



NATIONAL HIV/AIDS STRATEGIC FRAMEWORK

2017-2021



FEDERAL REPUBLIC OF NIGERIA
National HIV and AIDS Strategic Framework
2017-2021

FOREWARD

As we approach the beginning of the fourth decade of the HIV epidemic in Nigeria, we must reflect on the successes achieved in tackling this scourge and the challenges that lie ahead. The previous National Strategic Framework (NSF) 2010-2015 provided a structure and plan for advancing the multi-sectoral response to the epidemic in Nigeria. Its' goals were to reduce the number of new infections, produce equitable care and support, mitigate the impact of the infection and engender local ownership and sustainability. This document was widely accepted and implemented across the country due to the close collaboration from inception to implementation. Several successes were recorded in areas of treatment and prevention of HIV. More importantly, this framework provided the fulcrum for the enactment of the anti-discrimination bill, which is a major landmark in tackling prejudice and discrimination against people infected and affected by HIV.

The goal of the current NSF is to “Fast-Track the national response towards ending AIDS in Nigeria by 2030.” The framework incorporates the 90-90-90 strategy, Test and Treat, Sustainable Development Goals (SDGs) and the Option B+ model for elimination of mother-to-child transmission. The input made by partners and donors to the development of this framework cannot be overlooked. We gratefully acknowledge the commitment of the Government of Nigeria and advocate for increased support and ownership of the response.

I look forward to the utilisation of this strategy and the emergence of a truly Nigerian-owned, adequately resourced and sustainable national response.



Dr. Sani Aliyu
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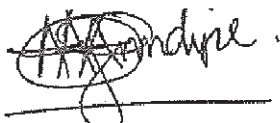
This document was developed via an all-inclusive process with contributions from all key sectors of the National HIV/ AIDS response. The support garnered from our partners; Civil Society Networks especially NEPWHAN, CiSHAN, ASWHAN, APYIN; Ministries and Agencies, SACAs and other key interest groups too numerous to itemise is duly acknowledged and appreciated.

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal care
ART	Antiretroviral Therapy
ARV	Antiretrovirals
BBFSW	Brothel-Based Female Sex Worker(s)
BCC	Behavior Change Communication
CBOs	Community-Based Organizations
CiSHAN	Civil Society on HIV/AIDS in Nigeria
CPT	Co-trimoxazole Preventive Therapy
CSOs	Civil Society Organizations
CSS	Community Systems Strengthening
CTX	Co-trimoxazole
DfID	United Kingdom Department for International Development
DHIS	District Health Information System
DOTS	Directly Observed Treatment – Short Course
EID	Early Infant Diagnosis of HIV
eMTCT	Elimination of Mother-to-Child Transmission of HIV
ENR	Enhancing National Response to HIV and AIDS in Nigeria
ETR	End Term Review
FBOs	Faith-Based Organizations
FCT	Federal Capital Territory
FGoN	Federal Government of Nigeria
FLHE	Family Life and HIV Education
FMoH	Federal Ministry of Health
FMWA&SD	Federal Ministry of Women Affairs and Social Development
GBV	Gender Based Violence
GFATM	Global Fund to fight HIV/AIDS, TB and Malaria
GoN	Government of Nigeria
HAD	HIV/AIDS Division
HAF	HIV/AIDS Fund
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IBBSS	Integrated Biological and Behavioral Sentinel Surveys
IDPs	Internally Displaced Persons
IDU	Injection Drug Users
IEC	Information, Education, Communication
IMNCH	Integrated Maternal, Newborn, and Child Health
IPs	Implementing Partners
JMTR	Joint Mid-Term Review
LACAs	Local Government Action Committee on AIDS
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistant TB

MIPA	Meaningful Involvement of People Living with HIV and AIDS
MPPI	Minimum Prevention Package of Interventions
MSM	Men who have Sex with Men
MTCT	Mother-to-child transmission of HIV
MTR	Mid Term Review
NACA	National Agency for the Control of AIDS
NACS	Nutritional Assessment, Counselling and Support
NARHS	National AIDS and Reproductive Health Survey
NASA	National AIDS Spending Assessment
NASCP	National AIDS and STI Control Programme
NBBFSW	Non-Brothel-Based Female Sex Worker(s)
NBTS	National Blood Transfusion Service
NDHS	Nigeria Demographic and Health Survey
NGOs	Non-Governmental Organizations
NHSSS	National HIV Sero-prevalence Sentinel Survey
NPHCDA	National Primary Health Care Development Agency
NSF	National Strategic Framework
NSP	National Strategic Plan
NTBLCP	National TB and Leprosy Control Program
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PABA	People Affected By HIV/ AIDS
PCRPP	Presidential Comprehensive Response Plan
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHDP	Positive Health, Dignity and Prevention
PLWHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SACA	State Action Committee on AIDS/State Agency for the Control of AIDS
SBCC	Strategic Behavioral Change Communication
SDPs	Service Delivery Points
SKM	Strategic Knowledge and Management
SMEDAN	Small and Medium Scale Enterprises Development Agency of Nigeria
SMoH	State Ministry of Health
SRH	Sexual and Reproductive System
STIs	Sexually Transmitted Infections
TasP	Treatment as Prevention
TB	Tuberculosis
TOR	Terms of Reference
TTIs	Transfusion Transmittable Infections
TWG	Technical Working Group

UNAIDS	United Nations Joint Program on HIV/ AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children’s Fund
UNWomen	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
USG	United States Government
VC	Vulnerable Children
VCA	Vulnerable Children and Adolescents
WHO	World Health Organization

Executive Summary

Nigeria has the second highest burden of Human Immunodeficiency Virus (HIV) infection in the world, with about 3.6 million people infected. Nigeria contributed 9% of the people living with HIV, 10% of new HIV infections, and 14% of HIV-related deaths in the world in 2013. To address her high HIV burden, Nigeria needs to institute a sustained and effective national response to prevent new infections and ensure the health and well-being of those infected and affected by HIV. The National HIV/AIDS Strategic Framework and Plan provides the backbone of such national response; serving as a crucial platform for uniting stakeholders towards achieving the national HIV control goals, and providing tools for mobilizing the required resources to that end.

The National HIV and AIDS Strategic Framework (NSF) 2017-2021 succeeds the National HIV and AIDS Strategic Framework 2010-2015 and the National HIV and AIDS Strategic Plan 2010-2015. This NSF was developed through a highly participatory and consultative process that involved a wide cross-section of stakeholders.

Vision of the National Strategic Framework

The vision of the NSF is “An AIDS-free Nigeria, with zero new infection, zero AIDS-related discrimination and stigma”

Goal of the National Strategic Framework

The goal of the National Strategic Framework is to “Fast-track the national response towards ending AIDS in Nigeria by 2030”

Thematic Areas and Cross-Cutting Issues

The National Strategic Framework has five thematic areas: (i) Prevention of HIV among general and key populations; (ii) HIV Testing Services (HTS); (iii) Elimination of Mother-to-Child transmission of HIV (eMTCT); (iv) HIV Treatment; and, (v) Care, Support and Adherence.

The thematic areas are underpinned by a number of cross-cutting programme enablers: (i) Gender and Human Rights (ii) Health Systems and Community Systems Strengthening, and Service Integration (iii) Coordination and Institutional Arrangement (iv) Policy, Advocacy and Resource Mobilization (v) Monitoring and Evaluation; and, (vi) Leadership, Ownership and Sustainability.

Thematic Area 1: Prevention of HIV among General and Key Populations

Strategic Objective: To significantly reduce the incidence of new HIV infections by 2021.

Targets

Target 1: 90% of the general population have access to HIV prevention interventions by 2021.

Target 2: 90% of key and vulnerable populations adopt HIV risk reduction behaviour by 2021.

Target 3: 90% of key and vulnerable populations have access to desired HIV prophylaxis by 2021

Target 4: 100% of Nigerians have access to safe blood and blood products by 2021.

Target 5: 90% of the general, key and vulnerable populations have access safe injection practices by 2021.

Strategic Interventions

1. Foster an enabling environment that facilitates access of adolescents, young people and other vulnerable populations to a combination of appropriate HIV prevention strategies.
2. Strengthen community structures for provision of equitable HIV prevention interventions.
3. Strengthen targeted strategic behaviour change communication for general, key and vulnerable populations.
4. Enhance the access of general, key and vulnerable populations to condom and lubricants.
5. Facilitate access of PWID to harm reduction strategies.
6. Identify and strengthen service delivery model(s) that can provide a combination of quality HIV prevention services to key and vulnerable populations.
7. Expand access of populations at substantial risk of HIV to HIV prevention prophylaxis.
8. Strengthen the management of non-HIV sexually transmitted infections.
9. Strengthen referral and linkages between HIV prevention and other health and social services.
10. Expand access of in-and out-of-school youths to Family Life and HIV Education.
11. Improve access to safe blood and blood products.
12. Improve injection safety and health care waste management practices.
13. Conduct appropriate research to identify strategies that support improved access to HIV prevention services.

Thematic Area 2: HIV Testing Services

Strategic Objective: To increase access to HIV testing services so as to enable 90% of people living with HIV to know their status and be linked to relevant services.

Targets

- Target 1:** 100% of key populations, 100% of children (age 1 to 9 years) of HIV-positive mothers, 80% of vulnerable population and 60% of general population access HTS by 2021.
- Target 2:** 95% of pregnant women access HTS by 2021.
- Target 3:** 90% of people tested for HIV screened for tuberculosis (TB), syphilis, hepatitis B and hepatitis C by 2021.
- Target 4:** 90% of HTS sites establish and maintain quality control measures by 2021.

Strategic Interventions

1. Foster an enabling environment for improved access to HTS and screening services for HIV co-infections.
2. Expand coverage of HTS services and screening for HIV co-infections.
3. Strengthen community systems to support testing and re-testing of key populations, vulnerable populations and pregnant women.
4. Strengthen targeted HTS demand generation programmes.
5. Promote integration of, and strengthen referrals and linkages systems between HTS, other HIV management services, blood transfusion service and other health-related services.
6. Integrate screening for HIV co-infections into HTS.

7. Institute and strengthen the quality management systems for all HTS sites.
8. Improve the logistics and supply chain management for all testing commodities.
9. Conduct appropriate research to identify strategies that support improved access to HTS.

Thematic Area 3: Elimination of Mother-to-Child Transmission of HIV

Strategic Objective: To eliminate mother-to-child transmission of HIV in Nigeria by 2021

Targets

- Target 1:** Modern contraceptive prevalence rate of 40% achieved among HIV-positive women by 2021.
- Target 2:** 95% of all HIV positive pregnant and breastfeeding mothers receive antiretroviral therapy by 2021.
- Target 3:** 95% of all HIV-exposed infants receive antiretroviral prophylaxis by 2021.
- Target 4:** 95% of all HIV-exposed infants have early infant diagnosis within 2 months of birth by 2021.
- Target 5:** 95% of all HIV exposed infants receive co-trimoxazole prophylaxis within 2 months of birth by 2021.
- Target 6:** 90% of HIV exposed babies have access to HIV serological test by the age of 18 months by 2021.

Strategic Interventions

1. Foster an enabling environment for HIV positive pregnant and breastfeeding mothers and HIV-exposed infants to access antiretroviral drugs.
2. Strengthen contraceptive demand generation programmes for HIV positive women.
3. Promote integration and strengthen referral and linkages between antenatal care, family planning, sexual and reproductive health services, maternal and child health and HIV services.
4. Expand access of HIV positive pregnant and breastfeeding mothers to antiretroviral therapy (ART) services.
5. Expand access of HIV exposed infants to early infant diagnosis (EID) services.
6. Expand access of HIV exposed infants to antiretroviral prophylaxis and co-trimoxazole prophylaxis within 2 months of birth.
7. Expand access of HIV exposed babies to HIV serological test at 18 months.
8. Strengthen community systems to support care for HIV exposed infant.
9. Institute and strengthen quality management systems for all eMTCT facilities.
10. Conduct appropriate research to identify strategies to facilitate the elimination of mother-to-child transmission (eMTCT) of HIV.

Thematic Area 4: HIV Treatment

Strategic Objective: All diagnosed people living with HIV (PLHIV) receive quality HIV treatment services, and at least 90% of those on antiretrovirals (ARV) achieve sustained virological suppression.

Targets

Target 1: 90% of diagnosed PLHIV are on antiretroviral therapy (ART) by 2021.

Target 2: 90% of diagnosed PLHIV on treatment are retained in care by 2021.

Target 3: 90% of eligible PLHIV receive co-trimoxazole prophylaxis by 2021.

Target 4: All PLHIV diagnosed with TB have access to TB services by 2021.

Strategic Interventions

1. Foster an enabling environment for people living with HIV and AIDS to access ART and opportunistic infection management services.
2. Expand access of people living with HIV and AIDS to ART, ART monitoring and co-infection management services.
3. Improve the logistics and supply chain management for ART commodities.
4. Institutionalize and strengthen the quality management systems for all ART and viral load assessment services.
5. Promote integration and strengthen referrals and linkages systems for HIV, TB, and non-communicable disease co-infection management.
6. Strengthen community systems for effective differentiated care.
7. Improve facility-based adherence, counselling and tracking mechanisms for PLHIV.
8. Conduct appropriate research to identify strategies that support the access of PLHIV to HIV treatment services and adherence to ART.

