their partners[8].

Socioeconomic Impact

Children

Beyond its health impact, HIV has severe socioeconomic implications. Children are exposed to their share of the HIV/AIDS burden either by being affected through mother to child transmission infection or through the loss of one or both parents from AIDS. Of the 17.5 million vulnerable children, an estimated 7.3 million have lost one or both parents due to various causes. Of these, 2.23 million were orphaned by HIV/AIDS, while about 260,000 children are living with HIV/AIDS. The 2008 National Situation Assessment and Analysis (SAA) on OVC (FMWASD, 2008) showed that not only has HIV and AIDS been a major cause of death of parents, especially in households where both parents have died, but also before the loss of a parent, social and economic vulnerability is exacerbated by serious illness of a parent or other adult member of the household.

Households and Communities

Within communities, families with HIV/AIDS infected persons are stigmatized. A stigma survey among HIV positive persons in Nigeria showed that 34% of affected persons were excluded from family events, 35% were verbally assaulted, 28% were physically assaulted and 29% suffered a loss of job or income. Beyond their

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[7] 2009 Mode of Transmission Study

[8] 2010 Mode of Transmission Study

immediate communities, 21% reported being denied health services generally and 8% SRH services specifically[9]

A large proportion of Nigerians live below the poverty line. In this context, HIV infection within the family or household does have implications. The average annual out-of-pocket expenditure for direct HIV services was N84, 480. The proportion of household income spent on HIV care was 14.5%[10]. There is an indication that HIV infection within the household is related to higher unemployment, increased time off work, and challenges meeting financial obligations – requiring sourcing for additional financial support outsides of their income.[11]
The death of family members have effect on dependency pattern, changes in household expenditure and income, sale of house hold assets, household livelihood and coping mechanism especially child labor and prostitution is very prominent.

Other sectors
The impact of the HIV/AIDS epidemic on the health, petroleum, education, and transportation sectors (just to mention some of the sectors) and the uniformed men in terms of susceptibility to new infections and vulnerability cannot be underestimated.

In the education sector, the epidemic weakens staffing levels, increase sickness absence levels. Teachers and support staff who are HIV infected or affected are likely to spend less time on work because of stigma, intermittent illness and caring for the sick. With a reported 10-15% infection rate in the Nigerian public sector HIV/AIDS, this can affect social and economic development.
Amongst the uniformed forces, the highest prevalence was seen in Benue state (army) with 4.4%and 4.5% in Kano State (police)[12]. The emerging issue of vulnerabilities to HIV transmission among communities in conflict and service personnel engaged in addressing internal conflicts, disasters and terrorism need to be addressed.

2.2 KEY INDICATORS OF THE NATIONAL HIV RESPONSE

Knowledge of HIV among Young People in Nigeria
Correct knowledge of HIV in the country among young persons is low (24.2%). It is however higher in males (25.4%) than females (19.3%) and is lowest in the 15-19 age group[13]. The IBBSS (2010) confirmed low level of accurate knowledge about HIV among high-risk groups. Correct knowledge of prevention of sexual transmission of HIV and rejection of major misconceptions are generally low among most at risk populations; the highest being 57.6% and lowest being 28.3%[14]. In Nigeria, sexual transmission accounts for 80% of HIV infection. The National HIV/AIDS Prevention Plan emphasizes that maintaining the HIV status for 95% of the population that is currently negative, is the most feasible approach for reducing the HIV incidence trajectory.

ART Service Coverage
Of the estimated 3.4 million persons living with HIV in the country, about 1.66 million of them require Anti-retroviral drugs. As at December2012, only 491,021 of these were receiving Anti-Retroviral drugs[15]. There are 566[16]sites offering ART services in the country as against the 1,660[17] sites required for adequate service

[9]UNAIDS HIV Epidemic Update 2012
[10]NACA 2011. Assessment of out-of pocket expenditure for HIV/AIDS services in Nigeria

[11] ODSACA (2012) Socioeconomic impact of HIV in selected LGAs in Ondo State
[12]IBBSS 2010

[13] NARHS 2009
[14]IBBSS 2010

[15]FMOH Update report 2011
[16]DHIS Database 8th July 2013

coverage. A further breakdown of this scenario depicts the extent of the gaps in ART coverage at the state level.

North Central Zone

Table 1: ART Coverage in North Central Zone

ANTIRETROVIRAL TREATMENT COVERAGE					
State	Prevalence Rate	Number of PLHIV	Number of PLHIV Eligible for ART	Number of PLHIV on ART	% treatment coverage
Benue	12.7	242,721	118,505	36,761	**31.0%**
FCT	8.6	164,362	80,247	23,582	**29.4%**
Kogi	5.8	110,849	34,120	7,404	**21.7%**
Kwara	2.2	42,046	20,528	5,516	**26.9%**
Nasarawa	7.5	143,339	69,983	10,970	**15.7%**
Niger	4.0	76,447	37,324	15,830	**42.4%**
Plateau	7.7	147,161	71,849	39,942	**55.6%**
All	**7.5**	**926,925**	**432,558**	**140,005**	**32.4%**

North Central zone has the highest zonal HIV prevalence but ranks 3rd out of the 6 geo-political zones in terms of number of PLHIV who are eligible for ART and are receiving treatment. In Nasarawa state of the 69,983 PLHIV who are eligible for ART, only 10,970 (15.7%) are receiving ART.

North East Zone

Table 2: ART Coverage in North East Zone

ANTIRETROVIRAL TREATMENT COVERAGE					
State	Prevalence Rate	Number of PLHIV	Number of PLHIV Eligible for ART	Number of PLHIV on ART	% treatment coverage
Adamawa	3.8	72,625	25,458	14,830	**58.3%**
Bauchi	2.0	38,224	18,662	8,534	**45.7%**
Borno	5.6	107,026	52,254	10,149	**19.4%**
Gombe	4.2	80,270	39,191	608	**1.6%**
Taraba	5.8	110,849	54,120	20,592	**38.0%**
Yobe	2.1	22,476	10,974	3,181	**29.0%**
All	**4.0**	**431,470**	**200,659**	**57,894**	**28.9%**

In the North East zone, the ART coverage in Gombe State is very low (1.6%) and the highest coverage is Adamawa State at 58.3%. This reveals the wide variation across the states within the geo-political zone in terms of ART coverage.

[17]This figure was based on the assumption that each ART site would serve 1,000 PLHIV on ART

North West Zone

Table 3: ART Coverage in North West Zone

ANTIRETROVIRAL TREATMENT COVERAGE					
State	**Prevalence Rate**	**Number of PLHIV**	**Number of PLHIV Eligible for ART**	**Number of PLHIV on ART**	**% treatment coverage**
Jigawa	1.5	28,668	10,997	2,989	**27.2%**
Kaduna	5.1	97,470	63,589	43,624	**68.6%**
Kano	3.4	64,980	31,726	15,456	**48.7%**
Katsina	2.0	38,224	18,662	6,320	**33.9%**
Kebbi	1.0	19,112	16,331	9,426	**57.7%**
Sokoto	3.3	63,069	30,793	3,613	**11.7%**
Zamfara	2.1	57,833	23,236	1,781	**7.7%**
All	**2.1**	**369,356**	**195,333**	**83,209**	**42.6%**

In the North West zone, 4 states have ART coverage above the national average of 28.2%. The ART coverage range in this zone is 7.7% (Zamfara) to 68.6% (Kaduna).

South East Zone

Table 4: ART Coverage in South East Zone

ANTIRETROVIRAL TREATMENT COVERAGE					
State	**Prevalence Rate**	**Number of PLHIV**	**Number of PLHIV Eligible for ART**	**Number of PLHIV on ART**	**% treatment coverage**
Abia	7.3	139,517	68,117	5,548	**8.1%**
Anambra	8.7	166,273	81,180	6,604	**8.1%**
Ebonyi	3.3	63,069	20,793	2,007	**9.7%**
Enugu	5.1	97,470	47,589	15,419	**32.4%**
Imo	3.0	57,336	27,993	3,180	**11.4%**
All	**5.1**	**523,665**	**245,672**	**32,758**	**13.3%**

The South East zone has the lowest ART coverage (13.3%) compared to the other zones. Enugu state has the highest ART coverage (32.4%) while Abia and Anambra States with HIV prevalence rate higher than the zonal average reporting the least coverage of 8.1%.

South-South Zone

Table 5: ART Coverage in South-South Zone

ANTIRETROVIRAL TREATMENT COVERAGE					
State	Prevalence Rate	Number of PLHIV	Number of PLHIV Eligible for ART	Number of PLHIV on ART	% treatment coverage
Akwa Ibom	10.9	208,319	101,709	41,406	**40.7%**
Bayelsa	9.1	173,918	84,913	2,016	**2.4%**
Cross River	7.1	135,694	66,251	8,478	**12.8%**
Delta	4.1	78,359	38,257	6,847	**17.9%**
Edo	5.3	101,293	49,455	14,110	**28.5%**
Rivers	6.0	114,671	55,987	9,328	**16.7%**
All	**6.5**	**812,254**	**396,571**	**82,185**	**20.7%**

The South-South zone has the second highest average of HIV prevalence compared to other zones. Bayelsa has the least ART coverage (2.4%) in the zone while having the second highest HIV prevalence (9.1%) in the zone.

South West Zone

Table 6: ART Coverage in South West Zone

ANTIRETROVIRAL TREATMENT COVERAGE					
State	Prevalence Rate	Number of PLHIV	Number of PLHIV Eligible for ART	Number of PLHIV on ART	% treatment coverage
Ekiti	1.4	26,757	13,064	1,501	**11.5%**
Lagos	5.1	97,470	72,589	35,050	**48.3%**
Ogun	3.1	59,247	28,926	5,798	**20.0%**
Ondo	2.3	43,957	21,461	14,394	**67.1%**
Osun	2.7	51,602	25,194	3,218	**12.8%**
Oyo	3.0	57,336	27,993	11,614	**41.5%**
All	**2.9**	**336,369**	**189,227**	**71,575**	**37.8%**

The South West zone has ART coverage range of 11.5% (Ekiti State) to 67.1% (Ondo State). This zone has the 2ndhighest ART coverage (37.8%) among other zones.

PMTCT Service Coverage

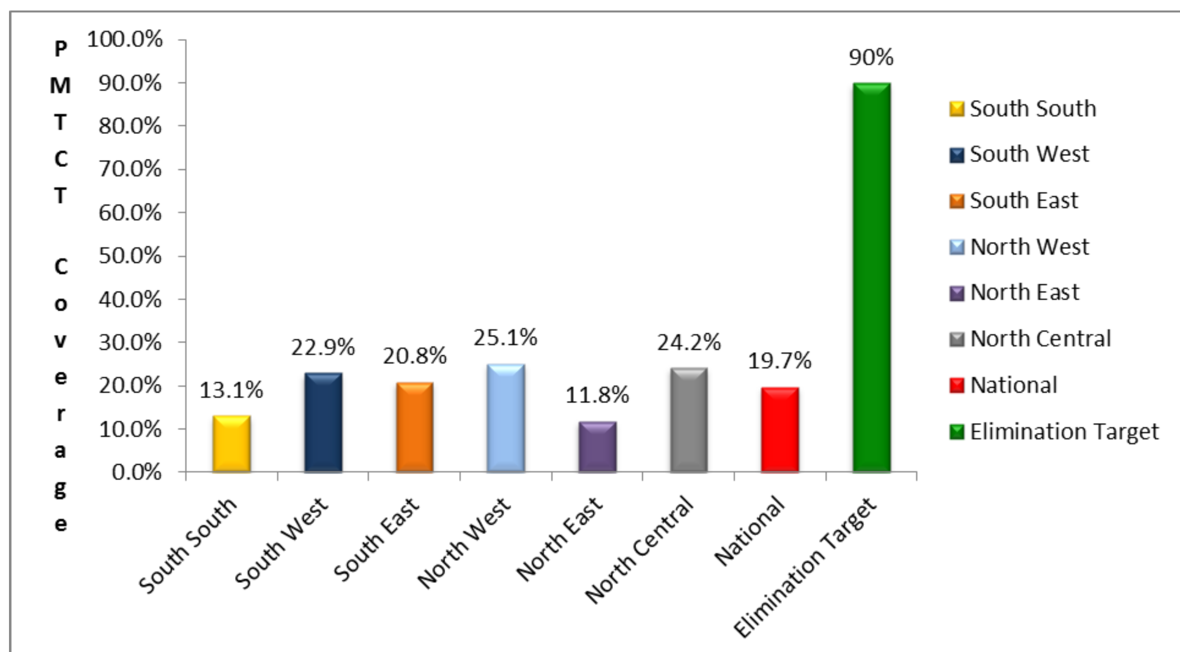
The PMTCT program commenced in the country in 2001, with 6 sites in the nation's tertiary health institutions. This number currently stands at 2,216[18]sites which represents only 13.5% of the required 16,378[19] sites for adequate service coverage. MTCT accounts for about 10% of new infections in Nigeria and Mother to Child

[18]DHIS Database 8th July 2013

[19]This data was based on the assumption that one PHC will serve a population of 10,000 persons

Transmission rate for the year 2011 was 24.5% (Spectrum Modeling). In the same year 2011, only 37,868 HIV positive pregnant women translating to15.9% of the women, received anti-retroviral drugs to reduce the risk of MTCT. In the year 2012, 40,065 HIV positive pregnant women received anti-retroviral drugs to reduce the risk of MTCT.