Thematic Area 5: HIV Care, Support and Adherence

Strategic Objective: To improve access of People Living with HIV (PLHIV), Vulnerable Children (VC), and People Affected by HIV/AIDS (PABA) to comprehensive rights-based care.

Targets

Target 1: 90% of PLHIV access quality care and support services by 2021.

Target 2: 90% of vulnerable children enlisted for care and support services have access to those services by 2021.

Target 3: 90% of males and females age 5-49 years display non-discriminatory attitudes towards PLHIV and PABA by 2021.

Target 4: 90% of PLHIV have access to Positive Health, Dignity and Prevention (PHDP) related services by 2021.

Strategic Interventions

1. Foster an enabling environment for PLHIV, PABA and VC to access HIV care and support services.
2. Expand access of all PLHIV to facility and community-based care and support services, including Nutritional Assessment, Counselling and Services (NACS), adherence counselling, mental health, sexual and reproductive health, rights and psychosocial care.

3. Strengthen the quality assurance mechanisms for community-based care and support services.
4. Integrate NACS, mental health, sexual and reproductive health and rights and psychosocial services into routine care for PLHIV.
5. Strengthen referral and linkages between care-and-support social services addressing the needs of Vulnerable Children (VC).
6. Strengthen the coordination mechanism for care and support services for VC.
7. Capacity building for health care workers and other service providers on relevant codes of conduct and respect for human dignity.
8. Strengthen behaviour change communications (BCC) targeted at reducing stigma and discrimination against people living with HIV and AIDS.
9. Advocacy for strengthened implementation of the HIV and AIDS anti-discrimination Act.
10. Promote access to justice for PLHIV and PABA through use of community-based and institutionalized mechanisms.
11. Conduct appropriate research to identify strategies for improved care and support for PLHIV and OVC, and for the reduction of HIV-related stigma.

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1. Background to the National Strategic Framework

1.1. Introduction

Nigeria has the second highest burden of Human Immunodeficiency Virus (HIV) infection in the world, with about 3.6 million people infected. Nigeria contributed 9% of the people living with HIV, 10% of new HIV infections, and 14% of HIV-related deaths in the world in 2013. To address her high HIV burden, Nigeria needs to institute a sustained and effective national response to prevent new infections and ensure the health and well-being of those infected and affected by HIV. The National HIV and AIDS Strategic Framework and Plan provide the backbone of such national response; they serve as a crucial platform for uniting stakeholders towards achieving the national HIV control goals and tools for mobilizing the required resources to that end.

The National HIV and AIDS Strategic Framework (2017-2021) is the fourth national strategic document on HIV/AIDS. It is designed to guide the national response to HIV and AIDS, building on the achievements of the previous Frameworks. Prior to the development of this new Framework, the National HIV and AIDS Response was guided by the 2001-2004 HIV Emergency Action Plan, the 2005-2009 National HIV and AIDS Strategic Framework, the 2010-2015 National HIV and AIDS Strategic Framework and the 2010-2015 National HIV and AIDS Strategic Plan. The lifespan of the 2010-2015 National HIV and AIDS Strategic Framework (NSF) and the 2010-2015 National HIV and AIDS Strategic Plan (NSP) was extended to the end of 2016 to accommodate the technical and logistic mobilization necessary for the development of the new strategic framework.

The development of the strategic framework took into consideration the country's aspirations of ending the AIDS epidemic by 2030; and identified critical priorities for achieving the 90-90-90 targets by 2020. The 90-90-90 targets specify that: "by 2020, 90% of all people living with HIV will know their HIV status; by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and by 2020, 90% of all people receiving antiretroviral therapy will have viral suppression." This framework also recognizes Nigeria's federal governance structure, her socio-cultural context, and the rights of all people in Nigeria to equitable access to HIV related services.

1.2. Country Context

Nigeria lies between latitudes 4°16' and 13°53' to the north of the equator and longitudes 2°40' and 14°41' to the east of the Greenwich Meridian. The country is located in the West African sub-region and is bordered by Niger in the north, Chad in the northeast, Cameroon in the east, and the Republic of Benin in the west. To the south, Nigeria is bordered by approximately 800 kilometers of the Atlantic Ocean. Nigeria is a federation comprising of 36 states and a federal capital territory (FCT), which enjoys the status of a state but is recognized as the administrative capital of the federation. The 36 states and the FCT are delineated into 774 local government areas (LGAs). For operational convenience, the country is divided into six geo-political zones: North-East, North-West, North-Central, South-East, South-West and South-South. The zoning is used for planning and implementation of national programmes and initiatives.

Nigeria is an ethnically and culturally diverse country, with about 374 identifiable ethnic groups. The three largest ethnic groups in Nigeria are Hausa/Fulani (Northern Nigeria), the Igbo (South-East Nigeria) and the Yoruba (South-West Nigeria). Together, these three ethnic groups make up more than half of the country's population. The National Population and Housing Census reported Nigeria's population as 140.4 million in 2006 with a growth rate of 3.2%. Projecting the population to slightly above 182 million in 2015, the United Nations ranks Nigeria as the seventh most populous country and one of the fastest growing populations in the world. About a quarter (24.9%) of the Nigerian population are women of reproductive age (15-49 years) and 31.7% are young people aged 10-24 years. Nigeria has a young population structure, as 62% of the population is within the age range of 0 to 24 years, and the median age is 17.9 years. Life expectancy in Nigeria was 53 years by the end of 2014. This figure is lower than the average of 59 years for the sub-Saharan Africa and 67 years for lower middle-income countries. The 2015 World Health Statistics, on the other hand, indicates Nigeria's life expectancy as 55 years for 2013 (55 years for females and 54 years for males). The country's current life expectancy figure is a substantial improvement over the 1990 figure of 46 years (47 years for females and 45 years for males).

Nigeria ranks 152 out of the 188 countries and territories covered by the United Nations Development Programme's Human Development Report. With a Human Development Index (HDI) value of 0.514 for 2014, Nigeria is categorized as a low human development country. Nigeria's HDI is lower than the average of 0.518 for sub-Saharan Africa. Nigeria's HDI value however increased from 0.467 in 2005 to 0.514 in 2014, representing an average annual rate of about 1.07% over the 10-year period. The HDI value for females (0.468) compares poorly with that of males (0.556), resulting in a gender development index (GDI) of 0.841. The inequality-adjusted HDI (IHDI) for Nigeria was 0.320 in 2014, reflecting a loss of 37.8% due to inequality in the distribution of the HDI dimension indices, which is greater than the average loss due to inequality of 32.0% for low HDI countries, and 33% for sub-Saharan Africa: these figures signify a relatively high level of inequality.

Traditional socio-cultural norms and practices are still very strong in many Nigerian communities despite the growing influence of globalisation. The tension between traditional values and modernization is apparent in many areas, particularly with regards to gender and human rights issues, the development and behaviour of young people, health beliefs and health-seeking behavior at community and household levels. On the one hand, a number of cultural norms and practices in Nigeria have positive values and implications for HIV prevention, treatment and care, such as the strong kinship and family network system, the emphasis on chastity and avoidance of pre-marital sex, as well as male circumcision. On the other hand, practices such as widowhood rites, female genital mutilation (FGM), denial of women's access to inheritance, encouragement of multiple sexual partners for males, and marriage of the girlchild to much older men in some communities may increase vulnerability to HIV.

Nigeria is the eighth largest oil exporter in the world and her economy is the largest in Africa after the Gross Domestic Product (GDP) rebasing of 2014. Oil accounts for almost 90% of the country's exports and about 75% of her consolidated budgetary revenues. Despite significant national economic growth that spanned decades, poverty level has remained high: the absolute poverty incidence is 62.6%. Over 80% of young people live in poverty, with young women and youth living in rural areas being the worst groups affected. The unemployment rate is high

with 26.06 million persons of the 79.9 million (32.6%) labour force being either unemployed or underemployed; the worst affected groups are young people aged 15-24 years and females. This is a developmental paradox that paints the picture of a small proportion of the population in great wealth co-existing with the vast majority of the population in great poverty. The poverty, unemployment and underemployment situation is likely to worsen with the current economic recession. The economic situation has significant implications for the HIV and AIDS response as poverty increases vulnerability to HIV and impacts negatively on the ability of people living with HIV to appropriately seek for, or adhere optimally to treatment.

The growing episodes of violence in the country including armed clashes between nomadic Fulani herdsmen and indigenous farming communities, and insurgency by the Jama'atu Ahlis Sunna Lidda'awati Wal-Jihad (otherwise known as *Boko Haram*) also have implications for increase in the incidence of HIV infection. Violent situations are associated with increased risk for sexual and reproductive rights violation such as rape, and risky sexual behavior such as selling of sex by young girls. The Boko Haram challenge resulted in the worst humanitarian crisis in Nigeria's history with about 15 million people affected since 2009, and over two million people internally displaced. Consequently, an estimated seven million people required humanitarian assistance in 2016. Natural disasters that result in displacement of populations also have implications for HIV incidence.

1.3. NSF 2017-2021 Development Process

The NSF was developed through a highly participatory and consultative process. It involved a wide cross-section of stakeholders at various stages of its development. These stakeholders included policy makers and government officials from federal and state levels, technical experts, representatives of the national HIV and AIDS Technical Working Groups (TWGs), representatives of the civil society, as well as bilateral and multilateral development partners. The civil society participants cut across various segments of stakeholders in the national response such as representatives of the Network of People living with HIV and AIDS in Nigeria (NEPWHAN), the Association of Young People living with HIV in Nigeria, interest groups with focus on women and children living with HIV, and the key population secretariat.

A Steering Committee with membership that included the National Agency for the Control of AIDS (NACA) and key partners such as the World Health Organization (WHO), United Nations Children's Fund (UNICEF), the Joint United Nations Programme on AIDS (UNAIDS) and the United States Government (USG) provided oversight for the entire NSF development. The NSF development process consisted of four key stages: (i) Preparatory stage; (ii) Framing of the national response priorities and strategies; (iii) Finalization and approval of the draft NSF; and, (iv) Development of the guidance notes for the state and sectoral HIV response plans.

The Preparatory Stage: Technically, the development of the NSF started in 2015 with the preparatory processes. As part of that effort, the Strategic Knowledge Management (SKM) Department of NACA generated data on the status of the HIV epidemic and national response in Nigeria and contracted independent Consultants to undertake the annual reviews, mid-term and end-of-term evaluations of the 2010-2015 National HIV/AIDS Strategic Plan (NSP).

The Policy department developed a roadmap for the NSF development in consultation with key partners and National Technical Working Groups. This was followed by the recruitment

and selection of Consultants who would work on the development of the NSF through a transparent process. An orientation programme was organized for all the selected Consultants to familiarize them with the NSF development plan and timelines, and provide them with an update on current national and global issues on HIV. The National Agency for the Control of AIDS, UNAIDS and WHO staff made technical presentations at the orientation meeting focusing, among others, on the state of the HIV epidemic and response in Nigeria, the UNAIDS' 90-90-90 target, and the WHO's consolidated guidelines on the use of antiretroviral therapy (ART) for the treatment and prevention of HIV.

The Framing of the National HIV Response Priorities and Strategies: A one-week interactive workshop was held with selected thematic and cross-cutting Consultants, leadership of the various National TWGs, and technical Experts from NACA, National AIDS and Sexually Transmitted Infection Control Programme (NASCP) of the Federal Ministry of Health (FMoH), and National Primary Health Care Development Agency (NPHCDA), relevant desk Officers from other key federal ministries/agencies, and the States Agencies for the Control of AIDS. Civil society organizations and representatives of people living with HIV and key populations also actively participated in the process. The objective of the workshop was to build consensus around the vision, goals, and objectives of the NSF, and to identify key priorities and strategies for the NSF. The output of the workshop formed the basis for the development of the zero draft of the NSF by the Consultants. NACA thereafter shared the zero draft of the NSF with a wide spectrum of stakeholders for comments and feedback.

Finalization and Approval of the Draft Strategic Framework: The feedback from stakeholders was used to revise the zero draft of the NSF. The revised draft NSF document was circulated to national stakeholders, including members of the Steering Committee, for further review. Further feedback was received during a one-day meeting of stakeholders, which involved members of the Steering Committee for validation of the draft NSF document. The feedback was used to finalize the draft NSF document, in readiness for presentation to the National AIDS Council for its approval.

Development of Guidance Notes for States and Sectoral Plans: The National HIV and AIDS Strategic Plan 2017-2021 (NSP) will be developed using a bottom-up approach: the NSF was developed by NACA while the states and the various sectors involved in the national HIV response have the responsibility for developing their HIV response plan. The NSF Consultants developed guidance notes to facilitate the development of the State and sectoral HIV plans. A costing template was also included in the framework. The guide was shared with stakeholders for their review and comments. Feedback received was used in revising and finalizing the guidance note. The document was also reviewed and approved by the Steering Committee.