FIGURE 4: STATUS OF PMTCT COVERAGE IN NIGERIA



Nigeria committed to the global target of elimination of mother to child transmission of HIV by 2015 i.e. reduce the number of new infections among children by 90%[20]. However, with less than 2 years to this deadline, the country is still at 19.7% PMTCT coverage for year 2012. To attain this goal the country would need to achieve an annual PMTCT coverage of at least 90%.

HCT Service Coverage

HCT is the entry point for most HIV and AIDS prevention and control programs. The proportion of people who received HCT doubled between 2003 and 2007. However, the uptake of HCT is still low among Nigerians. In 2012, the total number of persons who were counseled tested and received results in the last twelve months was only 2,792,611. Based on Nigeria's universal access target projections, a total of 14,663,189 persons should have been counseled tested and received their results in 2012.

Orphans and Vulnerable Children (OVC) Services

Nigeria has the highest burden of orphans and vulnerable children in the world estimated at 17.5 million (FMWASD, 2008) with HIV/AIDS as one of the major causes of orphan hood in Nigeria. It is estimated that 2.23 million children were orphaned by HIV. In the first half of 2012, about one half of a million, OVCs were served.

Financing HIV/AIDS in Nigeria

The National AIDS Spending Assessment (NASA) 2010 showed that the national response to HIV/AIDS in Nigeria has been highly dependent on international funds. Out of the total expenditure on HIV/AIDS in 2010, international funds account for 74.65% while government accounts for 25%. Although donor funds are high,

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[20]Global Plan for the Elimination of HIV in Children 2011-2015 (UNAIDS, 2011)

public funds have steadily increased from the 7.6% in 2008 to 25.18% in 2010.The study revealed that 37.44% of the total amount went to care and treatment, 12.45% to prevention, 0.42% to research and 0.04% to social protection and social services.

2.3 The National HIV Response: governance and institutional frame work

2.3.1 Governance

The National Agency for the Control of AIDS (NACA) leads the multi-sectoral HIV/AIDS response to HIV and is mandated to provide overall coordination of the national response. At sub-national levels, the State Agency for the Control of AIDS/State Action Committee on AIDS (SACA) and LGA Action Committee (LACA) perform similar functions at state and local government levels respectively. NACA transformed from "committee" to an agency in 2007 and as at the time of developing this document 35 out of 36 States SACAs have attained agency status, including the FCT. The Governing Boards of SACAs are usually chaired by the State Governors or their Designates who provide leadership and oversight to the response as well as support the Agencies in their resource mobilization efforts.

2.3.2 Institutional Arrangements

The primary mandate of NACA is to coordinate the national multi-sectoral response to HIV. This coordination responsibility entails establishing and sustaining relationships with a diverse state and non-state actors at national and sub-national levels. Such relationships include: NACA-SACA, NACA-Civil Society organizations (CSOs), NACA-private sector, NACA- public sector and NACA-development partners. NACA has established interactive platforms with SACAs and provides technical, financial and managerial oversight to SACAs, including World Bank HAF projects in all states. Technical Working Groups (TWGs) were established to provide technical advice on key thematic areas of the national response. The PCRP will leverage on these key structures to improve the scope and quality of priority interventions.

2.3.3 Key Implementing Agencies and Roles

The President's comprehensive response plan will be implemented by a range of stakeholders at various levels. The roles and responsibilities of the key stakeholders for the implementation of this plan are summarised below.

National Agency for the Control of AIDS (NACA)

The roles and responsibilities of NACA as specified in the Establishment Act of 2007 and are applicable to the PCRP implementation as outlined below.

a) Plan and coordinate the HIV/AIDS activities of the various sectors in country and in line with the national Strategic framework
b) Facilitate the engagement of all tiers of government and all sectors on issues of HIV/AIDS prevention, care and support
c) Advocate for the mainstreaming of HIV/AIDS interventions into all sectors of the society.
d) Mobilize resources (foreign and local) and coordinate equitable application for HIV/AIDS activities
e) Establish linkages to the National Technical Working Groups and other established NACA platforms that can support the implementation of the PCRP
f) Facilitate the development and management of the policies and strategies of all sectors to ensure sustained human, financial and organizational resources to support the successful implementation of the PCRP.
g) Establish, encourage and promote training programmes for the human resource required for implementation of the PCRP.
h) Support HIV/AIDS research in the country and cooperate with research-based institutions in Nigeria and other countries.

Federal Ministry of Health (FMoH)

The Federal Ministry of Health is responsible for coordination of the health sector component of the national HIV response. Other specific duties of FMoH include:

a) Develop policies and guidelines for the health sector response to HIV/AIDS
b) Develop training curricula for all cadres of health staff involved in service delivery for HIV/AIDS
c) Provide technical support in the revision of the State level health sector response plans
d) Provide technical oversight to the state level health sector service delivery activities for quality assurance and equitable distribution to key populations
e) To serve as the data warehouse for all national health sector data on HIV/AIDS
f) Support States in quantification for commodities required for the revised state HIV/AIDS plans
g) In collaboration with NACA, generate policy briefs on the health sector component of the response for decision makers
h) Be represented on the proposed technical review panel for review of grant applications to states and local implementing partners
i) In collaboration with relevant stakeholders coordinate efforts at strengthening the supply chain management systems as determined in the PCRP

Federal Line Ministries

The line ministries are engaged through the NACA-Federal Line ministries forum with the main purpose to strengthen the Line Ministries to effectively coordinate sustainable and gender-sensitive sectoral HIV/AIDS response. The roles and responsibilities of the NACA-Federal Line Ministries Forum will include:

a) To share information and proffer strategies to address gaps in implementation through provision of effective technical support and guidance
b) To discuss issues regarding the implementation of PCRP as it affects the line ministries
c) To exchange strategic information on HIV/AIDS issues
d) To provide technical assistance and other forms of support to the line ministries in their role in the PCRP/national response
e) To ensure compliance with national guidelines, policies, processes, procedures and direction on the HIV/AIDS programme and projects
f) To attend to any other issues that may arise.

State Agency for the Control of AIDS (SACA)

The roles and responsibilities of SACAs as defined by the National governance guidelines by NACA are applicable to the PCRP implementation as outlined below.

a) Plan and coordinate the HIV/AIDS activities of the various sectors and stakeholders in the state and in line with the State HIV/AIDS Strategic Plan.
b) Facilitate the engagement of all tiers of government and all sectors on issues of HIV/AIDS prevention, care and support
c) Advocate for the mainstreaming of HIV/AIDS interventions into all sectors of the society.
d) Mobilize resources and coordinate equitable application for HIV/AIDS activities
e) Establish linkages to the National Technical Working Groups and other established NACA platforms that can support the implementation of the PCRP
f) Facilitate the domestication and management of national guidelines and strategies of all sectors to ensure sustained human, financial and organizational resources to support the successful implementation of the PCRP.
g) Establish, encourage and promote training programmes for the human resource required for implementation of the PCRP at the state level.
h) Be the coordinating secretariat of the State HIV/AIDS Management Team (SMT).
i) Hold all state HIV/AIDS partners accountable transparently.

State Ministry of Health (SMoH)

In addition to the statutory role that state institutions play in the national response, the PCRP requires that State Governments through the SMTs carry out the following functions:

a) Review and cost priority interventions in the State HIV/AIDS plans in line with applicable local context and disease epidemiology
b) Constitute and Lead the State HIV/AIDS Management Team (SMT), primarily responsible for the health sector response to HIV/AIDS in the state. The SMT comprising relevant stakeholders in the HIV/AIDS response in the state with secretariat responsibilities housed under the state SACA. The membership includes but is not limited to the SASCP, Lead IP, Civil society, private sector and representatives of development partner and the academia
c) Conduct (with technical support from the FMoH) site assessment and selection of facilities for HIV service scale up
d) Mobilize resources (financial, human and material) to cater for health sector response of the *revised* State HIV/AIDs plan
e) Develop and implement capacity building plans for all cadres of health workers involved in the response
f) Develop with support from technical partners and FMoH, grant applications to the special HIV/AIDS fund for matching grants for implementation of priority interventions in keeping with the tenets of the PCRP and granting model
g) Generate, collate and share program activity data with the FMoH and NACA

Non-Governmental Organizations (NGOs), Faith-based Organisations (FBOs) and Civil Society Organization (CSOs)

The Civil society constituency will be involved in demand creation; advocacy for equity and gender mainstreaming of HIV services; service quality improvement from a consumer perspective and resource mobilisation. Other specific roles in the PCRP implementation will include:

a) Membership of the State Management Teams (SMTs)
b) Active involvement in advocacy for resource mobilization for the state response plans
c) Providing a civil society perspective score card for resource performance at National, State and LGA levels
d) Introduction of innovative approaches to increase service availability, demand creation and service utilization at State and LGA levels

Private Sector:

The private sector has a key role to play in the national HIV response, however their current involvement is poor and the PCRP seeks to address this through innovative approaches. Their limited involvement in the national response in resourcing and service delivery remains a significant missed opportunity. Private sector involvement is expected to be scaled up over the two year duration of the PCRP and beyond. The envisaged roles of the private sector include:

a) Financial and other contributions to improve the resource envelop for the National and State revised HIV/AIDS response plans. Operationalized corporate social responsibility mandates for companies and private establishments should become more visible
b) Private sector entities with skills in financial management, costing and resource mobilization can offer in-kind services to increase the capacity of SMTs to manage the accelerated response plans
c) Private hospitals with appropriate staff mix and technical expertise will be linked with national and state mechanisms to offer HIV prevention, treatment and care services. Commodity support, reporting tools, staff training will be offered to participating private health facilities.
d) The private sector health institutions will be required to routinely report program activity data to the LGA and State authorities in line with the data flow pattern in the NNRIMS Operational Plan 11(NOP II).

Local Implementing Partners:
The PCRP will increase the capacity of local implementing partners to deliver on HIV/AIDS services. Local implementing partners are expected to extend their services to reach the rural areas, key population groups and hard-to-reach populations. Local IPs will also support other state stakeholders to implement HIV services, through partner arrangements, sub-grant schemes, etc.

Development Partners
The role of development partners in the national response will continue to be leveraged in the implementation of the PCRP. Development Partners will contribute resources, technical assistance and support. Key areas will remain resourcing the response and technical support. The PCRP will seek to extend these key roles at both the National and the State levels. National level support will include financial and technical support to the coordinating mechanism and the special fund while at State level, technical assistance to states and capacity development for state level human resource pools will be expected. Development partners' participation in the National and State technical working groups will also be sustained.

2.4 CRITICAL ISSUES FOR THE NATIONAL RESPONSE

Critical issues for the national response can be summarized under systems issues and service delivery issues with reference drawing from the system and programmatic review reports of the response in the last five years.

A) Systems Issues

i. **Decreasing domestic and external funding for the national response:** The GARPR 2012[21]reports that funding gap remains a challenge to the national response. The current funding is not commensurate with the scale and complexity of the HIV/AIDS epidemic in Nigeria. The total funding for HIV treatment, care and support reduced by 28.5% in 2010 ($132,870,029) from $185,911,643 in 2008.

ii. **Overdependence on donor Support:** In 2008, only 7.6% of total funding for HIV/AIDS came from the public sector. Whilst this increased to 25.18% in 2010, however still fell short of required funding for the NSP as at December 2012.

iii. **Limitations with institutional architecture:** Linkages of the national response to other government structures and sectors are not well defined in the NSP II e.g. National Economic Empowerment and Development Strategy (NEEDS) and the Millennium Development Goals (MDGs). This constitutes missed opportunity for leveraging resources for the national response and overall national development.

iv. **Limited private sector participation in service delivery:** The contribution of the private sector to the national response to HIV has been low. Linkages to the private sector remains rudimentary resulting in little or no information about private sector activity being monitored by the national response. There are no clear mechanisms for integration of private sector efforts and data into the national system.

v. **Limited State Governments ownership and commitment to the response:** As at 2010, state governments contributed less than 0.3% of the total government funding for HIV in Nigeria, with the Federal government accounting for 99.7% of public funding.

[21] GLOBAL AIDS RESPONSE: Country Progress Report, Nigeria GARPR 2012

vi. **Challenges with HIV M & E systems:** The HIV M&E systems are challenged by the limited resources human and material resources at the State and LGA levels. Weak infrastructure for data management and undue reliance on paper-based data collection and management system continue to threaten the quality and reliability of generated data. Data use for decision making is also limited.

vii. **Supply chain management issues**: The supply chain system for HIV commodities is weak with challenges around drugs and commodities storage and logistics management. Given the non-existence of a harmonized Procurement and Supply Chain Management (PSM) implementation strategy and policy, PSM activities are often driven by vertical programme needs. This results in different organizations/programmes designing and implementing specific vertical PSM interventions that address only immediate need of their respective programmes. This has led to duplication of efforts at all levels of the supply chain, created avenue for parallel systems and inefficiencies in the procurement and supply chain systems.

B. Service delivery Issues

HIV Counselling and Testing (HCT): HCT coverage is inadequate especially in the hard to reach rural areas. Other impediments include persistent stock-out of HIV test kits, inadequate human resources for HCT services, and poor uptake of HIV services.

PMTCT: PMTCT coverage is still well below the desired targets (50% target for 2012). Only 15.9% of HIV positive pregnant women received ARV prophylaxis to reduce MTCT in 2011. Poor ANC attendance, inadequate infrastructure and human capacity especially in rural settings, stock out of HIV test kits and weak community mobilisation for service uptake contribute to the poor performance of the national PMTCT efforts.

Early Infant Diagnosis (EID): There are very few facilities providing Early Infant Diagnosis (274) and this falls below national EID need. The GoN/FMoH will need to allocate funding for the establishment of more EID facilities in Nigeria if the national target of 80% of HIV exposed infants having access to EID services in 2015 is to be met.

Biomedical Prevention: Transfusion of unscreened blood and re-use of syringes are still practiced in Nigeria especially in the rural communities. There are still new cases of blood transfusion related HIV infection managed in many facilities. Ignorance, weak infrastructure and poverty are biomedical prevention challenges in Nigeria. There are no concrete public engagement programmes that promote post exposure prophylaxis (PEP) access by the general public. PEP provision is still limited to about 20% of health facilities.

Treatment of HIV/AIDS and Related Health Conditions: There are still unmet targets for universal access to ART for eligible HIV positive Nigerians. As at Dec 2012, only 30% of those eligible for ART received treatment. Communities are still underserved in terms of ART sites, and laboratory equipment for patient monitoring remains inadequate.

SECTION 3

3. THE PRESIDENT'S COMPREHENSIVE RESPONSE PLAN FOR HIV/AIDS

3.1 THE OVERALL AIM OF THE PCRP

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; enrol 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 and4 million young person's and activate 2,000 new PMTCT and ART service delivery points across the country.

3.2 PCRP THEMES, PRIORITY AREAS AND OBJECTIVES

Table 7: Summary of PCRP Themes, Priority Areas and Objectives

Theme	Priority Areas	Objectives
Improved Coordination & Systems Strengthening of the National response	Improved financial resourcing and state ownership	To increase domestic funding for the HIV response by at least 50% by 2015
	Enhanced Coordination of National and State level response	To develop and sustain strong state-led coordination mechanism for the national response
	Addressing the Human Resource challenges of the national response	To significantly bridge the human resource gaps of the national response
	Improved data management for the national response	To strengthen the national health management information system and promote the use of data for informed decision making at all levels.
	Strengthen the Supply Chain Management (SCM) System for ATM commodities	To ensure health commodities security (HACs) for the three disease areas HIV&AIDS, TB and malaria
Accelerate Implementation of HIV Prevention, Care and Treatment services in Nigeria	Increasing Community Participation and dialogue	To mobilise communities for improved utilization of HIV/AIDS prevention, treatment, care and support services.
	HIV Counselling and Testing (HCT)	To provide access and linkages to 80 million Nigerians to know their HIV status and access HIV prevention care and treatment services as applicable.
	Prevention Interventions for Young People And MARPs	To reach 4 million young people and 500, 0000 MARPs with combination prevention package

Theme	Priority Areas	Objectives
	Prevention of mother to child transmission	To scale-up PMTCT service coverage to 90% of national need (6million Pregnant women tested for HIV and received result, 244,000 positive pregnant women receive ART to prevent transmission of HIV to their unborn babies) towards achieving elimination of MTCT by 2015
	HIV treatment	To scale-up ART services and achieve universal access targets by 2015
	TB/HIV collaborative activities	Reduce the burden of TB among PLHIV and burden of HIV among TB patients
	Care and Support	To promote survival and improve the quality of life of PLHIV and PABA especially OVCs
	Operations Research	To strengthen the evidence-base for the national response and effectively track progress

Theme 1: Improved Coordination & Systems Strengthening of the National response
The PCRP seeks to strengthen the leadership, planning, coordination, financing, and performance management capacity of state and non-state actors at National, State and LGA levels necessary to deliver the pre-determined targets for the national response. Facilitate States to assume more responsibility and tailor their individual State response, to their local context.

Priority Area 1: Improved financial resourcing and state ownership
Background:
The dwindling global funding for HIV in developing countries has raised concerns and required a renewed effort to bridge the existing funding gaps, especially in countries with high HIV burden. The recent political declaration in 2011[22] amongst other things recommended that: (1) Programmes must become more cost-effective and evidence-based and deliver better value for money; (2) Countries should break the upward trajectory of costs through the efficient use of resources; (3) Countries should close the global resource gap by 2015; (4) Countries should support and strengthen existing financial mechanisms; (5) Countries should expand voluntary and additional innovative financing mechanisms.

Nigeria is among the countries that are yet to meet the Abuja declaration target of 15% of National budget commitment to health[23]. The financing landscape of the national response in Nigeria is characterized by heavy dependence on external donor financing (75%) and limited domestic financing (less than 25%)[24]. Private sector investments are almost non-existent. Out of pocket expenditure for HIV/AIDS services consists of about 14.5% of household income[4].

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[22] UN General Assembly: Political Declaration on HIV and AIDS: July 2011

[23] Abuja Declaration on HIV/AIDS, Tuberculosis and other related Infectious Diseases, April 2001

[24] National AIDS Spending Assessment, 2010

For the implementation of the NSP, the funding scenario presumes that the Government of Nigeria (GON) will be contributing 50% of total HIV/AIDS financing by 2015. Government of Nigeria (GON) committed to this goal in the strategy documents, including the Nigeria-U.S. Partnership Framework on HIV/AIDS. The GON (Federal, State and LGA) is expected to contribute $241million (2013), $373 million (2014) and $470 million (2015) to be able to meet this commitment[25].

The National response has as one its biggest challenges, the limited involvement of states and local governments in the resourcing, planning and coordination of the response, whereas, the beneficiaries of the HIV and AIDS services are within their administrative jurisdiction. Clearly, the inadequate ownership of the HIV/AIDS response at the sub-National levels can explain the limited commitments and resourcing observed to date. The NSP 2010-2015 and the partnership framework recognize the need for states to play an active role in the national response to ensure success of the decentralization process, improve service access and sustainability of the response. Thus the PCRP recommends revision of state plans to reflect current realities including prioritization of interventions; use of cost-effective mechanisms; realistic targets for services based on the prevalent disease epidemiology in the state and addressing service access gaps. The PCRP also recommends as a minimum, 50% state financing of the revised state plans; the development of robust state resource mobilization and human resource strategies to meet this commitment. Accountability and performance measurement systems will also be developed to allow states generate information for monitoring the rejuvenated state responses tailored to their needs.

Goal:
To increase domestic funding for the HIV response through an active involvement of the Public (Federal, State and Local Governments) and Private sectors to bridge the funding gap for the NSP

Objectives:
1. Improve the HIV response financing by attaining 50% domestic funding of the HIV response by 2015 as Stipulated in the Nigeria-U.S. Partnership Framework on HIV/AIDS (2010-2015)
2. Improve planning and management of human resources to meet the changing needs of the epidemic
3. Significantly increase contributions of the various tiers of Government to the National response
4. Stimulate and sustain State ownership of the state-tailored HIV/AIDS response

Strategic Focus:
1. Advocate Executive order establishing a special fund for HIV and related diseases which will be managed by NACA and capacitated to sub-grant to States using the matching-grant model. This special fund should be sustained by seed funds from the Government, private sector contributions, MDG, SURE-P and other innovative financing mechanisms[26].
2. Support development of mechanisms for the fund to be operated in a matching grant model to states and other potential participants
3. Conduct financial gap analysis at state level and disseminate report to stakeholders
4. Advocate for up to 50% state financing of the State HIV/AIDS strategic plans through a mix of State specific innovative funding sources (Government, private sector, AIDS levy, WB credit, Sure-P, MDG etc.)
5. Support states to conduct a resource mapping exercise and develop a resource mobilization strategy
6. Conduct biannual President and Governors parley on HIV/AIDS. NACA will provide technical brief to invitees prior to the parley.

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[25] Nigeria-U.S. Partnership Framework on HIV/AIDS Implementation Plan (2010-2015)

[26] Concept note on innovative financing for HIV and related diseases in Nigeria, NACA, 2012

7. Conduct Federal level led follow-up advocacy visits to the State for sustaining State resourcing for HIV/AIDS; 8 visits in a year (2 per quarter). States to be visited will be dependent on the level of funding performance. Where possible, this could be tied to the good governance tour.
8. Develop a score card that will track states' funding for HIV/AIDS
9. Conduct capacity building events for State HIV/AIDS Management Teams for resource mobilisation at State level
10. Target States to resource at least 80% of the funding need allocated to it as contained in the PCRP document.

Priority Area 2: Enhanced Coordination of the State level response

Goal:

To develop and sustain strong state led coordination mechanisms for the national HIV response.

Objectives:

1. Create and strengthen 37 multi-stakeholder State Management Teams (SMTs) to manage State response to HIV
2. Develop human resource strategy for HIV/AIDS response in the states
3. Strengthen NACA's coordination function

Strategic Focus:

1. Develop a comprehensive state advocacy package for state level advocacy
2. Support the convening of state level HIV stakeholder meetings similar to the presidential parley at national level
3. Create and strengthen State Management Teams (SMT) [27]to manage the State HIV response
4. Develop management systems and tools to operationalize the grant making processes for the special fund including performance frameworks
5. Develop capacity of SMTs in proposal development to access matching grant from the proposed Special Fund, program management, performance based funding and other identified capacity gaps
6. Develop a cadre of National-State liaison officers that will play the role of portfolio managers for proposed grants to states
7. Establish zonal structures to enhance and strengthen coordination function of NACA
8. Secure office accommodation for all staff at the NACA headquarters
9. Secure office accommodation adequate for NACA zonal operations to support states in the zones.
10. Increase human resource capacity and capability of NACA to effectively coordinate the national response
11. SMTs to advocate inclusion of community-based responses in the State and LGA operational plans
12. Train LACA and CBOs on behaviour change communication strategies, community dialogues on HIV; supply chain management system and their roles in monitoring of availability of commodities

    Create a Community Champions Scheme (CCS) to identify notable persons in the community to be ambassadors for HIV/AIDS information.

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[27]State Management Team (SMT)-State Management Team comprising *relevant stakeholders* in the HIV/AIDS response in the state with secretariat responsibilities housed under the state SACA and membership including but not limited to the SASCP, Lead IP, Civil society, private sector and development partner representatives. Led by no less a person than the Commissioner of health

PRIORITY AREA 3: ADDRESSING HUMAN RESOURCE CHALLENGES OF THE NATIONAL RESPONSE

Background:

HIV and AIDS epidemic has exacerbated the human resource need and availability in health care settings. The priority of government in providing quality treatment, care and support services for PLHIV has further put pressure on an overburdened health care system. The distribution of limited human resources for health between urban and rural areas is another major challenge, with rural areas being particularly vulnerable to shortage of skilled health workers[28]. Effective delivery of HIV services requires adequate number and skill mix of health care workers at the federal, state and local government levels.

Goal:

To increase human resources skilled in HIV/AIDS service deliver in rural and urban settings

Objectives:

1. To ensure at least two trained health care workers are available in each of the newly established PMTCT-ART service delivery points
2. To provide resources for training, recruitment and retention of health workers in these sites within and beyond the two years of the plan
3. To exploit the benefits of task-shifting for the scale up and decentralization efforts of the HIV response

Strategic Focus:

1. Explore the task-shifting model for new service delivery points with shared responsibilities to PHC Nurses and Midwives
2. Provide training on service delivery for PMTCT and ART to PHC Nurses and Midwives
3. Link the trained service providers at PHC level to experienced service providers at secondary level for mentoring and coaching through a cluster model
4. Expand to all state schools of health technology a model of support for production of trained community health workers for HIV related service delivery

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[28]Chankova, Slavea, Ha Nguyen, David Chipanta, Gilbert Kombe, Ali Onoja, and Kayode Ogungbemi. September (2006): 'A Situation Assessment of Human Resources the Public Health Sector in Nigeria' Bethesda, MD: The Partners for Health Reform plus Project, Abt Associates Inc.

PRIORITY AREA 4: IMPROVED DATA MANAGEMENT FOR THE NATIONAL RESPONSE

Background:
Nigeria has adopted the District Health Information System (DHIS) as the platform for the National Health Information Management System (NHMIS). Whilst remarkable progress have been achieved with its roll out at the national level, same cannot be said for the states and LGAs where such challenges as inadequate IT equipment and infrastructure, weak data protection and backup systems, inadequate human capacity to manage the databases, and staff attrition still pose formidable challenges.
Goal: To strengthen the National Health Management Information System (NHMIS) to serve effective management tool for informed decision making at all levels.

Objectives:
1. Accelerate roll out of DHIS 2.0 to all LGAs with mobile phone technology to operational PHCs in the Country
2. Ensure availability of timely and high quality routine program monitoring data
3. Strengthen the use of quality epidemiological and program information for planning, policy and decision making

Strategic Focus:
1. Commit resources to accelerate the roll out of DHIS 2.0 to all LGAs as detailed in the NOP 2
2. Bridge funding gap for mobile phone technology deployment to 5,000 PHCs providing HIV/AIDS services in the country to enhance data reporting. Explore collaboration with the private sector to procure and maintain subscription.
3. Build capacity of 5,811 HCWs on the use of the data technologies.
4. Print and distribute M&E tools to all health facilities.