1.4. Rationale for the NSF 2017-2021

The 2010-2015 National Strategic Plan provided strategic direction for the HIV response in Nigeria. Its implementation resulted in the reduction of HIV prevalence, increased uptake of HIV testing, improved access of people living with HIV to treatment, and increase in the proportion of vulnerable children with access to care and support. The use of data from various national surveys and studies resulted in stakeholders reaching a consensus on the need for greater focus on high burden states and key populations for greater effectiveness and outcome. The development of HIV investment framework at the global level has further strengthened the focus on effectiveness and efficiency in HIV programming, resulting in call for greater focus

on key populations, and increasing access to high-quality, high-impact interventions. Also, new evidence-based guidelines on the use of antiretroviral drugs for treating and preventing new HIV infection as issued by the World Health Organization (WHO), and the resultant changes to the Nigeria's HIV treatment protocol in 2015 including adoption of the “test and treat approach”, as well as recognizing the need to use ARV for HIV prevention meant that current National HIV response in Nigeria needs to take on new approaches.

The NSF 2017-2021 is the nation's attempt to build on past successes, achievements and gains made with the NSF 2010-2015 and NSP 2010-2015; and further intensify her national response in view of the gaps and challenges that need to be addressed in order to achieve global and national goals. This new NSF aptly integrates lessons learnt from the earlier national HIV response and provides a pathway to achieving the national goals. The Framework provides the platform to align the national HIV and AIDS response with relevant global agenda, particularly the “Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030”, the Sustainable Development Goals (SDG), and the 90-90-90 agenda that sets the target: “By 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will have viral suppression.”

In addition, the new NSF provides a unifying framework for aligning all the efforts of all stakeholders in the HIV and AIDS field in Nigeria, including the government at the three tiers (Federal, State, and LGA), the civil society, the private sector, and the international development partners. Also, the guidance note included in the annex of the NSF provides a guide for all stakeholders for developing their strategic plans in a robust, evidence-driven, systematic and standard way that can easily feed into the National Strategic Plan.

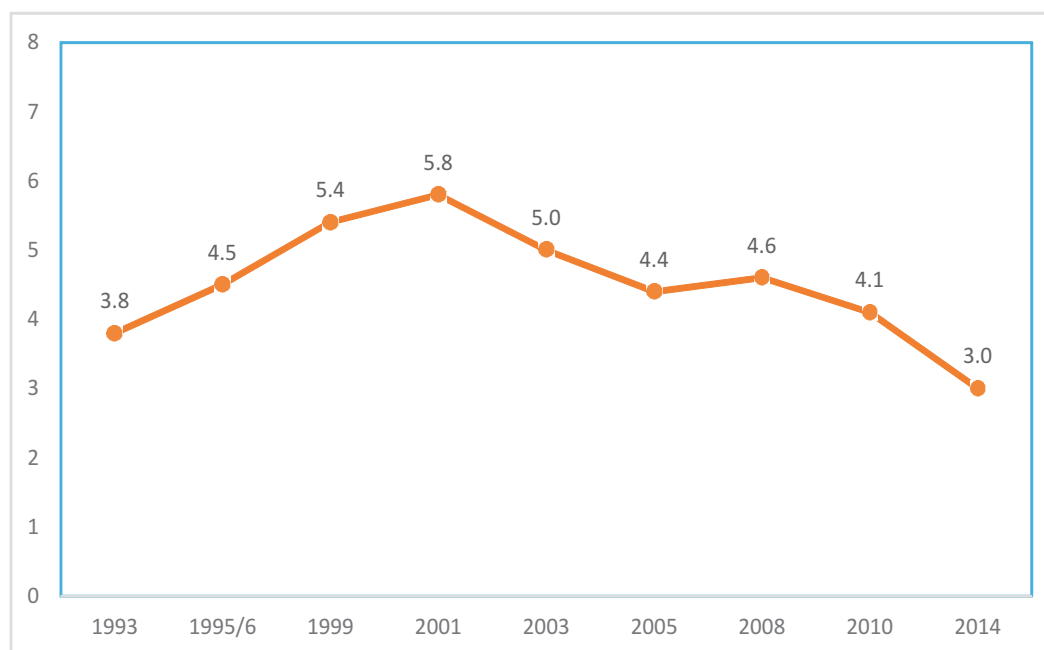
2. HIV Situation and Response in Nigeria

2.1. Status of HIV and AIDS Response in Nigeria

Nigeria's first official case of Acquired Immune Deficiency Syndrome (AIDS) was recorded in 1986. The trends of HIV infections were periodically monitored through the National HIV Sero-prevalence Sentinel Survey (NHSSS) among pregnant women attending antenatal care, and the Integrated Behavioral and Biological Surveillance Survey (IBBSS) for key populations. The integration of HIV testing into the National HIV/ AIDS and Reproductive Health Survey (NARHS) - a nationally representative household survey - provided Nigeria the opportunity to also monitor the trends of HIV prevalence in the general population. The results of these studies showed that the HIV epidemic in Nigeria had evolved over time to become a mixed epidemic: a general epidemic affecting the general population and a concentrated epidemic affecting key and vulnerable populations.

The results of the NHSSS showed the national HIV sero-prevalence among pregnant women increased from 1.8% in 1991 to 5.8% in 2001, then declined to 5.0% in 2003 and further to 4.4% in 2005, 4.1% in 2010 and 3.0% in 2014. The HIV prevalence among young people (age 15-24 years), a marker of trends in the incidence of new infections, progressively and consistently declined from 6.0% in 2001 to 2.9% in 2014 (Figure 1).

Figure 1: Trends in HIV sero-prevalence among pregnant women in Nigeria: 1991-2014

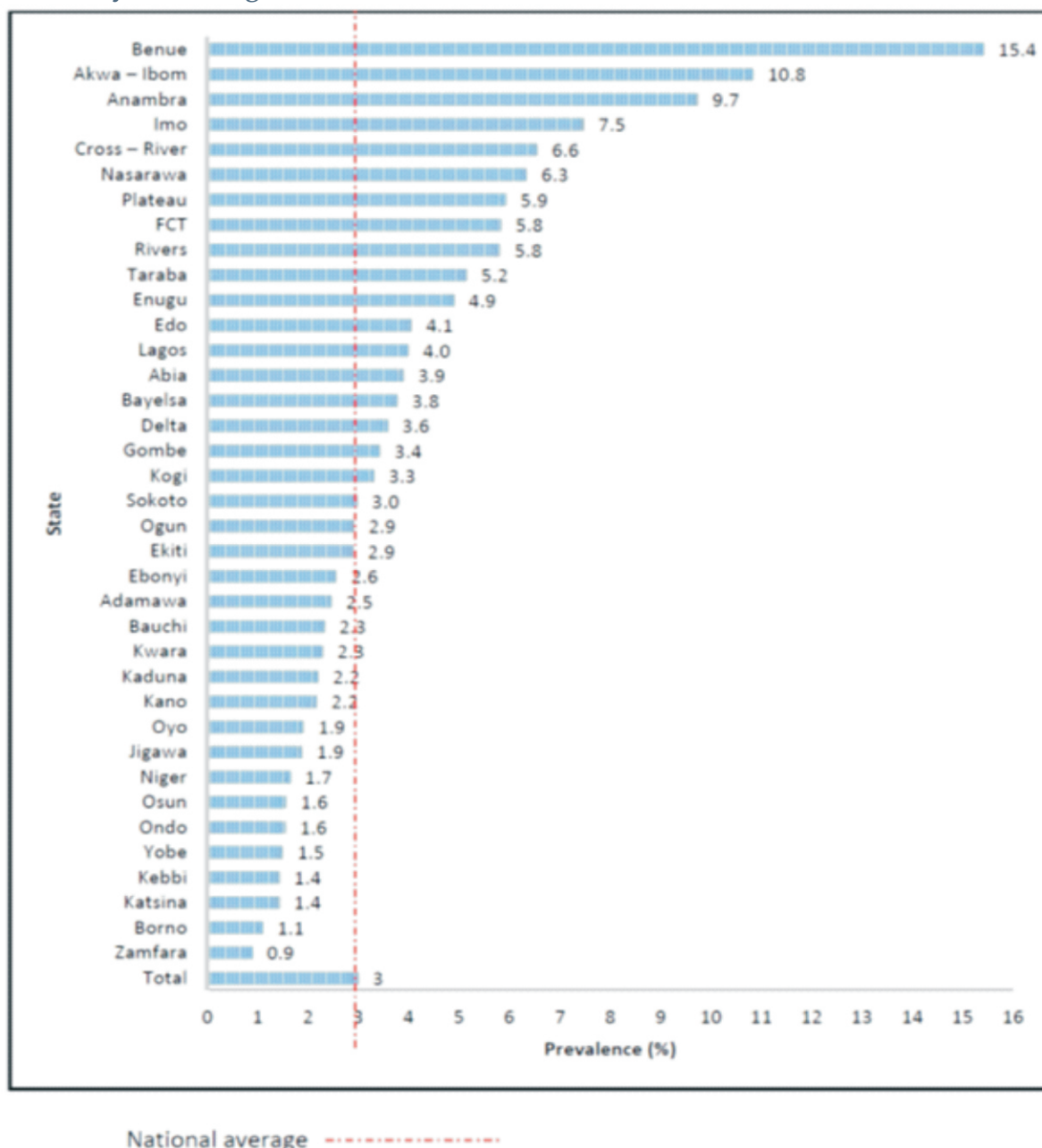


Source: FMoH, 2015.

HIV in Nigeria is geographically heterogeneous, with significant variations in the prevalence and trends of the epidemic at State and Zonal levels. In 2014, the sero-prevalence rate from HSS ranged from 0.9% in Zamfara State (North West zone) to 15.4% in Benue State (North Central zone). Only Zamfara State had less than one percent prevalence rate. Seventeen states and the

Federal Capital Territory (FCT) have HIV prevalence figures higher than the national average of 3.0%. The states are Benue (15.4%), Akwa-Ibom (10.8%), Anambra (9.7%), Imo (7.5%), Cross River (6.6%), Nasarawa (6.3%), Plateau (5.9%), Rivers (5.8%), Taraba (5.2%), Enugu (4.9%), Edo (4.1%), Lagos (4.0%), Abia (3.9%), Bayelsa (3.8%), Delta (3.6%), Gombe (3.4%), and Kogi (3.3%)(Figure 2).

Figure 2: HIV sero-prevalence among pregnant women in sentinel antenatal clinics by states: Nigeria, 2014



Source: FMOH, 2015

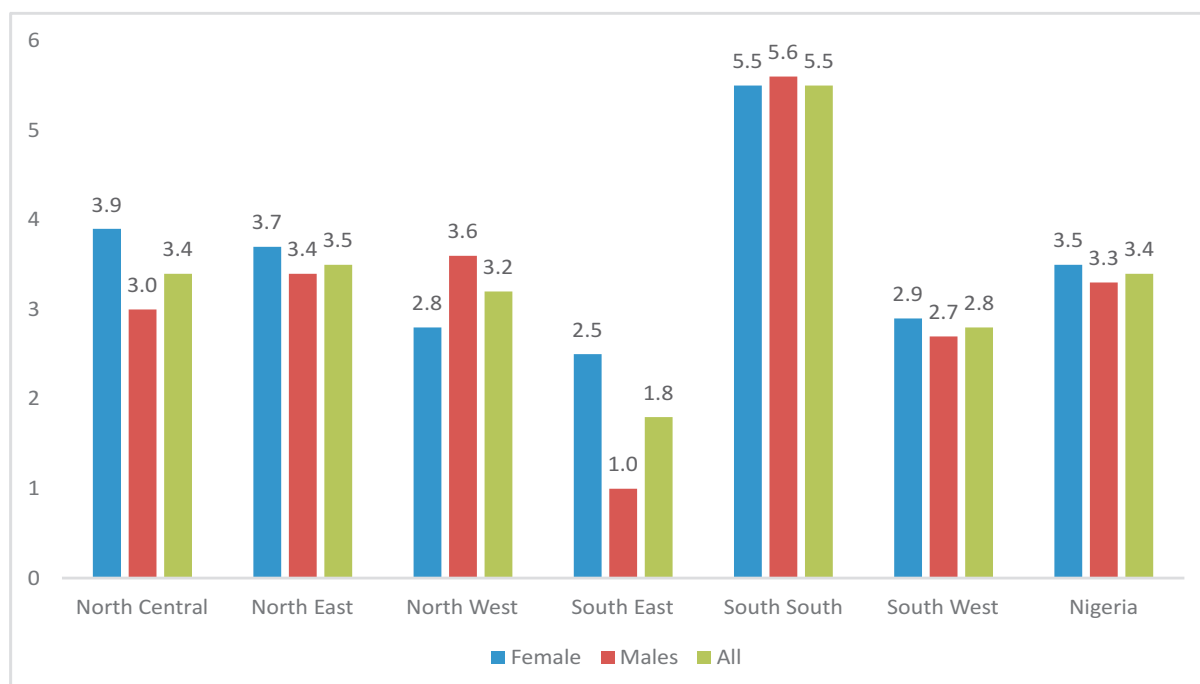
At zonal level, the sero-prevalence rate ranged from 1.9% in the North West to 5.8% in the North Central zone, and the urban rate was higher than the rural in each of the geo-political zones (Table 1).