PRIORITY AREA 5: SUPPLY CHAIN MANAGEMET

Background:
The uninterrupted availability of life-saving pharmaceuticals and diagnostics are critical to the successful expansion of public health programs, particularly the treatment program. However, this has been a challenge for the national HIV/AIDS program. Historically, the Government of Nigeria has invested minimally in strengthening the supply chain systems that are required to deliver life-saving treatment and diagnostics for HIV/AIDS, Tuberculosis (TB) and Malaria. Unlike most other components of public health programs, supply chain systems benefit from being highly centrally managed to meet the desired results of HIV/AIDS, malaria and TB programs.

Donors have set up their own parallel storage and distribution systems to cope with the demand because a robust federal system does not exist for AIDS, TB and malaria supplies. For HIV/AIDS medicines (anti-retroviral) alone, there were up to seventeen supply chains that were used to deliver HIV/AIDS drugs to facilities. However, in recent years NACA and the FMoH with support from PEPFAR, GFATM and other partners, have recorded measured success in the process of harmonizing these HIV/AIDS supply chains into a single robust supply chain system. When the harmonization is completed, the system will also serve as the platform for delivering other commodities e.g. Maternal and Child Health (MCH) commodities, and at strategic points within the supply chain, can be integrated with other public health program supply chains. This harmonization will also minimise wastages, delays, out-of-stock syndrome of crucially important drugs.

Currently, the unified HIV/AIDS supply chain system is predominantly donor-supported, but with increased financing under the PCRP, the Government of Nigeria will be able to take ownership of the crucial supply chain system. With additional financing, the Government of Nigeria will also be able to make several improvements to the unified system, namely: increase the scale of the system by expanding deliveries to hundreds of new health facilities; improve the performance of the system with the use of a performance management

framework; improve state-support of the system through supervision of logistics reporting from facilities, monitoring the re-supply of valuable commodities; and ensure better state-level understanding of the financial value of HIV/AIDS commodities being delivered to each state.

Specifically, additional financing at the state level would establish HIV/AIDS Supply Chain Focal Points in each state. Qualified personnel would be recruited and trained, and will be equipped to monitor and supervise all facilities being supplied HIV/AIDS commodities. The Supply Chain Focal persons will routinely meet at the zonal level to exchange data, share experiences and best practices, foster state competition for better supply chain performance, and will provide a platform for feeding information to the Federal Ministry of Health and NACA on HIV, TB and Malaria commodity availability across the country. This proposal was developed in partnership with key donors and would be complementary of government efforts.

Goal:
To ensure health commodities security for the three disease areas: HIV & AIDS, TB and Malaria

Objectives:
1. Strengthen organizational and technical capacities for supply chain management (SCM) at national and state levels through technical support and mentoring approach
2. Improve supply warehousing at the national and sub-national levels
3. Improve supply logistics and ensure that supplies reach the health facilities in the right quality and at the right time ensuring that logistics bottlenecks and mal-distribution of supplies are eliminated
4. Improve commodity data recording, reporting and retrieval for better quantification and commodity management.

Strategic Focus:
Strengthen SCM at Federal Level
- Develop a HR Strategic Plan for the Food and Drug Services (FDS) Department that includes organogram, job descriptions for all positions, performance expectations/performance indicators for all positions, staff orientation/induction kit etc.
- Train National level staff of the FMOH Dept. of Food and Drug Services (FMOH/F&DS) in the management of the SCM (at least 3 types of training SCM, Quantification, Program Management, LMIS/ Use of Data for Management Decision)
- Develop National Supply Chain Management Guidelines for Medicines and other Health Commodities
- Develop and Deploy LMIS database for managing supply chain logistics data and monitoring the supply pipeline.
- Conduct Monitoring and Supportive Visits to all health Programs storage & distribution facilities and structures to ensure compliance with national LMIS
- Complete the rehabilitation and upgrading of Federal Medical Stores Oshodi, Lagos to WHO Pharmaceutical storage grade.

Strengthen Management of Sub-central Warehouses
SCM Objective 2: Improve supply warehousing at the government approved sub-central stores
a. Rehabilitate & Upgrade the State Central Medical Stores (3)
b. Deploy/Employ Government Staff to manage warehouses under the mentorship of current partners staff (1 Supervisor (Warehouse Manager), 4 Advisors, 1 admin officer} X 5 Axial Warehouses
c. Training for about 25 staff (On the job training/induction of new by current axial staff)
d. Explore the Public Private Partnership approach
e. Monitoring and Supervision of private sector distribution agent
e. Print and distribute Logistics Management Information System (LMIS) Tools

Strengthen Supply Chain Management at State & LGA Levels

1. Revise Logistics technical Working Group (LTWG) TOR
2. Conduct an assessment of LTWG constitution in each state in line with TOR
3. Formation/Affirmation of LWTG (SMoH Commissioner & the Director Pharmaceutical Services)
4. Training of the State Logistics TWG on the national SCM system and their roles in ensuring effective distribution of supplies and reporting
5. Quarterly Reporting/ Meetings of LTWG to review SCM system and provide performance data to the SMoH (Honourable Commissioner)
6. Monitoring and Supervisory Visits (At least one visit to a secondary and 2 to PHC facility per quarter, LTWG will be responsible for organizing this to be paid for by the state)
7. Deploy/Hire One Data Clerk at the facility level to manage all data including Supplies data

THEME 2: Accelerate Implementation of HIV Prevention, Care and Treatment services in Nigeria

This theme speaks to the acceleration of key service delivery components of the national response to achieve greater population access to services including reduction in new HIV infections and HIV related morbidity and mortality.

PRIORITY AREA 6: INCREASING COMMUNITY PARTICIPATION AND DIALOGUE

Background:

The PCRP will accelerate implementation of HIV prevention, care and treatment service by creating an enabling environment for the implementation of programs at the grass-root level and support innovative strategies to ensure more persons get tested, receive treatment care and support. The current gaps include inadequate community directed programmes to address skewed awareness of HIV/AIDS prevention, treatment, care and impact mitigation services between men and women, inadequate financing of CBOs and lopsided direction of CBO activities targeting tertiary and secondary health facilities and urban centres mainly[29]. Face to face/persons to persons (Horizontal communication) and group/associations are more likely than non-interactive (vertical communication) methods to increase HCT uptake and behaviour change in young persons[30]. CBO engagement within communities increases service awareness and service utilization[1]. Therefore this priority area will focus on CBOs and other actors (families, social groups, households and neighborhoods) at the community level in order to address community and household factors that affect decision making and behaviors of targeted beneficiaries (Young persons and MARPs).

Goal:

To mobilize communities for improved utilization of HIV/AIDS prevention, treatment, care and support services.

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[29] NACA publication: Effects of the community response to HIV and AIDS in Nigeria. *(Final Report, July 2011)*

[30] Rodriguez-Garcia R, Bonnel R et al (2013), Investing in Communities Achieves Results: *Findings from an Evaluation of Community Responses to HIV and AIDS.*

Strategic Focus:

1. Strengthen LACAs & state based NGOs to identify CBOs/Community groups in 1762 wards
2. Train 2 CBOs & Community groups per ward on Advocacy (3 persons per CBO per ward i.e. 10,572 persons)
3. Conduct minimum of 2 advocacies per year with identified community leaders per ward per trained CBO
4. Develop LGA specific cost-benefit (C-B) models for HIV/AIDS & other related diseases
5. Identify, document and disseminate community success stories on HIV/AIDS using mass media (Radio)---(Community Voices i.e. 26 editions of community voices aired on Radio Annually)
6. Train 10 electronic and print journalists per state in 2 years (5 days residential training)
7. Award performance based mini media equipment grant (digital voice recorder and digital camera) to 10 Journalists per quarter
8. Hold bi-monthly community social mobilization partnership meetings for public sector, Media and CBOs

PRIORITY AREA 7: HIV COUNSELLING AND TESTING (HCT)

Background:

HIV Counselling and Testing in the general and targeted populations remains the bedrock of any national response, as it serves as the entry point into the continuum of HIV/AIDS Prevention, Care and Treatment services. The success of the HCT component of the national response directly correlates to the performance recorded in other service delivery areas. Current statistics and reports from several program reviews showed that access to HCT service is low in Nigeria.

The proportion of people who received HCT doubled between 2003 and 2007 but this trend has since been reversed. The total number of persons who were counseled, tested and received results stood at 3,371,220 at the end of 2008; 2,287,805 by the end of 2010 and in 2011, was only 2,056,578[31] while in2012 it was only 2,792,611. Aside from the fact that the number of persons accessing HCT services falls far below the universal access targets, there are indications that unmet HCT needs may be quite significant considering that the proportion of persons who desired HCT increased from 43% in 2007 to 73% in 2010[32].

Several national reviews of the response have documented challenges confronting the HCT program. Such challenges include the limited number of HCT services delivery points which are inadequate to meet the needs of the population; most services are still facility-based and located in secondary and tertiary health facilities, often inaccessible to hard-to-reach communities and have insufficient targeting of MARPs; reluctance of men to take HCT; inadequate commodities quantification leading to perennial test kit stock out, and weak test kit logistics for storage and distribution. Funding limitations have also contributed to this picture and clearly related to the global economic recession and strategic policy shifts by some donors.

The National response has reacted to these challenges and some strategic interventions have been put in place to address these challenges though with limited success. These interventions include: revision of the national HCT guidelines to embrace the use of PITC and the need for routine testing of patients based on an "opt-out" approach to increase HCT uptake; the current effort by the FMoH to decentralise services to PHCs and the community through integration of HCT into routine medical care; inclusion of prevention with positive interventions in the national prevention program; expanding community outreach and mobile HCT services and testing campaigns to rural communities and other hard to reach areas as well as MARPs.

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[31] Nigeria, GARPR, 2012

[32] Desk review report: Status of the HIV/AIDS Epidemic in Nigeria and the Global Fund Response, 2012.

The NSP midterm target of having 50% of the adult population tested by 2012[33] was realistic, but could only have been achieved if efforts and innovative interventions were in place to increase HCT access. Therefore there is the need to strengthen the national HCT program not only to satisfy unmet HCT needs but to raise public awareness around HCT and enhance service uptake- a key aim of the PCRP.

Strategic recommendations from the several reviews include increasing access to quality HCT services through integration of HCT into routine health care services at all levels; expansion of community outreach/mobile HCT services targeting the grassroots and hard to reach areas; designing and implementing HCT to address the needs of different population groups including MARPs; promotion of couple counselling with male involvement and the development of relevant materials and capacity building for service providers; and stronger emphasis on provider-initiated HCT to minimize missed opportunities.

Goal:
The PCRP HCT goal is to provide access and linkages for 80million Nigerians to know their HIV status and access HIV prevention care and treatment services as applicable.

Strategic Focus

1. ***National Testing Campaigns (2 per year):***To rapidly increase the proportion of Nigerians who have knowledge of their HIV status, the PCRP has prioritized the conduct of testing campaigns twice a year for the two year span of the plan. This will be in keeping with the UN General Assembly recommendation for hosting of International Voluntary Counselling and Testing (VCT) events as an effective way of increasing access to and awareness of VCT services. The National HCT technical working group will work closely with the logistics technical working group to design the methodology, commodity quantities needed and other related logistical considerations (including all related supply chain issues to other HCT strategies). The testing campaigns are targeted at reaching 40 million Nigerians annually to significantly service the national HCT unmet needs. Community linkages to care and other service delivery elements will be provided to HIV positive persons identified during the campaigns and the modalities will be detailed in the protocol to be developed for the campaigns. Community Volunteers will be trained to undertake Mobilization for HIV Testing Campaigns. Planned community linkage activities will include the provision of incentives for Community Volunteers to continue their campaigns outside of the Campaign Days and production of simple language appropriate IEC Materials that informs community members of where to go and what to do if testing result is positive.

2. ***Promotion of routine facility HIV testing with "opt-out" approach for clients:*** The PCRP proposes to accelerate this key component of the National guidelines through advocacy and presidential directives to service providers in the country. A policy paper will be developed and circulated widely and processes for compliance monitoring will be developed and tied to issuance/renewal of practising licenses for practitioners.

3. ***Scale up of Couples-counselling and testing for discordant couples:*** Scale up of Couple counselling and testing (CHCT) CHCT is known to increase condom use among sero-discordant couples, reduce their risk of HIV transmission by starting ART and/or practicing safer sex, are more likely to use ARV prophylaxis to prevent transmission to infants, communicate openly about their HIV risks and concerns, make shared decisions about care and treatment, family planning, and safer pregnancy, and they are more likely to support each another to adhere to ARV medication. In order to increase access to CHCT, PCRP will lay emphasis on scaling up of couple counselling and testing through advocacy,

[33] National HIV/AIDS Strategic Plan (2010-2015)

capacity building, promotion of CHCT, including the development of protocols and monitoring and evaluation plan to facilitate the implementation of the program

4. ***Scale up of testing activities among MARPs:*** The PCRP will sustain the emphasis on service access by MARPs in due consideration of their role in driving the HIV epidemic in Nigeria. The on-going National mapping and size estimation exercise for MARPs will be leveraged to design HCT service locations that target this key population. Linkage to the sexual and biomedical transmission targets of 500,000 MARPs will be made as part of the combination prevention strategy.
5. ***Greater involvement of the Private Sector:*** This approach will seek to significantly increase the number of HCT service access points in the country through engagement with the private sector health facilities and other first contact care providers outside the public system. The PCRP will seek to establish linkages with similar efforts in the PMTCT component of the plan including the state led decentralization to rural and hard to reach PHCs.