Table 1: HIV prevalence among pregnant women attending sentinel ante-natal clinics by zones: Nigeria, 2014

Geo-political zones	All (Urban and Rural)	Urban	Rural
North Central	5.8	5.0	3.7
North East	2.3	2.6	1.5
North West	1.9	2.0	1.0
South East	4.9	4.4	3.1
South South	4.9	6.3	3.4
South West	2.4	2.6	2.4
Total	3.0	3.2	1.8

Source: FMOH, 2015

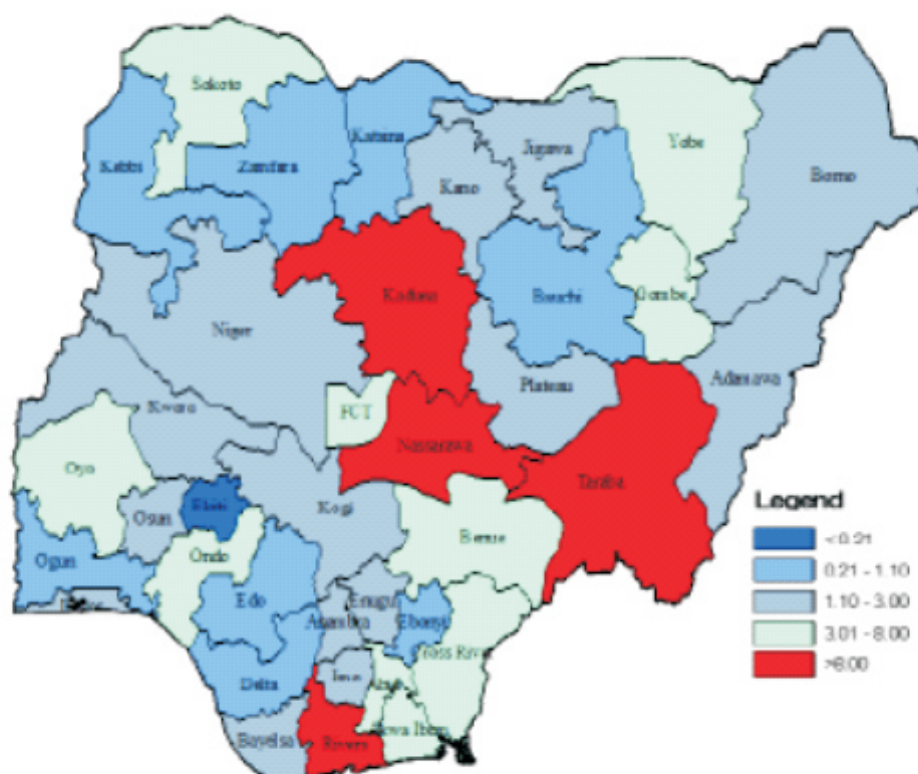
The HIV prevalence in the general population as reported by NARHS, had declined slightly from 3.6% in 2007 to 3.4% in 2012. In 2012, the HIV prevalence was lowest in the South East zone (1.8%) and highest in the South South zone (5.5%) – a different pattern from the report of the 2014 NHSSS. Nationally, the HIV prevalence in the general population is higher among women (3.5%) than men (3.3%) except in two zones: North West zone (2.8% for women and 3.6% for men), and South South zone (5.5% for women and 5.6% for men) (Figure 3).

Figure 3: HIV prevalence among the general population by zone and sex: Nigeria, 2012

Source: FMOH, 2013.

At the State level, HIV prevalence among the general population ranged from 0.2% in Ekiti and 15.2% in River States. Nine states had prevalence rate of less than 1%: Ekiti (0.2%), Zamfara (0.4%), Bauchi (0.6%), Ogun (0.6%), Delta (0.7%), Katsina (0.7%), Edo (0.8%), Kebbi (0.8%), and Ebonyi (0.9%). On the other hand, 11 states and the FCT had HIV prevalence rates higher than the national average of 3.4%.

Figure 4: HIV prevalence among the general population by states: Nigeria, 2012



Source: FMOH, 2013.

The HIV prevalence was highest among the population aged 35-39 years old (4.4%) and lowest among those aged 15-19 years old (2.9%); higher in the rural areas (3.6%) compared to the urban areas (3.2%) (Table 2); and lowest among those with no formal education (2.5%) compared to those formally educated (3.5-3.9%). HIV prevalence is also positively associated with economic status with a rate of 2.9% for the poorest group and a rate that ranges between 3.5% and 3.7% for the two wealthiest groups. Widows have the highest HIV prevalence rate (6.2%), followed by those divorced/separated (4.1%); the never married (3.1%) had the lowest rate.

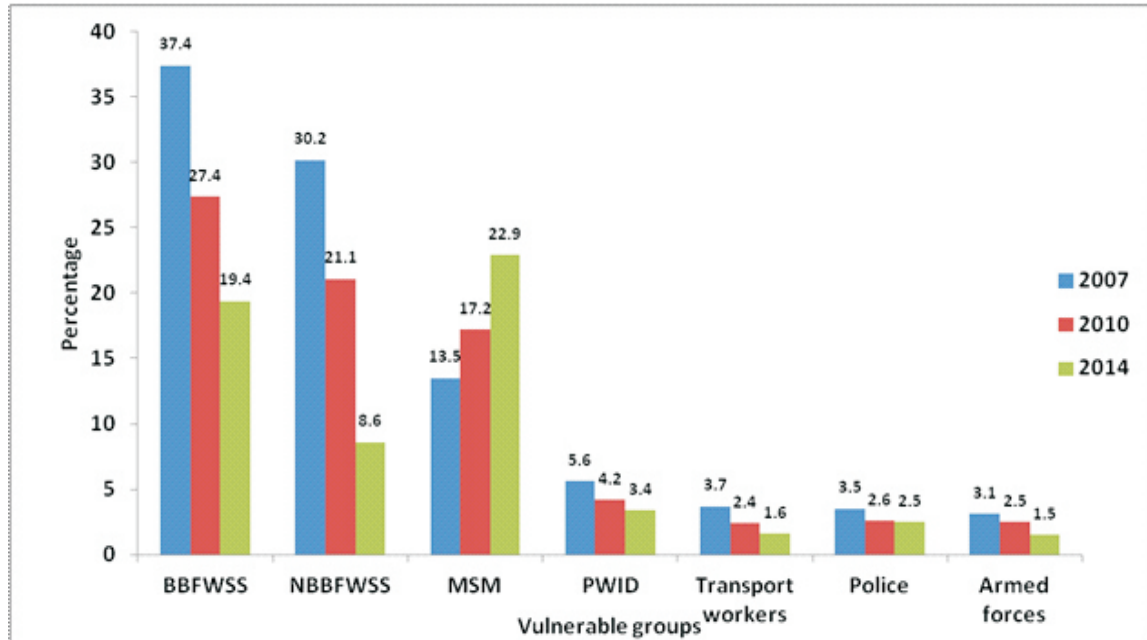
Table 1: HIV prevalence according to selected characteristics; Nigeria, 2012

Characteristics	HIV prevalence	95% CI
Location		
Urban	3.2	2.8 -- 3.6
Rural	3.6	3.3 -- 3.9
Education		
No Formal Education	2.5	2.1 -- 2.9
Qur'anic only	2.4	1.7 -- 3.3
Primary	3.9	3.3 -- 4.5
Secondary	3.9	3.5 -- 4.3
Higher	3.5	2.9 -- 4.2
Marital Status		
Currently Married	3.5	3.3 -- 3.8
Never married	3.1	2.7 -- 3.5
Separated/Divorced	4.1	2.7 -- 6.2
Widowed	6.2	4.4 -- 8.6
No response	2.6	0.9 -- 7.1
Wealth Quintile		
Poorest	2.9	2.5 -- 3.4
Poorer	3.2	2.7 -- 3.7
Average	3.6	3.2 -- 4.2
Wealthier	3.7	3.2 -- 4.3
Wealthiest	3.5	3.0 -- 4.2
Age Group (Years)		
15-19	2.9	2.4 -- 3.5
20-24	3.2	2.7 -- 3.8
25-29	3.4	2.9 -- 4.0
30-34	4.0	3.4 -- 4.7
35-39	4.4	3.7 -- 5.2
40-44	2.9	2.3 -- 3.6
45-49	3.7	3.0 -- 4.6
50-64	3.3	2.6 -- 4.2
Total	3.4	3.2 -- 3.6

Key populations contribute significantly to the national HIV epidemic. The 2009 study on the mode of transmission of HIV in Nigeria reported that three key population groups – people who inject drugs (PWID), females who sell sex (FWSS), and men who have sex with men (MSM) – constitute about 1% of the adult population in Nigeria but contribute almost 23% of new HIV infections. Together with their sexual partners, these three key population groups contribute 32% of new infections although they constitute only about 3.4% of the adult population.

The IBBSS reported an overall prevalence of 9.5% for a group of seven key and vulnerable populations in Nigeria in 2014 – MSM, PWID, brothel-based FWSS (BBFWSS), non-brothel-based FWSS (NBBFWSS), transport workers, armed and police forces. MSM (22.9%), BBFWSS (9.4%), NBBFWSS (8.6%), and PWID (3.4%) had HIV prevalence higher than that recorded in the general population. On the other hand, the HIV prevalence among members of the armed forces (1.5%), transport workers (1.6%), and members of the police force (2.5%) was lower than that of the general population. The HIV prevalence among BBFWSS, NBBFWSS, and PWID had progressively decreased since 2007 while that for MSM had increased over the same period (Figure 5).

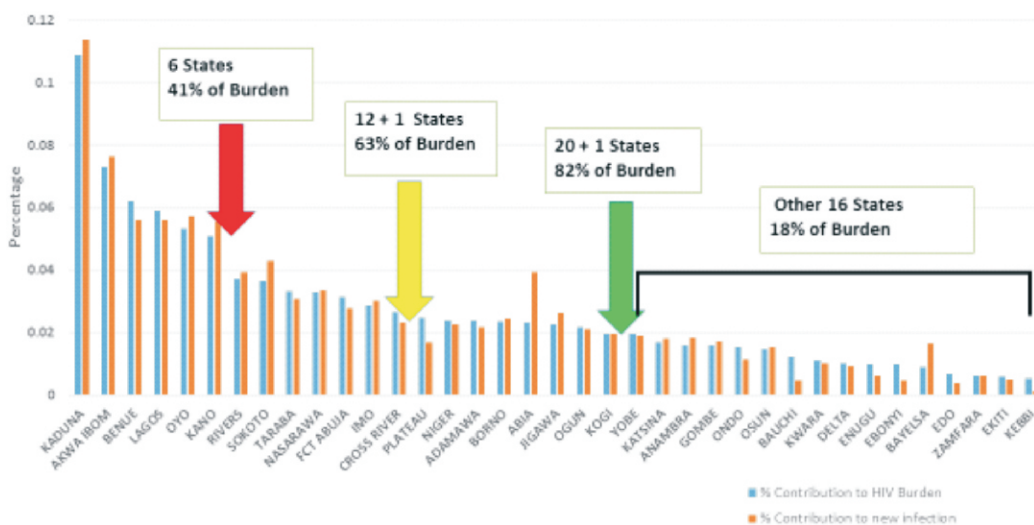
Figure 5: Trends in HIV prevalence among key and vulnerable populations: Nigeria, 2007 - 2014



Source: FMOH, 2013

As shown by the UNAIDS estimation models, six states – Kaduna, Akwa Ibom, Benue, Lagos, Oyo, and Kano – account for 41% of people living with HIV in Nigeria. Together with Rivers, Sokoto, Taraba, Nasarawa, Imo, Cross River, these 12 states and the FCT (12+1 priority states) account for 62% of the HIV burden in Nigeria. This data is particularly crucial as it integrates data from various other national surveys, and is strategic from the perspective of an investment approach.

Figure 6: Projected HIV burden and new infections; Nigeria, 2014



Source: UNAIDS, 2014

Overall, UNAIDS estimates show that the number of new HIV infections in Nigeria decreased by 35% between 2005 and 2013, and by 19% among children between 2009 and 2012/13.

2.2. Risk Factors for HIV Infection in Nigeria

The mode of transmission study conducted in 2009 indicated that 80% of new HIV infections in Nigeria are attributable to heterosexual transmission, while mother-to-child transmission (MTCT) and transfusion of infected blood and blood products ranked next as the most common modes of HIV transmission. There are, however, indications that the proportion of new HIV infections attributable to each of these modes of transmission may have changed in the recent years, at least among some population groups such as adolescents and other young people. While risky sexual behavior such as early sexual debut and unprotected sexual intercourse with multiple and concurrent sexual partners, inter-generational sex and transactional sex still constitute major risk factors for HIV infection among young people, other high risk behavior such as injection of drugs and unprotected anal sexual practices are growing among this population group particularly in the rapidly growing urban and poor peri-urban communities.

The growing incidence of rape, gender-based violence and poor health-seeking behavior for non-HIV sexually transmitted infections have so far received inadequate attention, and now need to be factored more into the dynamics of HIV transmission in Nigeria. With the HIV epidemic in Nigeria now in its third decade, there is a cohort of adolescents and young people who were infected with HIV through MTCT route. As indicated in the 2016 National HIV Strategy for Adolescents and Young People 2016-2020, mother-to-child transmission “may account for a fairly high proportion of the infections among adolescents age 10–19 years” in Nigeria.

In addition to behavioral risk factors, environmental factors also constitute risks for HIV infection. For example, poor handling and disposal of highly infectious wastes generated in healthcare settings may increase the risk for HIV transmission. In addition, structural drivers also play a role in the HIV epidemics in Nigeria. These include those social factors that increase people's vulnerability to HIV infection such as poverty, gender inequality, human rights violations and the persistence of HIV and AIDS-related stigma and discrimination. Some of the key factors associated with HIV transmission in Nigeria are summarized in Table 3.

Table 3: Factors that predispose to HIV transmission in Nigeria

Route of transmission	Local practices/behaviour or conditions	Epidemiological implication
Sexual route	<ul style="list-style-type: none"> -High mobility of sex workers -Multiple and concurrent sex partners -High risk sexual behaviours/practice of itinerant/travelling workers (e.g. transport workers, uniformed service providers, migrant labourers and travelling public servants) -High prevalence of sexually transmitted infections -High risk homosexual practices (e.g. non-use and incorrect use of condoms) -Trafficking of girls and young women and sexual violence 	<ul style="list-style-type: none"> -Facilitates geographical spread Increases the risk of HIV within the relationship network -Increases the risk to the sexual network, contacts and families, and facilitates the geographical spread -Enhances the risk if HIV transmission -Increase the risk of HIV to the group, their other sexual partners -Increases local and international risk and also prevalence of more divergent HIV strains
Blood transfusion and injection safety	<ul style="list-style-type: none"> -Inadequate screening of blood for blood transfusion and use of inappropriate blood screening methods -Over-prescription of injectable medications and potential re-use of injection needles - Unverified HIV vaccine claims that involve the transfusion or inoculation of human blood for supposed curative or preventive purposes 	<ul style="list-style-type: none"> -Iatrogenic infection and risk to families and contacts - Iatrogenic infection, needle stick injury -Increase the risk to recipients, families and sexual contacts
Mother to child transmission (Vertical transmission)	<ul style="list-style-type: none"> -Poor use of antenatal care services -Delivery outside health facility without skilled birth attendant -low prevalence of exclusive breastfeeding -poor access and use of reproductive healthcare 	<ul style="list-style-type: none"> -Increase the risk of mother to child transmission of HIV
Inoculation through skin practices, blood-letting procedures	<ul style="list-style-type: none"> - Use of unsterilized instruments for procedures within health and non-health settings e.g. unsafe abortion, female genital mutilation, 'gishiri' cut - Unsterile traditional blood letting -use of unsterile instruments for barbing, shaving, pedicure, traditional marking and tattooing 	<ul style="list-style-type: none"> - Increase the risk of HIV transmission

Source: NACA, 2010.

2.3. National Response to HIV and AIDS

The overarching priority of the 2010-2015 National Strategic Plan was to “reposition the prevention of new HIV infection as the centerpiece of the national HIV/AIDS response”. Six priority thematic areas were identified, with gender issues mainstreamed into the programmatic strategies and activities. The thematic areas were:

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

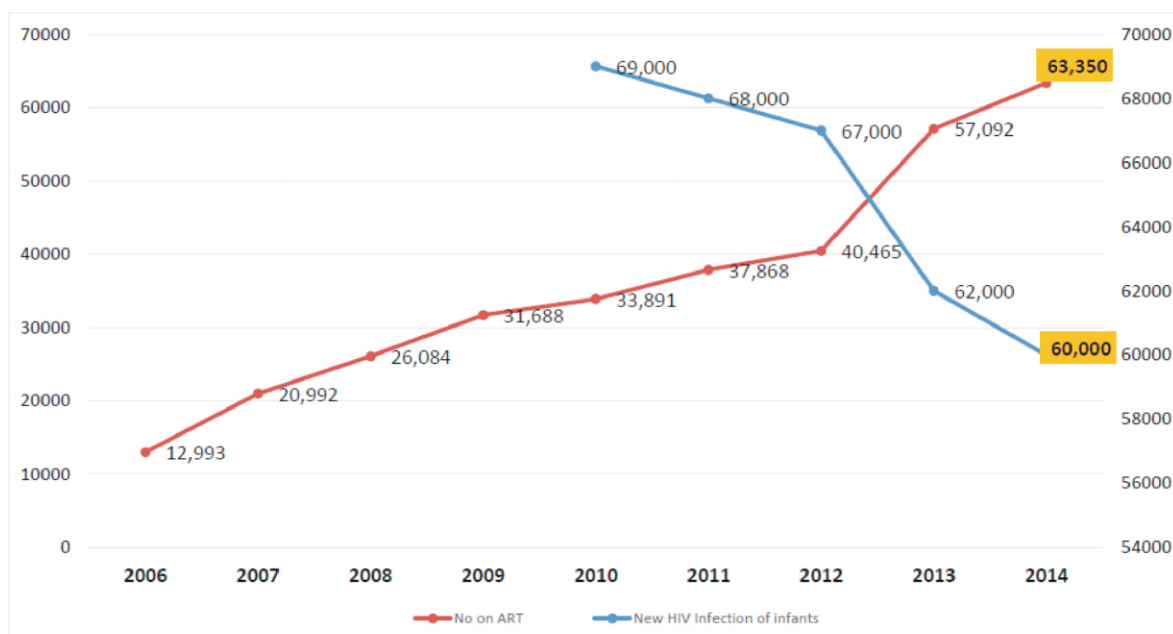
At the end of 2015, an estimated 3,037,363 people were living with HIV in Nigeria, including 238,504 children aged 0-14 years and 1,639,593 women age 15 years and above. The end-of-term evaluation report of the National HIV and AIDS Strategic Plan 2010-2015 and other data sources provide an insight into the progress and achievement recorded, and the challenges that the national HIV response faced. The summary of findings is presented below.

Promotion of behavior change and prevention of new HIV infections: At the end of 2015, only 25.4% of adults and 24.4% of young persons (15-24 years) had comprehensive knowledge about HIV transmission. Slightly more than half (55%) of sexually active males and females used condom consistently with non-marital sex partners. Also, 54.8% of sexually active young adults reported using a male condom at the last sexual intercourse with non-marital sex partner. Almost a tenth (8.1%) of young women and men aged 15-24 years had engaged in transactional sex, and 16% of young women and men aged 15-24 years had more than one sex partner. Only 26.3% of the general population had undertaken HIV counselling and testing (HCT).

The proportion of key populations (MSM, BBFWSS, NBBFWSS, PWID) who were aware of HIV was very high (over 98%), while the proportion that had comprehensive knowledge ranged from 44.2% for BBFWSS to 64.9% for MSM. Up to 25% of some of the key population communities still have misconception about how HIV infection is transmitted. Almost three-quarters (72%) of the key population had a HIV test conducted in the last 12 months, but 98% of those tested received their HIV test results. Among the key populations, the proportion of those who use condom consistently and who tested for HIV and received their test results was least among the PWID.

Among the pregnant women, 46% had accessed HCT services, and 30.2% of the estimated 209,861 HIV-positive women who required prevention of mother-to-child transmission of HIV (PMTCT) accessed the required services. With the support of partners, especially the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), the number of sites providing PMTCT services increased to 6,546 as at December 2014, and 7265 in 2016. More than two-thirds (72.6%) of HIV-exposed infants who were attended to in health facilities had access to ARV prophylaxis; and 12.4% of HIV-exposed infants had early infant diagnosis (EID) within two months of birth and received their test results.

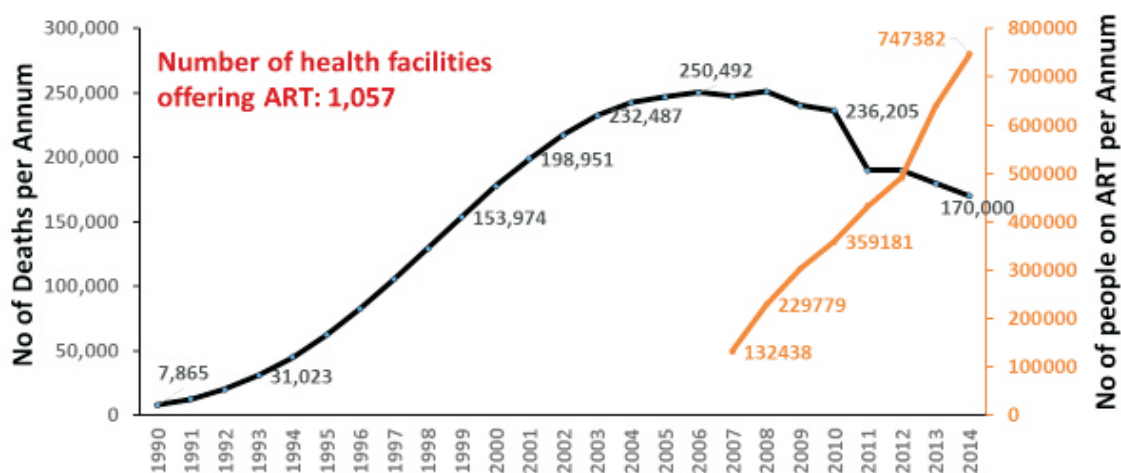
Figure 7: HIV-positive pregnant women on ART and new HIV cases averted among infants: Nigeria, 2006-14



Source: UNAIDS, 2014

Treatment of HIV/AIDS and Related Health Conditions: Of the estimated 3,049,971 people living with HIV who are eligible for antiretroviral therapy, only 853,992 (28%) were on the therapy. This number consisted of 809,304 adults 15 years and above, and 44,688 children 0-15 years. The coverage achieved was 18.7% for children, 20.7% for men, and 34.7% for women. Also, 10.9% of clients in HIV care (treatment and pre-ART) were placed on isoniazid prophylaxis, and 76.3% were placed on co-trimoxazole prophylaxis. Over two-thirds (68%) of those in HIV care were screened for tuberculosis.

Figure 1: Trends in ART provision and uptake in Nigeria: 1990 - 2014



Source: UNAIDS, 2014

Care and support of people living with HIV, people affected by AIDS, and orphans and vulnerable children: In 2015, 202434 new clients were enrolled into Pre-ART care, and many treatment sites had also engaged PLHIV and community volunteers to provide support services for PLHIV clients within the facilities and at the community level. The national care and support guidelines were developed in 2014. HIV treatment programmes supported the operations of community-based and home-based care programmes for people living with HIV. The national hub-and-spoke health care delivery model helped facilitate linkages between newly diagnosed PLHIV and hospital facilities. Also, the provider-initiated testing and counselling services enhanced the identification of PLHIV and facilitated their linkage to facility-based ART services. The level of HIV-related stigma reduced with 72% of the general respondents indicating willingness to care for relatives living with HIV. However, there are still challenges with addressing the needs of orphan and vulnerable children (OVC): at the end of 2014, 20.3% OVC were not attending school regularly and 18% had been sexually abused.

Policy, advocacy, human rights, and legal issues: The Act to Protect the Rights of the People living with HIV (HIV and AIDS Anti-discrimination Act) was passed by the National Assembly in 2013 and signed into law in June 2014. The law has been domesticated in eight of the 36 states of the federation. However, the adoption of the HIV and AIDS anti-discrimination Act has been a challenge. PLHIV still face discrimination based on pre-employment HIV test results, or they lose their jobs due to a change in HIV status. There has been no dedicated budget for anti-stigma activities at the national level. A system of reporting and documenting violations of the rights of PLHIV is also absent. The Same Sex Marriage Prohibition Act, which was passed by the National Assembly in May 2013, and signed into law on 13 January 2014, had unintended negative effects on the access of MSM to HIV treatment and care. While the NSP identifies specific actions to address the needs and rights of women and girls, it only partially includes activities to engage men and boys and transgender.

The use of the 2013 Presidential Comprehensive Response Plan (PCRP) as an advocacy tool to facilitate the mobilization of resources for the HIV response at the national and state levels resulted in significant improvement in the national and state governments' investments in the HIV response.

Gender issues: Gender was a cross cutting issue in the 2010-2015 NSP. Achievements recorded regarding gender in the national HIV response include: capacity building for the mainstreaming of gender in HIV/AIDS response, development of gender mainstreaming indicators and tools for the national HIV/AIDS response, development of a draft NACA Gender Policy, dissemination of the report of the mapping of laws, policies and services on gender-based violence (GBV) and its intersections with HIV in Nigeria. Other achievements include the development of Guidelines for Gender Mainstreaming and Capacity Building in the National HIV Response, Conduct of Legal Environment Assessment and the development of the Plan of Action to remove legal and human rights barriers to HIV and AIDS response in Nigeria with the support of Federal Ministry of Women and Social Development, UNAIDS, UN Women, UNDP and other partners.