PRIORITY AREA 8: PREVENTION INTERVENTIONS FOR YOUNG PEOPLE AND MARPs

Background:
Effectiveness of any prevention intervention program depends on the extent to which interventions reach people at high risk of contracting the virus. The relative risk of infection varies between specific subpopulations and the general population. Understanding the epidemiology of HIV, drivers of the epidemic among different sub-populations and human behaviour are important in improving the HIV prevention response.

It is important to understand trends so that predictions of where the infections are likely to occur can be made; and this information can be used for HIV programming to reduce the spread of the virus. Nigeria's HIV epidemic is mixed. Most of the new infections are still attributable to high risk subpopulations. Since no data on incidence exists in Nigeria, prevention efforts mainly rely on models developed to estimate the number of new infections by transmission category. The national Mode of Transmission (MOT) study 2010[34] attributes 40% of new infections occurring in Nigeria to MARPs and their clients and this sub-population group constitutes approximately 4% of the adult population in the country. Thus prevention efforts for the PCRP will focus on subpopulation at greatest risk of becoming infected or transmitting HIV and these are MARPs and Young People (Women 20-24 years old, men 24-29 years) in Nigeria.

A comprehensive package of services /interventions to reduce the risk of HIV transmission will be individually focused at a scale that will increase health seeking behaviour and reduce HIV incidence. The HIV prevention programme will be data driven, evidence-based and informed by the on-going size estimation and geographic mapping exercise of the WB/USAID/GFATM supported projects and data from states specific studies. Rapid assessment of HIV programs will be conducted and effective HIV programmes will be scaled to increase geographic coverage and coverage of 80% of the identified target population within the state. States with high HIV prevalence in Nigeria will be prioritized. The PCRP will apply the combination prevention approach and the Minimum Prevention Package (MPP) as outlined in the National HIV Prevention Plan and these will be tailored to specific scenarios and context as appropriate.

Goal: Reduction of new HIV infections amongst targeted subpopulation (Youth and MARPs)

[34] National Mode of Transmission Study, 2010

Objectives:

1. To reach 4 million young people and 500, 000 MARPs with combination prevention package
2. Strengthen capacity of local stakeholders to develop, manage and evaluate effective HIV services for young persons and MARPs.

Strategic Focus:

1. Strategically target the combination prevention approach and minimum prevention package among young persons and MARPs, with increased intensity and coverage as guided by disease epidemiology and prevalence of HIV in 36+1 states.
2. Strengthen the capacity of media, state and community based stakeholders to develop, manage and evaluate effective HIV services for young people and MARPs including:

a) Targeted behavior change communication programs using various approaches to disseminate information, behavior change strategies through the expansion of the school-based Family Life, HIV and AIDS Education (FLHE) and NYSC HIV/AIDS Program

b) Innovative demand creation and community mobilization including providing supportive services that will link people to HIV prevention and treatment services, reduce stigma, etc.(See Priority Area 2, priorities 9 below)

c) Increased visibility of HIV/AIDS programmes and interventions at the national, state and LGA levels

PRIORITY AREA 9: PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT) OF HIV

Background:

Mother to child transmission of HIV accounts for about 10% of the HIV burden globally, with Nigeria contributing about 30% of the global burden of mother to child transmission of HIV. In Nigeria, there are over 6 million annual births and over 200,000 pregnant women requiring ARV prophylaxis and treatment annually. Although, the provision of PMTCT service began in 2001, and efforts to scale began since 2005, the coverage to date remains low at 19.7%. The PMTCT sites have increased to 2,216 (as at Dec 2012), but are well below the 16,378 sites required nationally.

The PCRP initiatives will complement existing national initiatives (including those supported by donors: USG supported PEPFAR –Nigeria program, the Global Fund grant. The PMTCT program will be implemented in all 36 states with a special focus on the 12+1 States with high HIV prevalence: Abia, Akwa-Ibom, Anambra, Bayelsa, Benue, Cross River, FCT, Kano, Kaduna, Lagos, Nasarawa, Plateau and Rivers. While focusing on strengthening the scale-up of PMTCT in all states, the strategic focus will be on building state and local government capacity to direct the implementation of PMTCT programs and provide oversight, supportive supervision and mentorship in line with the UNGASS framework for PMTCT scale-up.

Focus on 36+ 1 states**:** The 2010 National HIV sero-prevalence sentinel survey reported a national median HIV prevalence rate among pregnant women attending ANC as 4.1%. The survey showed that 17 states and the FCT had HIV prevalence rates that were higher than the national median. The PCRP will focus efforts especially on states with high HIV prevalence and high burden of the disease. Twelve states listed above and the FCT will be given priority for immediate PMTCT scale up and saturation of existing ANC service outlets with PMTCT services offered to HIV pregnant women. However, expansion of PMTCT services will also occur and continue in other states, and these states will also benefit from the PCRP.

Goal:

To scale-up PMTCT service coverage to 95% of national need towards achieving elimination of MTCT by 2015

Strategic Focus:

The PMTCT strategic focus will complement on-going GoN, USG PEPFAR and GFATM supported PMTCT initiatives and cover all states. The strategic focus of the PCRP includes the following:

a) ***Strengthen coordination of PMTCT services at state and local government levels*:** An initial needs assessment and capacity building process of state level SACA/SASCP staff will focus on the following:

- A rapid assessment of health capacity gaps in 36 + 1 states to identify specific staffing gaps for PMTCT, service delivery, etc.
- Recruitment and re-deployment of skilled health personnel for PMTCT based on the findings of rapid assessment and ensuring appropriate staff mix.
- Provide capacity building program for staff (programs training, administrative training and management , mentorship training , leadership training,)

b) ***Develop & sustain implementation of a communication strategy for PMTCT*:** The program will support the development of a communication and demand creation strategy. This will be implemented through an advocacy, awareness sensitization program, procurement and distribution of IEC materials for PMTCT. Specific advocacy sessions will target a range of community champions and opinion leaders including traditional and community leaders, women leaders, women groups, men forum, etc. These advocacy sessions will encourage uptake of ANC/PMTCT services, delivery at health facilities and partner testing and involvement.

c) ***Prevention of Unintended Pregnancies in HIV positive women*:** Integration of sexual reproductive health services (especially family planning) and HIV programs is an important care package for HIV positive women, is included in the PCRP. Support for PMTCT prong 2 approach in these states will involve promoting and providing family planning programs: during ANC, postpartum period and immunization program. Family planning methods will either be procured and/integrated in all PMTCT service outlets and staff in these services will be trained to provide services to all clients regardless of HIV status.

d) ***Prevention of HIV transmission from infected mother to her infant:*** A core principle of the President's plan will involve direct state level support in activating PMTCT services in health facilities across 36+1 states. Activities will involve specific site identification, assessment and activation for PMTCT service. The activated PMTCT site will be supported to offer a range of PMTCT services including: routine HIV counselling and testing of pregnant women and their partners, infant feeding counselling, modification of obstetrics practices and provision of ARV prophylaxis to mother-infant pair.

e) ***Providing appropriate treatment, care and support to mothers living with HIV and their children:*** The President's plan will provide access to ARV prophylaxis and treatment for all HIV positive clients regardless of status in PMTCT programs. The mother-infant pair will also be followed-up at delivery and provided with necessary medications including Co-trimoxazole, infant feeding counselling, early infant HIV diagnosis (EID), infant ARV prophylaxis and treatment (when needed either on-site or through referral).

The PCRP will support the establishment of at least 1 PCR machine per State; DBS kits and transportation of samples. Pregnant women will be encouraged to enrol in mother support groups and in life long treatment and HIV support programs when necessary.

f) ***Strengthen monitoring and evaluation for PMTCT services:*** This program will strengthen the capacity of State Teams to monitor and evaluate PMTCT services. Specifically, monitoring and evaluation support for the PMTCT service will include: distribution of national PMTCT registers and forms, support for PMTCT data collection, cleaning, analysis and transfer of State data to national levels. In addition, PMTCT supportive site supervision & mentorship will be provided in all States and as well as hosting state level feedback meetings on PMTCT activation. These measures will contribute to the increasing the quality of PMTCT services, level of service reporting and feedback.

g) ***Strengthen supply chain management for PMTCT:*** The logistics management system, forecasting and distribution of HIV test kits and ARV/ART for PMTCT services will be strengthened. The state HIV program will be capacitated to ensure long term sustainability in service delivery.

h) ***Innovative demand creation mechanisms:*** This program will explore the use of innovative demand creation mechanisms to attract and retain pregnant women within health facilities offering skilled attendance at labour and PMTCT services. This is targeted at addressing the current challenge of loss to follow up of women who attend ANC and have deliveries outside health facilities for varied reasons. The use of incentives (Conditional cash transfers, distribution of MAMA kits, linkages to community health insurance where operational, strengthening of ward development health committees etc.) will be explored

PRIORITY 10: HIV TREATMENT

Background

Nigeria with 3.4 million HIV-positive individuals ranks second among the countries with the highest HIV/AIDS burden in the world, next only to South Africa. The ART programme in Nigeria commenced in 2002 and has largely been supported through the United States President's Comprehensive Plan for AIDS Relief (PEPFAR) and the GFATM in partnership with the Government of Nigeria (GoN). The number of ART sites has increased from 491 sites in 2011[35] to 566 sites by Dec 2012. These sites are located in tertiary, and secondary health facilities (mainly) and some primary health care facilities, spread across the 36 states of Nigeria and the FCT.

The uptake of ARVs has increased from 302, 973 (2009) to 491,021 (December 2012), but achieved ART coverage in 2012 is 30%, which is well below the NSP 2012 target of 56%. ART service provision at the primary care level is limited and minimal even though the PHC remains the first point of contact for healthcare for most Nigerians residing in rural communities. Significant numbers of existing ART facilities are facing huge infrastructural and human resource constraints that limit their capacity to enrol new patients on ART. The increase in the number of PLHIV requiring treatment, in line with the current WHO and national guidelines has increased the coverage gap for ART. Also, poor access to ART services remain a major limiting factor as ART sites in the country are inequitably distributed and mostly located within urban areas. Other challenges include stock out of anti-retroviral drugs, limited referral linkages between HCT and TB DOTS sites.

The PCRP seek to address the gaps in service coverage, scale up ART services and increase ART uptake among eligible PLHIV. Specifically, the HIV treatment component of the plan seeks to:

1) Increase ART access across the 36 states and FCT through the establishment of 1000 new ART sites across the states with consideration for Public (including PHCs) and private health facilities in the 36 states of the country

2) Enrol 600,000 eligible HIV positive adults and children on ART over the life span of the plan.

Achieving these objectives requires increasing and strengthening the capacity of the State coordination mechanisms in the development, implementation and monitoring & evaluation of HIV/AIDS prevention, care and treatment programs at State level. It is important to leverage on the technical expertise of the lead implementing partners, public and private health facilities in the state. It is imperative that state governments identify and scale up ART services, strengthen the product and supply chain systems and ensure the availability of ARVs at service delivery points. Opportunities to strengthen the synergies of all partners implementing HIV/AIDS and other related disease programs will be a key component of the success of PCRP initiatives.

[35] Nigeria, GARPR, 2012

Goal
To scale-up ART services and achieve universal access targets by 2015

Strategic Focus

1. To upgrade at least 2 new "state owned" ART comprehensive HIV/AIDS treatment services per state preferably in local governments without any ART centres.
2. Federal government to activate at least 2 ART site (public or private) per LGA.
3. To upgrade PMTCT sites with CD4 testing capabilities to ART initiation sites. To achieve this, the 2,000 new PMTCT sites to be established and equipped with Point-of-care CD4 machines will be supported to begin ART initiation with community linkages for Care. Staff will receive training on ART initiation and monitoring using the task sharing approach. The facilities will also be linked to ART-experienced secondary health facilities for purposes of mentoring and quality assurance.
4. To procure and supply point of care CD4 machines to another 500 PMTCT sites drawn from existing PMTCT sites in public sector and new private sector facilities. These facilities will also be capacitated to provide ART services to increase the pool to a total of 2000 new ART sites. Potential public sector facilities will include at least two model PHCs per state in line with the national autonomous PHC Model of decentralization.
5. To accelerate the decentralization of ART refill services to additional PHCs across selected states of Nigeria
6. Improve the institutional capacity of National and State Coordination mechanisms to develop, implement, supervise, monitor and evaluate HIV/AIDS treatment programs
7. Strengthen contact tracking and adherence support to minimise treatment default including loss to follow up.