Institutional architecture, systems, coordination, and resources: In line with the design of the national response, implementation has been multi-sectoral in nature, with NACA serving as the national coordinating body. Other federal-level sectoral agencies such as the Federal Ministry of Health, Federal Ministry of Education, Federal Ministry of Youth and Sports,

Federal Ministry of Women Affairs and Social Development have played leadership roles in their sectoral responses. The State Agency for the Control of AIDS coordinates the response at each state level, while the Local Agency for the Control of AIDS (LACA) coordinate activities at the local government level. The civil society and PLHIV have played active roles in the response to different dimensions across the three levels of governance.

The human and institutional capacity of the States and the Local Governments to lead the national HIV response was strengthened by funding support from the World Bank, United States Government (USG), and the United Kingdom Department for International Development (DfID) through “Enhancing Nigeria's Response to HIV/ AIDS” (ENR) programme. However, the ability of LACAs to anchor the community HIV response remains weak. Multiple platforms and reporting structures for coordinating all partners engaged in the HIV response were set up by NACA. However, the coordinating framework for the CSO HIV response is still poorly developed.

Systems for HIV commodity procurement and supply logistics management have been developed but the challenge of commodity stock-out remains, with 18% of facilities providing HCT services reporting test-kit stock-out in 2015. The HIV commodity procurements system is currently not cost-effective. The strengthening of contraceptives logistics management system through efforts such as the Family Planning Review and Re-supply Meeting supported by the United Nations Population Fund (UNFPA) also contributed to the furthering of the PMTCT agenda, although stock out of FP commodities persists at various levels. HIV/ AIDS resource tracking is weak due to poor reporting on HIV funding by partners engaged in the HIV response in Nigeria. According to the National AIDS Spending Assessment (NASA), 27.2% of the financing of the HIV intervention in Nigeria was provided by the Government and 2.1% provided by the private sector in 2014; the international development partners provided the rest. Only 8.3% of states fund up to 30% of their own HIV response.

Monitoring and evaluation systems: Data collected at the national and state levels are analyzed and used to inform strategic decision-making and evidence-based HIV programming in Nigeria. The HIV response evaluation process has also improved significantly. Annual reviews, a mid-term review and an end of term evaluation of the 2010-2015 NSP were conducted. The outcomes of the review informed the design and implementation of the stakeholders' programmes. Data quality has improved significantly through the adoption of the national (integrated) DHIS 2.0 platform. The state monitoring visits by federal-level Experts have helped to improve the data quality, and so have the LGA, State, and National data verification exercises.

Efforts at integrating the existing DHIS platforms, which could help the country report on both health sector and non-health sector HIV response progress in Nigeria, started in 2013 and have not been concluded yet. This gap in the DHIS initiative has an impact on the collection and reporting of data from the non-health sector. The HIV-response activities of the private-health sector are also not captured by the national response. The poor in-country dissemination of HIV related information has also limited the sharing of best practices and lessons learnt. Also, as the national HIV response matures, there is the need to focus the performance measures on impact and coverage indicators, and less on process indicators.

3. Development Context, Guiding Principles and Goals

3.1. Framework Development Context

The NSF is developed in the context of the following:

1. *The 1999 Constitution of the Federal Republic of Nigeria*: This affirms the national philosophy of social justice and guarantees the fundamental rights of every citizen to life, dignity and freedom from discrimination of any sort.
2. *National development vision and key national policy-related documents*: The Nigerian economic recovery plan and strategy provides the economic and development framework for the country and the HIV and AIDS response; the National Health Act (2014) defines the health system, and delineates the roles and responsibilities of the various levels of government and other stakeholders in the health arena, as well as their relationships. The 2016 Health Policy provides “stakeholders in health with a comprehensive framework for harnessing all resources for health development towards the achievement of Universal Health Coverage”, and, the NACA Act specifies the statutory roles and responsibilities of NACA as the national coordinating agency for the national response.
3. *Regional agenda and commitments*: These include the African Health Strategy 2016-2030 with the vision of “an integrated, inclusive and prosperous Africa, free from its heavy burden of disease, disability and premature death”; and the Maputo Plan of Action 2016-2030 for the Operationalization of the Continental Policy Framework for Sexual And Reproductive Health and Rights, which prioritizes, among others: the strengthening of “primary health care systems by linking comprehensive, quality Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), HIV/AIDS, Malaria/TB services at all levels of the health system. The country is also committed to the implementation of the 2001 Abuja Declaration (African Union Member States' commitment to strengthen their responses to AIDS, Tuberculosis and Malaria and to allocate at least 15% of their budget to health), and the follow-on Abuja+12 Declaration.
4. *Global agenda and programme development in the HIV and AIDS field*: These include the Sustainable Development Goals (SDGs), investment approach to HIV policy and programming for improved cost-effectiveness and impact; the UNAIDS 90-90-90 agenda that sets the target that “By 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy will have viral suppression”; the “Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030”, and WHO's consolidated guidelines on the use of antiretroviral drugs for treating and preventing new HIV infection – all to which the government of Nigeria is fully subscribed.

3.2. Guiding Principles of the NSF

The provisions of the NSF are guided by the following principles:

1. *Political leadership and ownership*: Strong political leadership of the national and state HIV and AIDS responses, driven by a sense of ownership, and with commitment to transparent and prudent management of financial resources at all levels of the response.
2. *Partnerships and multi-sectoral collaborations*: Synergy between all multi-sectoral partners for the purpose of stronger collaboration and partnerships between all stakeholders, including government, civil society organisations, networks of people living with HIV, and international development partners.
3. *Rights and gender-responsiveness*: Respect for gender equality and fundamental human rights through adoption of rights-based and gender-responsive approaches in HIV programming by all stakeholders and at all levels.
4. *Meaningful involvement of people living with HIV and AIDS*: Commitment to the meaningful involvement of people living with HIV and AIDS (MIPA) through institutionalization of the engagement of people living with HIV in the implementation of the HIV response; and respect for the rights and dignity of all persons living with HIV.
5. *Strategic Investment programming*: Targeted strategic investment driven by the latest evidence in the field of HIV and AIDS, with the aim of optimizing the utilization of resources and maximizing the returns on investment in the HIV response.
6. *Optimization of the health system*: Strengthening of the health system as a basis for effective delivery of quality HIV prevention, treatment, care, support and adherence programmes.
7. *Community involvement, engagement and participation*: Strengthening the community systems and related elements as a fundamental to achieving the goal and objectives of the NSF.

3.3. Vision of the NSF

The vision of this 2017 – 2021 NSF is: **“An AIDS-free Nigeria, with zero new infection, zero AIDS-related discrimination and stigma”**

3.4. Goal of the NSF

The goal of the NSF is: **“To fast-track the national response towards ending AIDS in Nigeria by 2030”**

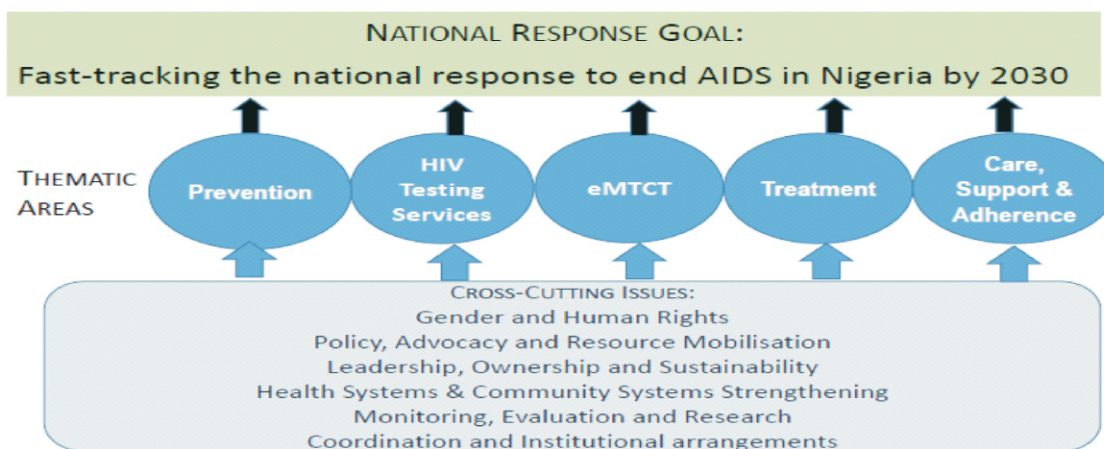
3.5. Thematic Areas of the NSF 2017-2021

The thematic areas of the NSF are programmatic foci that aim to directly reduce the risk and transmission of HIV, incidence of new HIV infection, and HIV and AIDS-related morbidity and mortality. The NSF has five thematic areas:

1. Prevention of HIV among General and Key Populations
2. HIV Testing Services
3. Elimination of Mother-to-Child transmission of HIV (eMTCT)
4. HIV Treatment
5. Care, Support and Adherence

The thematic areas are underpinned by a number of cross-cutting issues and programme enablers: (i) Gender and human rights; (ii) Health systems and community systems strengthening, and service integration; (iii) Coordination and institutional arrangement; (iv) Policy, advocacy and resource mobilization; (v) Monitoring and evaluation; and, (vi) Leadership, ownership and sustainability.

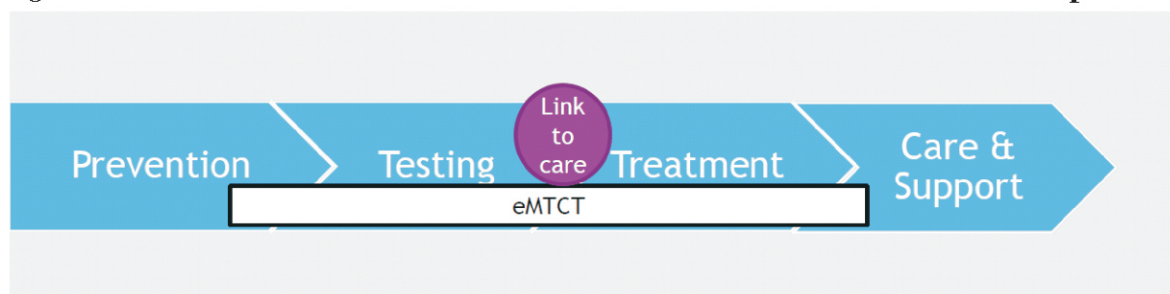
Figure 9: National Goal and Linkage with Thematic Areas and Cross-cutting Issues



4. Objectives, Targets, and Strategic Interventions

The objectives of the NSF are inter-related, and are the expected results from the delivery of evidence-based, cost-effective and high impact interventions that will enable Nigeria to attain its overarching goal of fast-tracking the national response towards ending AIDS in the country by 2030, and the accomplishment of the 90-90-90 target as its immediate five-year overall targets. As such, the thematic areas function as logically-linked elements in a continuum of prevention, treatment and care for HIV in operational terms, rather than discreet and stand-alone interventional areas.

Figure 10: The thematic areas and continuum of interventions in the national response



4.1. HIV Prevention among General and Key Populations

4.1.1. Rationale

The national HIV prevention programme strategically focuses on reducing the number of new HIV infections in Nigeria. The national HIV prevention efforts are therefore geared towards reducing the risk of HIV transmission acquired through risky sexual behavior, unsafe blood and blood products, use of non-sterile needles in people who inject drugs (PWID), and mother-to-child transmission. The Framework also recognizes the efficacy of HIV combination prevention approaches by the application of a mix of evidence-based behavioral, biomedical and structural interventions to prevent new HIV infections based on the needs of, and its relevance for the target population. It also recognizes HIV testing services (HTS) as the bridge between prevention interventions and treatment efforts. Furthermore, the Framework recognizes that biomedical transmission of HIV (and other transfusion transmissible infections such as Hepatitis B and Hepatitis C) through unsafe blood transfusion services, unsafe injection practices and poor healthcare waste management is a distinctively avoidable risk given the available knowledge and technologies, and previous policy decisions and efforts of the Federal Ministry of Health on safer blood transfusion and safe injection practices.

The HIV prevention programmes are developed using an investment approach that facilitates access of those disproportionately affected by HIV transmission to targeted and effective HIV prevention services. The minimum prevention package intervention (MPPI) is an effort to ensure that populations receive a combination of appropriate interventions at a dose and intensity that can lead to behavior change. The Framework also acknowledges that implementation of harm reduction strategies for PWID, and promotion of access to pre-

exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), Treatment as Prevention (TasP) and effective treatment of sexually transmitted infections are critical elements of HIV prevention programmes. However, for convenience, HIV Testing Services, elimination of mother-to-child transmission of HIV (eMTCT), treatment, care, support and adherence are treated separately in this chapter in sections 4.2, 4.3, 4.4 and 4.5 respectively.

The targets for this thematic area were guided by the need to: (i) achieve the 90-90-90 target, (ii) eliminate the transmission of HIV through unsafe blood transfusion, and (iii) drastically reduce the risk of HIV and other transmissible infections through unsafe injection and poor health waste management practices.

4.1.2. Strategic Objective

To significantly reduce the incidence of new HIV infections by 2021.

4.1.3. Targets

- Target 1:** 90% of the general population have access to HIV prevention interventions by 2021.
- Target 2:** 90% of key and vulnerable populations adopt HIV risk reduction behaviour by 2021.
- Target 3:** 90% of key and vulnerable populations have access to desired HIV prophylaxis by 2021
- Target 4:** 100% of Nigerians have access to safe blood and blood products by 2021.
- Target 5:** 90% of the general, key and vulnerable populations have access to safe injection practices by 2021.

4.1.4. Strategic Interventions

1. Foster an enabling environment that facilitates access of adolescents, young people and other vulnerable populations to a combination of appropriate HIV prevention strategies.
2. Strengthen community structures for provision of equitable HIV prevention interventions.
3. Strengthen targeted strategic behaviour change communication for general, key and vulnerable populations.
4. Enhance the access of general, key and vulnerable populations to condom and lubricants.
5. Facilitate access of PWID to harm reduction strategies.
6. Identify and strengthen service delivery model(s) that can provide a combination of quality HIV prevention services to key and vulnerable populations.
7. Expand access of populations at substantial risk of HIV to HIV prevention prophylaxis.
8. Strengthen the management of non-HIV sexually transmitted infection.
9. Strengthen referral and linkages between HIV prevention and other health and social services.

10. Expand access of in-and out-of-school youths to family life and HIV education.
11. Improve access to safe blood and blood products.
12. Improve injection safety and health care waste management practices.
13. Conduct appropriate research to identify strategies that support improved access to HIV prevention services.

4.1.5. Targets and Indicators for Thematic Area

Table 4: HIV Prevention among General and Key Populations: Targets and Indicators

Indicators	Baseline	Target
Target 1: 90% of general population have access to appropriately-targeted HIV combination prevention (minimum prevention package intervention) by 2021		
1.1: % of general population with comprehensive knowledge of HIV transmission and prevention	25% (2012) ¹⁸	90%
1.2: % of young people (15 – 24 years) with comprehensive knowledge of HIV transmission and prevention	25% (2012) ¹⁸	90%
1.3: % of women and men aged 15-49 who have had sexual intercourse with more than one non-marital, non-cohabiting partner in the past 12 months who used a condom during their last sexual intercourse	Female: 29.3% Male: 19.8% (2013) ⁴	90%
1.4: % of women and men aged 15–49 years who have had sexual intercourse with more than one partner in the past 12 months	13.7% (2012) ¹⁸	5%
1.5: % of never-married sexually active young people (15-24 years) who used a condom at last sexual intercourse	Females: 43.6% Males: 57.9% (2013) ⁴	90%
1.6: % of women and men with STIs who sought treatment from health facility or health professional in the past 12 months	Females: 40% Males: 45% (2013) ⁴	90%

Target 2: 90% of key and vulnerable populations adopt HIV risk reduction behaviour by 2021		
2.1: % young people (disaggregate by age and sex) with more than one sexual partner who used condom at last sexual intercourse.	26% (2012) ¹⁸	90%
2.2: % of FWSS who used condom at last sex act	91.8% (2014) ¹⁷	98%
2.3: % of MSM who used condom at last anal sex with male partner	82% (2014) ¹⁷	98%
2.4: % of PWID who used condom use at last sexual intercourse	83.2% (2014) ¹⁷	98%
2.5: % of PWID who used sterile needles consistently in the last 3 months	Not available	90%
2.6: % of young people (15-19, 20-24 years) population reporting condom use at last sexual intercourse	Not Available	90%
Target 3: 90% of the key and vulnerable populations have access to desired HIV prophylaxis by 2021		
3.1: % of key population using PrEP in priority population	Not available	90%
3.2: % of health facilities providing PrEP	Not available	90%
3.3: Number of reported HIV exposures that received post-exposure prophylaxis (excluding HIV exposed babies)	To be determined	100%
Target 4: 100% of Nigerians have access to safe blood and blood products by 2021		
4.1: % of health facilities providing transfusion that meets requirements for sufficient and safe blood transfusion	To be determined	100%
4.2: % of health facilities with good injection practices	80% (2016) ²⁵	100%
4.3: % of facilities with no stock-out of injection safety boxes in the last 3 months	To be determined	10%
Target 5: 90% of the general, key and vulnerable populations have access safe injection practices by 2021.		
5.1: Proportion of health care facilities using reuse-prevention (auto-disable) injection equipment for therapeutic purposes	To be determined	95%

5.2: Proportion of health care facilities with no stock-out of reuse-prevention (auto-disable) in the last three months	To be determined	95%
5.3: Proportion of health care facilities where used injection equipment can be observed in places where they prevent exposure of health care workers to needle stick injuries	To be determined	<5%
5.4: Proportion of health care facilities with safety boxes in all injection areas	To be determined	95%

4.2. HIV Testing Services

4.2.1. Rationale

HIV testing remains the entry point for HIV prevention, treatment and care services. Past national HIV prevention programmes in Nigeria had focused on improving access of Nigerians – the general population and those at substantial risk for HIV (key and vulnerable populations) – to HIV counselling and testing (HCT) services. In line with the new World Health Organization (WHO) consolidated guidelines and the national goal of fast tracking the end of the AIDS epidemic by 2030, the country adopted the use of HIV Testing Services (HTS) in place of the HCT. The full range of HTS encompasses counselling (pre-test information and post-test counselling); linkage to appropriate HIV prevention, treatment and care services; and coordination with laboratory services to support quality assurance and the delivery of correct results. Access to accurate, high-quality HTS for diverse populations and settings with targeted approaches would improve yield and optimize the investment in HTS.

This Framework aims to expand the coverage of HTS to populations in greatest need, to increase access to services, to improve the quality of testing services and to help achieve the new UNAIDS target of diagnosing 90% of all people living with HIV by 2020. Additionally, this Framework is designed to facilitate the provision of equitable, gender-sensitive, rights-based HTS over the next five years. It is expected that all programme implementers will adhere to the principles of HTS namely consent, confidentiality, counselling, correct results and connection.

The targets for this thematic area were guided by a number of considerations: the need to (i) achieve the 90-90-90 target, and (ii) eliminate the transmission of HIV from mother to child; (iii) achieve a higher coverage of HIV testing among key populations, with the knowledge that coverage is currently higher than 90% in some groups.

4.2.2. Strategic Objective

To increase access to HIV testing services so as to enable 90% of people living with HIV to know their status and be linked to relevant services.

4.2.3. Targets

Target 1: 100% of key populations, 100% of children (age 1 to 9 years) of HIV positive mothers, 80% of vulnerable population and 60% of general population access HTS by 2021.

Target 2: 95% of pregnant women access HTS by 2021.

Target 3: 90% of people tested for HIV screened for TB, syphilis, hepatitis B, and hepatitis C by 2021.

Target 4: 90% of HTS sites establish and maintain quality control measures by 2021.

4.2.4. Strategic Interventions

1. Foster an enabling environment for improved access to HTS and screening services for HIV co-infections.
2. Expand coverage of HTS services and screening for HIV co-infections.
3. Strengthen community systems to support testing and re-testing of key populations, vulnerable population and pregnant women.
4. Strengthen targeted HTS demand generation programmes.
5. Promote integration of, and strengthen referrals and linkage systems between HTS, other HIV management services, blood transfusion service, and other health-related services.
6. Integrate screening for HIV co-infections into HTS.
7. Institute and strengthen the quality management systems for all HTS sites.
8. Improve the logistics and supply chain management for all testing commodities.
9. Conduct appropriate research to identify strategies that support improved access to HTS.

4.2.5. Targets and Indicators for Thematic Area

Table 5: HIV Testing Services: Targets and Indicators

Indicator	Baseline	Target
Target 1: 100% of key populations, 100% of children (age 1 to 9 years) of HIV-positive mothers, 80% of vulnerable population and 60% of general population access HTS by 2021		
1.1: % of people tested and received HIV test results in the last 12 months	26.3% (2012) ¹⁸	60%
1.2: % of people living with HIV (disaggregated by age and sex) who have been tested positive	<p><i>Children <15years:</i> (17,675) (1.7%) - Males: (9,123) (0.86%) - Females: (8,552) (0.81%)</p> <p><i>Adult >15 years:</i> 246,801 (3.7%) - Females: (152,535) (2.3%) - Males: (94,266) (1.4%) (2015)²³</p>	90%
1.3: % of FSW, MSM, PWID who tested for HIV and received their test results within the last 12 months	<p>FSW: 97.1%</p> <p>MSM: 97.0%</p> <p>PWID: 93.5%</p> <p>(2014)¹⁷</p>	100%

1.4: % of HIV-negative FWSS, MSM, PWID who re-tested for HIV and received their test results within the last 12 months	Not Available	100%
1.5: % of children of HIV-positive mothers (age 1 to 9 years) tested for HIV and received their test results within the last 12 months	Not Available	100%
1.6: % of vulnerable population ¹ (disaggregated by specific groups) tested for HIV and received their test results within the last 12 months	Not Available	80%
Target 2: 95% of pregnant women access HTS by 2021		
2.1: (Number and) % of pregnant women tested for HIV and received their test results in the last 12 months	(2,780,170) 44.42% (2015) ²³	95%
Target 3: 90% of people tested for HIV screened for TB, syphilis, hepatitis B, and hepatitis C.		
3.1: % of HIV-people screened for TB, syphilis, hepatitis B and Hepatitis C and received their test results within the last 12 months (disaggregated by disease)	Not available	90%
Target 4: 90% of HTS sites establish and maintain quality control measures by 2021		
4.1: (Number and) % of health facilities providing HTS	(8,308) 35.1% (2015) ²²	
4.2: (Number and) % of health facilities with stock out of HIV test kits within the last 3 months	(1,497) 18.0% ²²	0%
4.3: (Number and) % of HTS centers with instituted quality improvement	To be determined	90%

¹Defined by the National Prevention Plan as including prisoners and those in close setting, adolescents, young women, internally displaced persons, widows, divorcees, single mothers and persons with disabilities.

4.3. Elimination of Mother-to-Child Transmission of HIV

4.3.1. Rationale

The elimination of mother-to-child transmission of HIV (eMTCT) requires: (i) the prevention of new HIV infections in young people; (ii) prevention of unintended pregnancies in HIV-infected women; (iii) prevention of transmission of HIV from infected mothers to their children; and, (iv) provision of treatment, care and support to infected mothers, their husband/partners and children. This Framework embraces the Family Planning Blueprint (Scale-Up Plan), for Nigeria and its target of increasing the contraceptive prevalence rate to 36% by 2018, as fundamental to preventing unintended pregnancies in HIV-infected women. This framework aims at providing an effective platform for the country's efforts to eliminate new HIV infection in children born to mothers who are HIV positive in line with the national aspiration defined in the 2013 Presidential Comprehensive Response Plan. The current national test and treat programme shall enhance the achievement of the goal of eliminating new HIV infections in infants. The eMTCT interventions aim to prevent the transmission of HIV from infected mothers to their children; and ensure that all HIV negative infants born to HIV positive mothers remain so throughout infancy. Section 4.1 of this Framework addresses prevention of new HIV infections in young people, while section 4.2 addresses access of pregnant women to HTS in order to identify those living with HIV and link them with quality services to prevent and eliminate mother-to-child transmission of HIV.

The targets for this thematic area were based on (i) the level of globally specified coverage for HIV-related interventions that is needed to achieve the elimination of mother-to-child transmission of HIV; and (ii) the national target set for contraceptive prevalence level in the national Family Planning Blueprint.

4.3.2. Strategic Objective

To eliminate mother-to-child transmission of HIV in Nigeria by 2021

4.3.3. Targets

- Target 1:** Modern contraceptive prevalence rate of 40% achieved among HIV positive women by 2021.
- Target 2:** 95% of all HIV positive pregnant and breastfeeding mothers receive antiretroviral therapy by 2021.
- Target 3:** 95% of all HIV-exposed infants receive antiretroviral prophylaxis by 2021.
- Target 4:** 95% of all HIV-exposed infants have early infant diagnosis within 2 months of birth by 2021.
- Target 5:** 95% of all HIV exposed infants receive co-trimoxazole prophylaxis within 2 months of birth by 2021.
- Target 6:** 90% of HIV exposed babies have access to HIV serological test by the age of 18 months by 2021.

4.3.4. Strategic Interventions

1. Foster an enabling environment for HIV positive pregnant and breastfeeding mothers and HIV-exposed infants to access antiretroviral drugs.
2. Strengthen contraceptive demand generation programmes for HIV positive women.
3. Promote integration and strengthen referral and linkages between antenatal care, family planning, sexual and reproductive health services, maternal and child health and HIV services.
4. Expand access of HIV positive pregnant and breastfeeding mothers to antiretroviral therapy services.
5. Expand access of HIV exposed infants to early infant diagnosis (EID) services.
6. Expand access of HIV exposed infants to antiretroviral prophylaxis and co-trimoxazole prophylaxis within 2 months of birth.
7. Expand access of HIV exposed babies to HIV serological test at 18 months.
8. Strengthen community systems to support care for HIV-exposed infants.
9. Institute and strengthen the quality management systems for all eMTCT facilities.
10. Conduct appropriate research to identify strategies to facilitate the elimination of mother-to-child transmission of HIV.