To achieve the above stated objectives, the PCRP proposes the following programme activities to be undertaken by State Management teams:

i. Select local government areas in the state with high HIV/AIDS burden and conduct a comprehensive assessment of secondary and model primary health care facilities to determine suitability for the activation of ART services.
ii. Conduct a rapid situation analysis of HIV treatment services in the private medical facilities in the state and identify those facilities suitable for ART service delivery
iii. Identify at least two suitable public facilities (either secondary health facilities or model PHCs) per state for initiation of ART services under the state owned scheme and a number of private facilities willing to offer ART services
iv. Using the ''hub and spoke model'', identify suitable PHCs that can serve as ART refill sites to existing congested ART facilities in the state.
v. Develop a state specific costed work plan that will address the scale up of HIV/AIDS treatment services in each state. State work plans shall incorporate the following critical activities

- *Coordination:* In line with state specific HIV/AIDS treatment scale up plans, coordinate the activities of all development partners and stakeholders implementing HIV/AIDS related activities to ensure the provision of high quality and sustainable service delivery
- *Training and capacity development*: Training of relevant health care workers on adult and paediatric ART, Laboratory services, adherence and drug refill issues and allied trainings to support quality comprehensive HIV/AIDS care and treatment. Task sharing at PHCs will be adopted to allow non-medical doctors initiate ART. The training should be according to the national guidelines
- *Procurement and supply chain management*: Procurement of medical commodities and drugs: such as drugs for OIs including co-trimoxazole for preventive therapy, and laboratory consumables/reagents

- *Maintenance:* Provision and maintenance of equipment such as laboratory equipment (including those for haematology, chemistry, CD4 count, PCR machines (where feasible) , and early infant diagnosis facilities)
- *Infrastructural development*: Construction and renovation of the new centres and provision of furniture, equipment and necessary clinical service items to ensure quality service delivery
- *Referral Linkages*: Development/strengthening of effective referral system and linkage of HIV/AIDS services (ARV and management of OIs) with other related health problems including TB, RH, and malaria
- *Service Integration*: Ensure that all components of HIV services delivery are physically and functionally integrated to the existing health care services as feasible.
- *Supervision* : Monitoring and supervision of services including the provision of mentorship to improve site level service delivery quality will be done using the cluster model
- *HMIS* : Strengthen state level and national HIV/AIDS recording and reporting systems
- *Sustainability*: Clearly articulate state level strategies and measures that will demonstrate long term sustainability of HIV/AIDS services

Priority Area 11: TB/HIV Collaborative activities

Background:
HIV is a major risk factor for developing Tuberculosis (TB). Tuberculosis is the commonest cause of morbidity and mortality among People Living with HIV (PLHIV). TB/HIV collaboration is needed to mitigate the dual burden created by interactions between TB and HIV.

Goal
To reduce the burden of TB among PLHIV and burden of HIV among TB patients

Objectives
1. Increase TB diagnosis among PLHIV by expanding access to new diagnostic molecular techniques.
2. Ensure prevention of TB through provision of Isoniazid preventive Therapy to 200,000 eligible PLHIV annually.
3. Provide integrated TBHIV services at all service points.

Strategic Focus
1. Procure, install and maintain 200 Gene Xpert machine including cartridges annually in comprehensive HIV service delivery sites.
2. Procure Rifabutin@ for treatment of 1000 PLHIV on second line ARVs that develop TB disease annually.
3. Procure Isoniazid for 200,000 Eligible PLHIV annually

Priority Area 12: HIV/AIDS Care and Support

Background:
With the improvement in the medical treatment of HIV and AIDS, there is reduction in AIDS-related morbidity and mortality. There is a need to address the other non-medical challenges of PLHIV and PABA.

Goal:
The goal of this priority area is to promote the survival and improve the quality of life of persons living with HIV/AIDS (PLHIV) and people affected by HIV/AIDS (PABA) especially Orphans and other Vulnerable Children (OVC)

Objectives:
1. To improve access to quality care and support for PLHIV

2. To link PLHIVs especially females, marginalised persons and people with special needs to income generating activities (IGA) and poverty alleviation programmes
3. To reduce stigma and discrimination targeted at PLHIV and PABA
4. To establish and strengthen gender responsive OVC coordinating mechanism at all levels

Key interventions:

1. Support the production and distribution of national guidelines for care and support.
2. Strengthen institutional and human capacities for MDAs and CSOs providing care and support services
3. Develop, print and distribute directories of programmes of income generating activities and poverty alleviation
4. Advocate for the passage of the anti-stigma at the national and state level
5. Advocate for the domestication of the child acts rights in all 36+1 states
6. Develop tools for gender mainstreaming

Priority Area 13: Operations Research to Generate Evidence

Background:

Resourcing the national response requires effective and efficient use of human and material resources. Operations research will generate the evidence-base that will inform the improvement of HIV and AIDS programmes at the national sub-national levels.

Goal:

To strengthen the evidence-base for the national HIV response and effectively track progress made in the response.

Objectives:

1. To identify HIV/AIDS research priorities and implementation science research questions
2. To conduct short duration research that seeks practical solutions to existing operational challenges of managers, administrators, policy makers and relevant practitioners
3. To leverage on opportunities provided by the OR to improve access, coverage, equity, and research capacity of researchers
4. To communicate the findings from the studies to programme and policy managers for programme and service improvement and expansion.
5. To Promote and monitor the utilization of HIV/AIDS research outputs in national programming

Strategic Focus/Study areas:

1. Decentralization and integration of Services

- Study on Integrated PMTCT/MNCH service delivery at PHC levels
- Integration of SRH and HIV services

2. ART and PMTCT service delivery

- Research on comprehensive HIV service delivery through the Private sector
- Cohort analysis for ART in Nigeria (*Kaplan-Meier* Analysis)
- Effective strategies for delivering PMTCT services
- Effective strategies for community engagement and demand creation of HIV services

3.3 Duration of the PCRP

The comprehensive response plan will have a two year duration spanning *July2013–June 2015*

3.4 Guiding principles of the PCRP

High-level government commitment, national leadership and ownership: The PCRP is built around a high level commitment from the national leadership and a systematic approach to attain increased and sustained support and ownership by the other tiers of government in Nigeria. The plan encourages a State and LGA level initiated HIV/AIDS response tailored to the applicable epidemiology and social context (including self-determined priorities) and substantially resourced from within.

Innovation: The PCRP seeks to adopt innovative approaches to accelerating key interventions and improving the broader coordination mechanisms for the HIV response in Nigeria.

Multi-sectoral and multi-stakeholder partnerships: The PCRP will continue to adopt the multi-sectoral and multi-stakeholder involvement model enshrined in the National Strategic Plan in its implementation of detailed activities. Emphasis will be placed on leveraging resources particularly as it concerns bridging the resourcing gap for the national response on one hand and increasing service coverage on the other.

Evidence-based interventions: The PCRP will be strongly reliant on available evidence supporting cost-effective interventions that yield the greatest impact. A higher value for money ratio will be strongly weighted in the selection of interventions for prioritization.

Active approach to service delivery: The PCRP is designed to be a gap bridging tool to rapidly improve selected indices that track the service coverage in the country.

Strengthened coordination, transparency and accountability: The PCRP seeks to strengthen the response coordination mechanism through greater involvement by and delegated responsibility to lower tier coordination units. The provision of opportunities for State Management Teams (SMT) to tailor the response to local context including resourcing is a vital element of the plan. The promotion of public reporting; use of accountability frameworks, matching grants and performance based financing will contribute to improved results.

3.5 Implementation arrangements for the PCRP

3.5.1 Governance & Accountability

The Presidential Comprehensive Response Plan (PCRP) is a governance response to the HIV and AIDS response in Nigeria. The President, Dr. Goodluck Ebele Jonathan has recognized that the Public sector low investment in the HIV and AIDS response presents the country in a negative light with regards to her commitment and leadership of the national HIV and AIDS response. The Presidential directive therefore to produce the PCRP is a positive step in government responsiveness to this challenge.

According to the UNDP in its publication Global Crisis-Global Action 2001, *"success in mitigating the HIV and AIDS epidemic is dependent upon how well the overall national response to HIV and AIDS is governed, managed and coordinated"*.

Nigeria, with support from various bi-lateral and multi-lateral partners, has sought to improve governance for HIV and AIDS in the last decade. This had resulted in the development of policies on HIV/AIDS, the enactment of various laws establishing the NACA and SACAs; strategic direction and oversight of a unified HIV/AIDS program through the various cycles of strategic plans: HEAP (2001-2004), NSF (2005-2009), NSP (2010-2015); an effective coordination mechanism to enable a truly multi-sectoral response supported by improved donor

coordination; and an enabling national/sub national environment for effective local responses through the strengthening of the SACAs and LACAs.

Governance has also been described as the provision of leadership and strategic direction. Leadership is said to inspire and mobilize people through vision and strategic focus on results that are needed. It also provides policy guidance, promotes participation and dialogue, and encourages others to take positive actions for an expanded and comprehensive response to HIV/AIDS. Developing partnerships, advocating for change, and building consensus around strategic directions are three key elements of leadership capacity development in HIV/AIDS.

Thus, the PCRP as envisioned by President Goodluck Jonathan seeks to elevate Nigeria's HIV and AIDS governance towards achieving the NSP results and in aligning with efforts to achieve MDG Goal 6.
However, two areas of governance that need to be improved: the financing of the response, and resource accountability at all levels.

The PCRP is based on a Performance Management and Accountability Model. This model recognizes three major components to the national HIV and AIDS response in this plan to be anchored on:

A. ***Strategic Planning:*** That Nigeria in line with the universally acceptable standard of one strategic framework for the country has developed the PCRP to align with the Vision and Goals of the NSP 2010-2015. The PCRP is a governance initiative to reposition the national response by strengthening the strategic directions outlined in the NSP and responding to emerging issues arising from the national response (section 2.4) of this plan. The implementation of the PCRP will ensure that the goals and objectives of the NSP are met at the national levels and at the states and LGA levels. It is envisaged the implementation of the state and LGA plans should then lead to improved response performance.

B. ***Performance Management***: The critical components of performance management are: to set appropriate performance measurement mechanisms through the establishment/adoption of measurable indicators; to consider the various risk factors that pose obstacles to the delivery of an effective response especially as it relates to such issues as effective supply chain management; response coordination and facilitation of service delivery through the provision of adequate resources (human, material and financial) as well as service standards to enable quality service delivery, mentoring and supportive supervision, continuous service improvements, DQAs monitoring and evaluation that underpins high quality services.

C. ***Accountability:*** Accountability also includes financial auditing and accountability of decision makers to the people whose lives are affected by their decisions. Thus, in this model, public reporting by all levels of government through financial reporting, service reporting by appropriate MDAs in the multi-sectoral response (NHMIS/NNRIMS), stewardship reporting at the levels of the presidency and state governments will not only ensure accountability but will enable improved service delivery (performance management) and will then through the feedback loop influence further strategic planning**.**

3.5.2 Programmatic leadership, planning, and coordination of implementation

The National Agency for the Control of AIDS (NACA) established by an Act of the National Assembly[36]is charged as the government agency for the coordination and facilitation of the national response. This agency domiciled in the Presidency was established to ensure that the national response is in line with international standards.

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[36] NACA bill, 2006

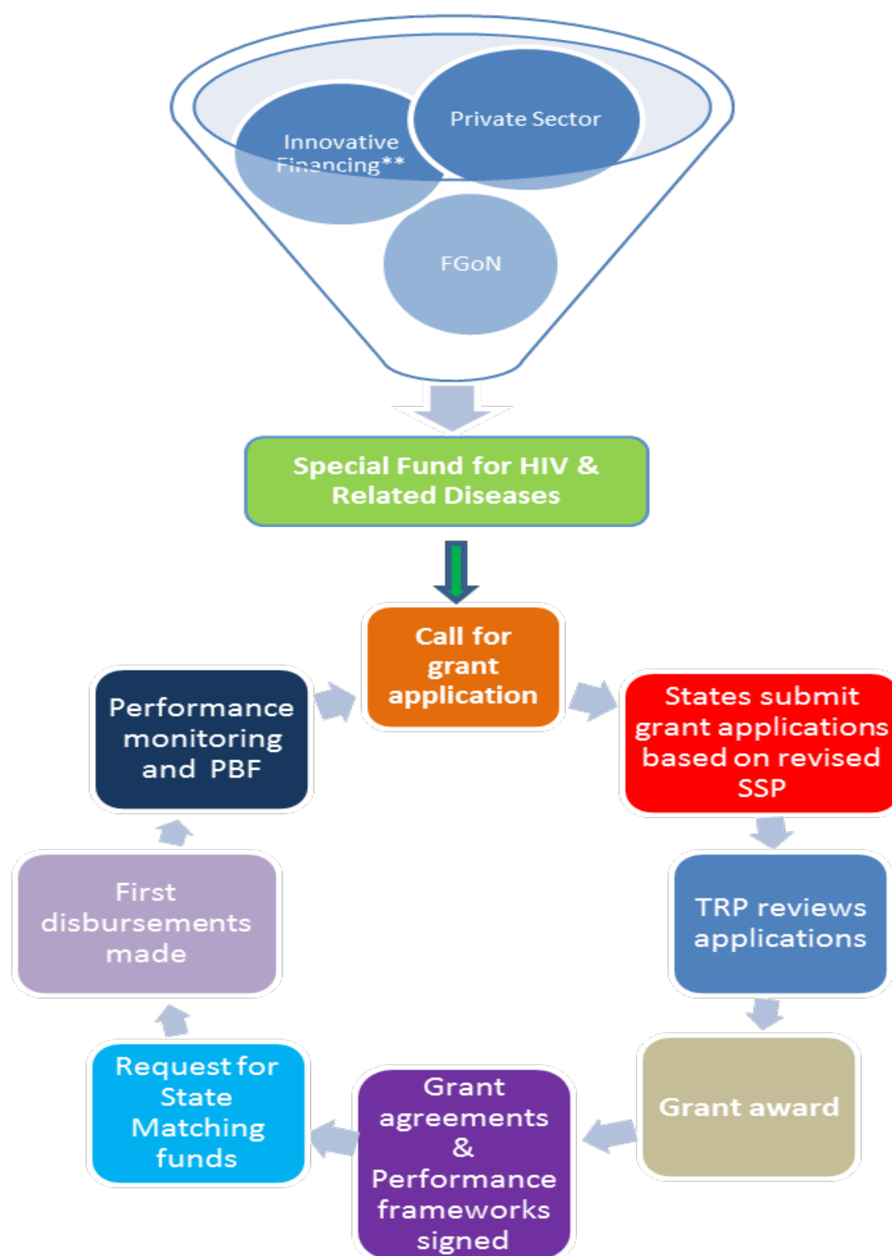
Consistent with the FGN vision for establishing NACA, the programmatic leadership, planning and implementation coordination of the PCRP will continue to reside in NACA at the national level and with SACA at the state level. Through existing structures of coordination at the national and state levels such as with the Treatment Technical Working Group (TTWG), Prevention Technical Working Group (PTWG) and MDAs (especially the ministries of health, education, women affairs and social development, youths, sports, agriculture etc. will continue to play their leadership roles in the facilitation of service delivery and in reporting of service data.

The role of NACA and NACA Board in providing programmatic oversight and governance oversight to the national response must be clearly understood as different from the role of implementers such as the MDAs. Thus oversight in this sense refers to the structural division of responsibilities between oversight bodies (NACA & NACA Board) and implementers (MDAs). There needs to be separation in order to ensure effective organizational action toward agreed upon results, as well as to avoid conflicts of interest. Overseers and evaluators of programs should not be involved in internal, non-strategic decisions, but they do help set and evaluate overall strategy and review the performance of top management. This principle is well established in NGOs and private organizations through a board mechanism or similar structure. It is the duty of the board to set strategy and review performance, but not implement daily operations.

3.5.3 State and LGA level involvement – Matching grant model

The roles of the State Governments and the various LGAs are indispensable to the attainment of the NSP and therefore the PCRP goals and strategic objectives as most of the services are delivered at these levels. Furthermore, most of the priority interventions require that both at the secondary and primary health care levels as well as within the communities, state and local governments should not only provide leadership and strategic directions in line with the model, but also be accountable to the public through financial, stewardship and service reporting.

FIGURE 5: PROPOSED FUNDING & MATCHING GRANT MODEL



The PCRP therefore plans that a Financing Pool be established and this is a noted successful practice in other African countries[37]. In the proposed model, the FGN will provide resources to this pool and the States match the fund granted to states from the pool in a 50-50 ratio. This matching grant model allows for joint ownership of the fund at state level and promotes mutual accountability for both the fund and the expected results.

All States and LGAs will have access to the fund through a grant mechanism that ensures that draw down on funds is dependent on accounting for the last tranche of funding as well as on results based on plans for the period.

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[37] UNAIDS, Efficient and Sustainable HIV Responses: Case studies on country progress, 2013

The fund will be domiciled in NACA, whose responsibility will be to warehouse the fund and set up robust grant making systems that lends itself to transparency, accountability and performance based financing tenets. It must be noted that this mechanism is already operational and effective in service delivery through the donor funds such as the WB grant, the GFATM as well as with the PEPFAR.

3.5.4 Private sector involvement

Private sector involvement in the HIV/AIDS response has been twofold 1) Resourcing the National response and 2) Expanding access to service delivery.

On resourcing the national response, the National AIDS Spending Assessment Report[38] 2010 indicated that the private sector in Nigeria remains a very low contributor (0.1%) to the national HIV and AIDS response. The PCRP recognizes this challenge and places significant emphasis on resourcing the national response through increasing private sector contributions. Details of this process are contained in the concept note annexed to this document on innovative financing of the response. The special fund for HIV and related diseases will serve as the recipient pool for future generated funding from this initiative.

On expanding access to service delivery, the private sector has remained an untapped resource to the detriment of the national response. Overwhelming evidence abounds to showcase the private sector as a means to increase access to health services in light of public sector constraints.[39]The PCRP recognizes this missed opportunity and draws evidence from the recent diagnostics exercise in Nasarawa state during which the full potential of private sector engagement in scale up of PMTCT services was identified. The PCRP will seek to achieve greater involvement of the private sector in service delivery and will prioritize their involvement in the national and state revised strategies. A step wise approach is recommended preceded by the conduct of diagnostics exercises and a gradual but sustained pattern of engagement. Studies will be commissioned to characterize and cost the private sector model with a view to a methodical scale up. As states are encouraged to establish new service delivery points, the PCRP recommends early involvement of private for profit establishments.

3.5.5 Harmonisation, Alignment & Technical support

The development partners' contribution to the national response till date has been significant and indeed has helped in bringing the response up to its current level of success. The FGN is appreciative of this support and will in the near foreseeable future continue to rely on this support in order to reverse and mitigate the effects of the epidemic on the nation.

Nonetheless, as the nation responds to the need for ownership and leadership of the response in line with the Paris Declaration, it seeks continuous harmonization and alignment of donor and development partners support with the nations vision and strategic direction.

The FGN and the State governments will therefore continue to have representatives of development partners at the various platforms for coordination and implementation of the response. At the State level the proposed representation of development partners in the SMT is to improve harmonization and alignment at that level.
Given the critical role of the development partners in the provision of technical support at the national and state levels, the FGN will continually rely on the partners for technical inputs in the implementation and reporting of this plan.

Indeed, partnership development indicators are set in the PCRP Performance Framework to ensure that mutual accountability also exists at this level.

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[38] NASA, 2010 Report

[39] B. O'Hanlon et al: Leveraging the private health sector to sustain national HIV programs in the context of diminishing donor resources: XIX International AIDS Conference Washington DC USA

3.5.6 Capacity Building

The unavailability of both organizational and technical capacity to respond to the HIV and AIDS epidemic has been well documented. NACA in partnership with development partners have been seeking solutions to capacity issues in the response. The National Harmonized Organizational Capacity Assessment Tool (NHOCAT) and subsequent organizational capacity assessments (OCA) are already taking place at both national and state levels with NACA and SACA constituent entities including MDAs, Civil Society Networks and their member organizations and FBOs conducting capacity assessments based on OCA. Indeed the WB-Grants are being applied to supporting organizational and technical capacity building in many states already.

An area that may require rapid scale-up of technical capacity building will be at the LGA levels especially at the Primary Health Care (PHC) Centres where the training of service providers and community service facilitators would be required e.g. Ward Development Committees will need to be trained.

PCRP will therefore foster systems to build and support training of critical mass of skilled staff especially at PHC levels for effective HIV/AIDS service delivery and address the skewed deployment and high attrition rate of health personnel at this level.

3.5.7 Strengthening the HMIS for HIV

Monitoring and Evaluation (M&E) is a key component of the multi-sectoral response to HIV/AIDS in Nigeria. Generation of complete and reliable data that lends itself to regular data quality audits remains a gold standard for any national HIV response. This standard reinforces the confidence of would-be users for decision making and tracking of progress made in the national response. The NNRIMS remains the national HMIS for HIV in Nigeria and this is aptly recognized in the PCRP. However, recent reviews[40] of the HMIS shows amongst other challenges that limited resources and inadequate capacity are key factors militating against the states, LGAs and facilities implementing their M&E mandates and current data on HIV and AIDS activities are not complete and readily available to many stakeholders who may require such data or information for policy or programmatic decisions.

The PCRP takes direction from the HMIS system strengthening efforts articulated in the NOP II[41]and prioritizes efforts seeking to improve the completeness of reporting; data reliability and data use for decision making. Key interventions selected for support in the PCRP will target these key aspects which are anticipated to impact greatly on the decision making, management and progress reporting for the national response over the lifetime of the PCRP and beyond.

3.5.8 Resource mobilisation & Financial Management

3.5.8.1 Resource Mobilisation

The PCRP recognizes the huge funding gap that exists for the NSP which is estimated at N62bn as at December 2012. Being a gap filling mechanism, the PCRP will seek to catalyse efforts at improving the resourcing profile of the NSP. The PCRP proposes three modes of support to the funding gap viz.:1) creation of a special funding pool with seed monies from the Government of Nigeria through the MDG, SURE-P sources initially and sustained by direct allocation from the subsequent annual federation budgets; 2) delegation of responsibilities to the states to fund to an appreciable level, their revised State HIV strategic plans from local sources and matching grants from the special fund; 3)innovative financing mechanisms for HIV and related diseases as put forward in the NACA concept paper

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[40] Joint Annual Review of the National Response to HIV/AIDS, 2011

[41] The Nigeria National Response Information Management System (NNRIMS) Operational Plan II

3.5.8.2 Financial management and Accountability

In this Plan, the OECD definition of accountability[42]has been adopted as the obligation to (i) demonstrate that work has been conducted in accordance with agreed rules and standards and (ii) report fairly and accurately on performance results vis-à-vis mandated roles and/or plans.

Each State of the Federation through its State Management Teams (SMT) headed by no less a functionary as the State Commissioner for Health will draw down on the funds through the states approved operational plans in line with the NSP and PCRP as well as with focus on the states priority interventions occasioned by the burden of the epidemic in the state.

Funds draw down will be based on the governance and accountability framework guiding this PCRP. Each State is expected to present quarterly financial and service delivery reports (SMT to the State Governor) as well as Stewardship report (Governors to each other through the Governors Forum and at the NEC). The Presidency will present to the public and relevant stakeholders a bi-annual parley on HIV and AIDS Response (financial & service delivery). A performance based funding model will be adopted to reward performance and stimulate development across states. A performance framework will be agreed upon and serve as the basis of reporting. Performance indicators will be developed and agreed upon as part of the accountability process.

3.6. MONITORING AND EVALUATION OF THE PCRP

Tracking progress made with the implementation of the PCRP will be conducted through a monitoring and evaluation system that utilizes existing methods and resources for tracking progress with the NSP. A tracking indicator pool will be developed for the systems strengthening and coordination areas and will be included in the performance framework (Annex B) to this plan. Service delivery indicators will be drawn from the NOP II indicator lists applicable to each service delivery area. Similar tools and reporting pathways will be adopted for the PCRP and data pooled with that of the national reporting mechanisms for the response.

Another unique approach to the PCRP M&E system will be the allocation of targets to states to promote accountability and stimulate ownership and comparability across states. Indices around resourcing the response; levels of state government responsiveness to commitments and service delivery yields will also be tracked.

Existing reporting tools and reporting frequency will be adopted to ensure full integration with existing response mechanisms.

A performance dashboard will be created to be used for summary reporting to the President and the Nigerian Governors Forum and this will form a tool for advocacy within and beyond the lifetime of the PCRP.

Beyond this, the matching grants will have accompanying performance frameworks through which performance based financing would be implemented for participating states.

The PCRP will be evaluated after the two year period to extract best practices for use in improvement of the national response.

[42] Source OECD 2002 Extract

This chapter specifies the required investment for the PCRP and how the resources are allocated to the planned priority areas of intervention. It shows that the PCRP reduces unit cost of service delivery and describes its impact on the HIV epidemic. In addition, the need to develop a longer term investment case is outlined.

4.1 RESOURCE NEEDS

The PCRP work plan has been developed and costed adopting a strategy level approach and using costing elements referenced from existing national documents including the NSP. A cost-effective approach has been applied by the costing team to generate realistic funding estimates for the various components of the plan.

The PCRP will require an investment of ₦ 262.7 billion (USD 1.7 billion) over a two year period starting in 2013. This presumes that development partners will sustain their present level of support and funding to the national response. If the PCRP is fully funded by GON (Federal State and LGAs) as envisaged, it will significantly increase the proportion of domestic funds invested in HIV response to 60% of total required funding by 2015.

The vast majority (96.3%) of the planned PCRP investment will be allocated to accelerating the implementation of HIV prevention, care and treatment services (priority areas 7-12). It will allow for a rapid scale-up of coverage with HIV counselling and testing (priority area 7), prevention of sexual transmission (priority area 8), PMTCT (priority area 9), and HIV care and treatment (priority area 10). The remaining 3.7% of the planned PCRP investment will fund efforts to improve coordination and strengthen systems of the national response.

S/N	Priority Area	COST (NAIRA)	COST(USD)
1	Financial Resourcing and State Ownership	67,647,128	436,433
2	Coordination of the National & State level Response	6,832,311,293	44,079,428
3	Human Resources for Health	403,321,600	2,602,075
4	Data Management	392,278,063	2,530,826
5	Supply Chain Management (SCM)	336,754,937	2,172,612
6	Increasing Community Participation and dialogue	1,500,316,945	9,679,464
7	HIV Counseling and Testing	99,231,363,273	640,202,344
8	Prevention (Sexual Transmission)	28,290,380,333	182,518,583
9	PMTCT	51,736,547,808	333,784,179
10	HIV Treatment	71,787,853,760	463,147,444
11	TB/HIV collaboration	915,895,000	5,909,000
12	Care & Support	1,091,899,430	7,044,512
13	Operations Research to Generate Evidence	154,000,000	993,548
Total		**262,740,569,570**	**1,695,100,449**

Table 8: PCRP COST DISTRIBUTION BY PRIORITY AREA

1.1. IMPACT ON UNIT COST OF SERVICE DELIVERY

The implementation of the PCRP will lead to improved efficiency of service delivery, stemming from economies of scale and built-in measures to increase management, technical and allocation efficiency as synthesized in Figure 7. As a consequence, unit costs of services delivered are expected to drop; these potential savings will be assessed and included into the longer term investment case (see below).

FIGURE 6:PCRP IMPACT ON SERVICE DELIVERY COSTS

Allocation efficiency
- Prioritize key areas of intervention
- Adopt an active approach to service delivery (e.g. testing campaigns, outreach to underserved populations) to improve service utilization

Technical efficiency
- Use point of care machines rather than CD4 machines
- Remove chemistry assays from regular ART programs

Management efficiency
- Promote private sector involvement in service delivery to improve access and reduce maintenance cost in public facilities
- Leverage bulk procurement initiatives in partnership with USG and the Global Fund
- Increase state ownership and reliance on local resources to reduce overhead cost

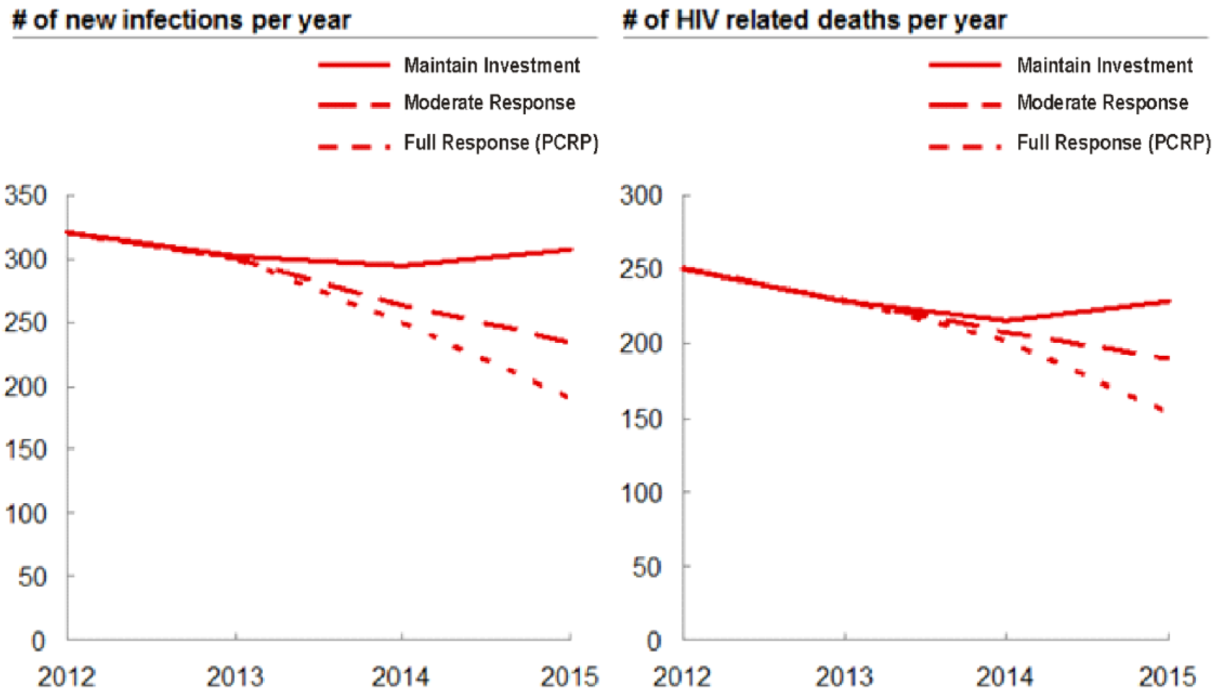
1.2. IMPACT ON THE EPIDEMIC

Accelerating domestic investment as envisaged in the PCRP will have substantial impact on the evolution of the HIV epidemic in Nigeria. Over the two-year period of PCRP spending, the number of new infections will drop by over 40% (compared to maintaining current investment levels) to less than 100,000/year. This translates into 210,000 new infections prevented over the two-year period.

The number of persons on ART will increase by 100% to more than 1 million. This will result in an early reduction of the number of AIDS deaths by 21% to 115,000/year by 2015, which translates into 92,000 deaths averted.

New infections due to mother to child transmission (MTCT) will be reduced by more than 80% compared to maintaining the current level of investment. This will lead to a significant reduction of the number of children AIDS deaths by 2015.

FIGURE 7: PCRP SIGNIFICANTLY REDUCES NUMBER OF NEW INFECTIONS AND AIDS DEATHS



In addition, investing now is attractive because an improvement in current service levels and consequent reduction in new infections and patients in need of treatment will save future treatment cost: **The PCRP will lead to saved treatment costs of over ₦ 266 billion (1.2 billion USD)**.

1.3. FUNDING THE STATE LED INTERVENTIONS FOR HIV AND RELATED DISEASES

By the PCRP design, the Federal Government of Nigeria is expected to make a direct investment of N57.9 billion into the national response to fund certain aspects of the plan that is exclusively Federal responsibilities. The Federal Government will thereafter be expected to invest an additional N78 Billion as support to all States responses in a performance driven manner. However, this fund will be a virtual fund to be accessed by States based on performance and those that meet their own financial commitment target as allotted in the PCRP. The allocation of costs to States was based on State HIV burden. The states will be expected to invest a total of N105billion of their own funds while the Private sector will be expected to fund the balance of N 20.4 billion. The cost distribution by state is as depicted in the table below

TABLE9: PCRP DOMESTIC FUNDING SHARE

TOTAL COST OF THE PRESIDENTS PLAN:	NGN 262,740,569,570
DIRECT FEDERAL COST ALLOCATION	NGN 57,980,335,361
FEDERAL CONTRIBUTION TO STATES:	NGN 78,964,471,712
TOTAL STATE CONTRIBUTION	NGN 105,319,739,075
TOTAL PARTNERS /PRIVATE /OTHERs	NGN 20,476,023,421

FIGURE 8: PCRP DOMESTIC FUND SHARE BY %

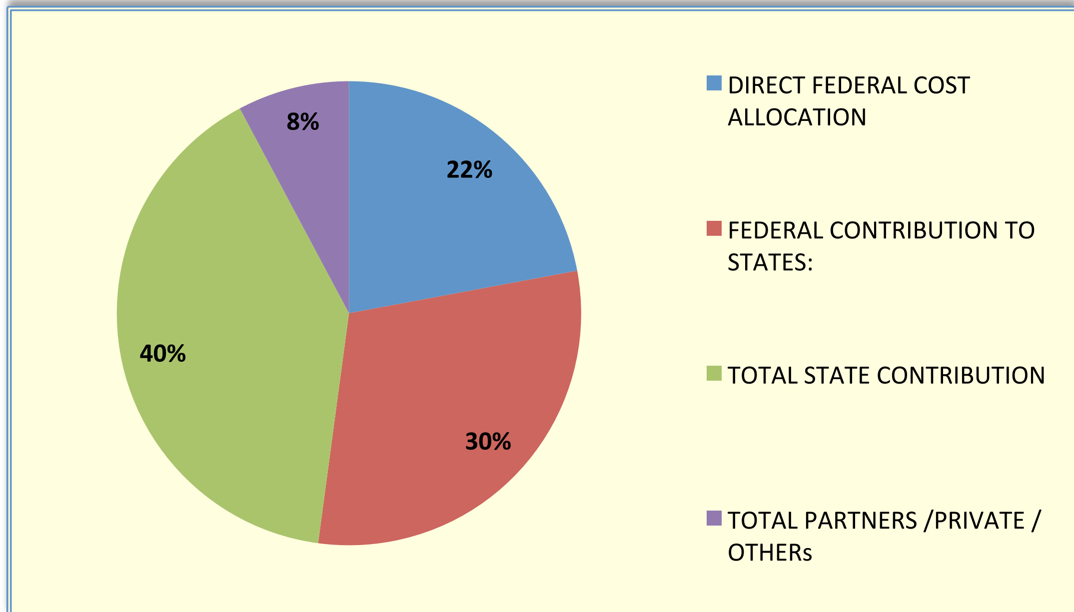


Table 10: Cost Allocation to Federal and State Governments for the Proposed Special Fund

State	State HIV Prevalence (FMoH 2010)	Projected State HIV Burden (EPP Estimates)	Federal Government contribution to shared cost (N)	State Government contribution to shared cost (N)	Private Sector contribution to shared cost (N)
Abia	7.3	139,517	3,240,213,603	4,321,670,795	840,209,378
Adamawa	3.8	72,625	1,686,686,533	2,249,636,852	437,369,265
Akwa Ibom	10.9	208,319	4,838,127,161	6,452,905,708	1,254,559,208
Anambra	8.7	166,273	3,861,624,431	5,150,484,372	1,001,345,423
Bauchi	2.0	38,224	887,729,754	1,184,019,396	230,194,350
Bayelsa	9.1	173,918	4,039,170,382	5,387,288,251	1,047,384,293
Benue	12.7	242,721	5,637,083,940	7,518,523,164	1,461,734,123
Borno	5.6	107,026	2,485,643,312	3,315,254,308	644,544,180
Cross River	7.1	135,694	3,151,440,628	4,203,268,855	817,189,943
Delta	4.1	78,359	1,819,845,996	2,427,239,762	471,898,418
Ebonyi	3.3	63,069	1,464,754,095	1,953,632,003	379,820,678
Edo	5.3	101,293	2,352,483,849	3,137,651,399	610,015,028
Ekiti	1.4	26,757	621,410,828	828,813,577	161,136,045
Enugu	5.1	97,470	2,263,710,873	3,019,249,460	586,995,593
FCT	8.6	164,362	3,817,237,944	5,091,283,402	989,835,705
Gombe	4.2	80,270	1,864,232,484	2,486,440,731	483,408,135
Imo	3.0	57,336	1,331,594,631	1,776,029,094	345,291,525
Jigawa	1.5	28,668	665,797,316	888,014,547	172,645,763
Kaduna	5.1	97,470	2,263,710,873	3,019,249,460	586,995,593
Kano	3.4	64,980	1,509,140,582	2,012,832,973	391,330,395
Katsina	2.0	38,224	887,729,754	1,184,019,396	230,194,350
Kebbi	1.0	19,112	443,864,877	592,009,698	115,097,175
Kogi	5.8	110,849	2,574,416,287	3,433,656,248	667,563,615
Kwara	2.2	42,046	976,502,730	1,302,421,335	253,213,785
Lagos	5.1	97,470	2,263,710,873	3,019,249,460	586,995,593
Nasarawa	7.5	143,339	3,328,986,579	4,440,072,735	863,228,813
Niger	4.0	76,447	1,775,459,509	2,368,038,792	460,388,700
Ogun	3.1	59,247	1,375,981,119	1,835,230,064	356,801,243
Ondo	2.3	43,957	1,020,889,217	1,361,622,305	264,723,503
Osun	2.7	51,602	1,198,435,168	1,598,426,184	310,762,373
Oyo	3.0	57,336	1,331,594,631	1,776,029,094	345,291,525
Plateau	7.7	147,161	3,417,759,554	4,558,474,674	886,248,248
Rivers	6.0	114,671	2,663,189,263	3,552,058,188	690,583,050
Sokoto	3.3	63,069	1,464,754,095	1,953,632,003	379,820,678
Taraba	5.8	110,849	2,574,416,287	3,433,656,248	667,563,615
Yobe	2.1	22,476	521,995,592	696,217,404	135,357,000
Zamfara	2.1	57,833	1,343,146,959	1,791,437,139	348,287,122
TOTAL			**78,964,471,712**	**105,319,739,075**	**20,476,023,421**

1.4. Longer term investment case

In addition to this comprehensive plan, NACA with the support of UNAIDS is working on an investment case with the time horizon 2015 - 2025. It is important that we already plan now for the next phase of activities, together with the states, to sustain and further expand important gains made through the implementation of the PCRP.

The investment case will include practical and evidence-based additional solutions to achieve fully funded, effective and efficient programming and implementation of the national response to HIV. As part of the long term investment case, we plan to perform a detailed analysis of unit cost data to refine the cost estimates.

This investment case will allow for a refined estimate of investment impact over a longer time frame and strengthen the case for continued domestic and foreign investments in the fight against HIV/AIDS in Nigeria.

ANNEXES

Performance Framework

Work Plan

Budget