4.3.5. Targets and Indicators for Thematic Area

Table 6: Elimination of Mother-to-Child Transmission of HIV: Targets and Indicators

Indicators	Baseline	Target
Target 1: Modern contraceptive prevalence of 40% achieved among HIV-positive women by 2021		
1.1: Modern contraceptive prevalence for HIV-positive women	Not available	40%
1.2: Level of unmet needs for family planning among HIV-positive women	Not available	
Target 2: 95% of all HIV positive pregnant and breastfeeding mothers receive antiretroviral therapy by 2021.		
2.1: Rate of MTCT per 100,000 live births	To be determined	<50%
2.2: % of HIV positive pregnant women who receive ART	30% (2015)	95%
2.3: (Number and) % of health facilities (public and private) providing eMTCT/PMTCT services	(7265)	95%

2.4: % of facilities offering ART for HIV-positive pregnant and breastfeeding mothers with quality assurance mechanisms	To be determined	95%
Target 3: 95% of all HIV-exposed infants receive antiretroviral prophylaxis by 2021		
3.1: % of infants born to HIV positive women who receive ARV prophylaxis	15.44% (2015)	95%
3.2: % of facilities offering ART for HIV-exposed infants with quality assurance mechanisms	To be determined	95%
Target 4: 95% of all HIV-exposed infants have early infant diagnosis services within 2 months of birth, by 2021		
4.1: % of HIV exposed infants receiving early infant diagnosis within 2 months of birth	9%	95%
Target 5: 95% of all HIV exposed infants receive co-trimoxazole prophylaxis by 2021		
5.1: % of infants born to HIV infected women started on co-trimoxazole prophylaxis within 2 months of birth	10.26% (2015)	95%
Target 6: 90% of HIV exposed babies have access to HIV serological test by the age of 18 months by 2021		
6.1: % of HIV exposed babies who have antibody serological testing by the age of 18 months	To be determined	90%

4.4. HIV Treatment

4.4.1. Rationale

HIV treatment reduces mortality and morbidity among PLHIV, improves their quality of life and reduces their potential to infect others. Nigeria adopted the recent World Health Organization's policy of test and treat, and the consolidated guidelines on the use of ART for treatment and prevention of HIV. The national HIV treatment programme is focused on increasing access of people living with HIV to antiretroviral therapy, providing them access to isoniazid prophylaxis for tuberculosis prevention; and reducing their risk for other opportunistic infections using co-trimoxazole prophylaxis. The programme also promotes screening and treatment of all persons living with HIV for tuberculosis, and screening and treatment of all newly infected or relapsed tuberculosis cases for HIV infection. The treatment programme also embraces the principle of differentiated care, which is a responsive, client-centered approach that simplifies and adapts HIV services across the cascade to better serve individual needs and reduce unnecessary burdens on the health system, with a view to increasing access and quality of ART services, and retention in care.

This Framework aims to drive Nigeria's efforts at providing effective, quality, gender-responsive and rights-based ART services to all persons who test positive for HIV in an equitable and sustainable manner over the next five years. As indicated in sub-section 4.1.1, this Framework also recognizes and embraces the use of ARV for prevention in the context of PrEP and PEP for eligible individuals. Overall, the strategic interventions will help to ensure that Nigeria meets the 90-90-90 goals by 2020.

The targets for this thematic area were guided by the need to achieve the 90-90-90 targets, and the importance of controlling TB promptly among people living with HIV.

4.4.2. Strategic Objective

All diagnosed PLHIV receive quality HIV treatment services, and at least 90% of those on ARV achieve sustained virological suppression.

4.4.3. Targets

Target 1: 90% of diagnosed PLHIV are on ART by 2021.

Target 2: 90% of diagnosed PLHIV on treatment are retained in care by 2021.

Target 3: 90% of eligible PLHIV receive co-trimoxazole prophylaxis by 2021.

Target 4: All PLHIV diagnosed with TB have access to TB services by 2021.

4.4.4. Strategic Interventions

1. Foster an enabling environment for people living with HIV and AIDS to access ART and opportunistic infection management services.
2. Expand access of people living with HIV and AIDS to ART, ART monitoring and co-infection management services.
3. Improve the logistics and supply chain management for ART commodities.
4. Institutionalize and strengthen the quality management systems for all ART and viral load assessment services.
5. Promote integration and strengthen referral and linkage systems for HIV, TB, and non-communicable disease co-infection management.
6. Strengthen community systems for effective differentiated care.
7. Improve facility-based adherence counselling and tracking mechanisms for PLHIV.
8. Conduct appropriate research to identify strategies that support the access of PLHIV to HIV treatment services and adherence to ART.

4.4.5. Targets and Indicators for Thematic Area

Table 7: HIV Treatment: Targets and Indicators

Indicator	Baseline	Target
Target 1: 90% of diagnosed PLHIV are on treatment by 2021.		
1.1: % of PLHIV currently on ART (disaggregated by age, sex, regimen, pregnancy and breastfeeding status)	28% (2015)	90%
1.2: (Number and) % of health facilities providing ART	(1,078 in 2015) ² 30	90%
1.3: % of ART sites with stock out of ARV within the past 3 months	TBD	0%
Target 2: 90% of diagnosed PLHIV on treatment are retained in care		
2.1: % with HIV on ART who are retained on ART by 12, 24, 36, 48, 60 months after initiation (disaggregate by age and sex)	By 12 months: 12.7% By 24 months: 21.1% (2013) ³¹ Adult: Not available	90%
2.3: % of PLHIV and on ART with a viral load test result	82,212 (11%) ²²	90%
2.4: % of PLHIV on ART are virologically suppressed (<1000c/ml)	To be determined	90%
Target 3: 90% of eligible PLHIV are receiving co-trimoxazole prophylaxis by 2021		
3.1: % of PLHIV who received co-trimoxazole during the reporting period	76.3%	90%
Target 4: All PLHIV have access to TB services by 2021		
4.1: % of people in HIV care who were clinically screened for TB in HIV care setting	68% ³²	100%
4.2: % of PLHIV in HIV care who are started on INH prophylaxis during the month	TBD	100%

² The number of health facilities eligible to offer ART service is not known, and percentage can, therefore, not be determined

4.3: % of newly-diagnosed PLHIV without active TB placed on isoniazid preventive therapy (IPT) within the reporting period	10.9% ²¹	100%
4.4: % of estimated PLHIV with incident TB cases that received treatment for TB within one month of TB diagnosis	12.2% (2014)	100%

4.5. HIV Care, Support and Adherence to Treatment

4.5.1. Rationale

HIV and AIDS care, support and adherence programme is the holistic and comprehensive client-focused, community centered care service provided by a multidisciplinary team at all stages of the HIV infection¹. It is an integral part of the HIV and AIDS continuum of management that facilitates access of people living with HIV (PLHIV), people affected by HIV (PABA) and children vulnerable to HIV (VC) to HIV care services outside of the health care facilities. It also facilitates the retention of Clients in care. The issue of retention in care, especially with focus on ARV, is addressed under the HIV thematic area (Section 4.4).

The access of PLHIV, PABA and VC to HIV and AIDS care, support and adherence services has so far been facilitated by the Hub-and-Spoke model (integrated cluster system) adopted by the Federal Ministry of Health for the delivery of comprehensive health care for all Nigerians. This health care delivery approach recognizes the potential impact that engagement of PLHIV-led organizations, and the engagement of PLHIV in the delivery of care for their peers.

This NSF is designed to facilitate, among others, the implementation of the 2011 comprehensive guidelines on nutritional care for PLHIV, the 2014 Act to Protect the Rights of the People living with HIV (HIV and AIDS Anti-discrimination Act), the 2014 guidelines on care and support of PLHIV, the 2016 plan of action on the removal of legal and human rights barriers to HIV and AIDS response in Nigeria, and the 2015 National Plan of Action for orphans and vulnerable children. Furthermore, the Framework will support the implementation of the 2013-2020 National Priority Agenda for Vulnerable Children by adhering to the vulnerable children's standard of services. The Framework also incorporates the prevention of HIV re-infection interventions into routine care for PLHIV as part of positive health, dignity and prevention (PHDP) strategy.

The targets for this thematic area were decided based on: the need to drastically address the issue of HIV-related stigma and discrimination; the high premium that is laid on improving the quality of life of people living with HIV; and, the need to achieve the 90-90-90 targets.

4.5.2. Strategic Objective

To improve access of People living with HIV (PLHIV), vulnerable children (VC), and people affected by HIV / AIDS (PABA) to comprehensive rights-based care.

4.5.3. Targets

- Target 1:** 90% of PLHIV access quality care and support services by 2021.
- Target 2:** 90% of vulnerable children enlisted for care and support services access those services by 2021.
- Target 3:** 90% of males and females age 5-49 years display non discriminatory attitudes towards PLHIV and PABA by 2021.
- Target 4:** 90% of PLHIV access positive health, dignity and prevention related services by 2021.

4.5.4. Strategic Interventions

1. Foster an enabling environment for PLHIV, PABA and VC to access HIV care and support services.
2. Expand access of all PLHIV to facility- and community-based care and support services, including nutritional assessment, counselling and services (NACS), adherence counselling, mental health, sexual and reproductive health, rights and psychosocial care.
3. Strengthen the quality assurance mechanisms for community-based care and support services.
4. Integrate NACS, mental health, sexual and reproductive health and rights and psychosocial services into routine care for PLHIV.
5. Strengthen referral and linkages between care and support social services addressing the needs of VC.
6. Strengthen the coordination mechanism for care and support services for VC.
7. Capacity building for health care workers and other service providers on relevant codes of conduct and respect for human dignity.
8. Strengthen behaviour change communications targeted at reducing stigma and discrimination against people living with HIV and AIDS.
9. Advocate for strengthened implementation of the HIV and AIDS anti-discrimination Act.
10. Promote access to justice for PLHIV and PABA through use of community-based and institutionalized mechanisms.
11. Conduct appropriate research to identify strategies for improved care and support for PLHIV and OVC, and for the reduction of HIV-related stigma.

4.5.5. Targets and Indicators for Thematic Area

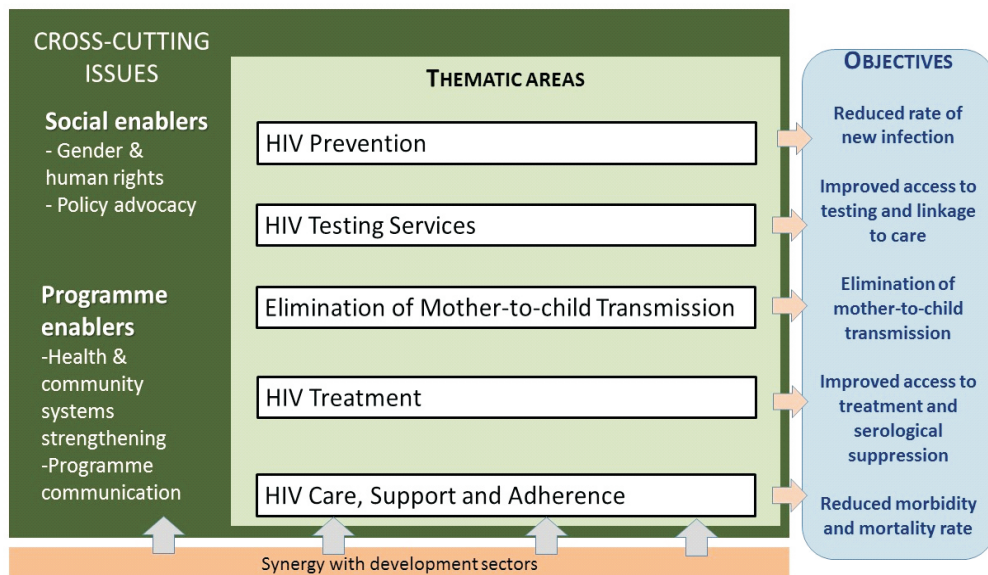
Table 8: HIV Care, Support and Adherence: Targets and Indicators

Indicator	Baseline	Target
Target 1: 90% of PLHIV access care and support services by 2021.		
1.1: (Number and) % of PLHIV receiving community-based care services	(70,041) 34.6%	90%
1.2: (Number and) % of PLHIV receiving (disaggregated by age and sex) adherence support	161,110 (19.3%) ²²	90%
Target 2: 90% of vulnerable children enlisted for care and support services access those services by 2021.		
2.1: (Number and) % of eligible vulnerable children enlisted in care receiving social support services	(1,024,538) ²²	90%
Target 3: 90% of males and females age 5-49 years displaying non-discriminatory attitudes towards PLHIV and PABA by 2021.		
3.1: (Number and) % of States with anti-stigma and discrimination law	22% ²²	100%
3.2: (Number and) % of children aged 5-14 years willing to care for people living with HIV (disaggregated by age group: 5-9 years, 10-14 years)	Not available	90%
332: (Number and) % of men and women age 15-49 years willing to care for people living with HIV	72% ⁴	90%
Target 4: 90% of PLHIV access PHDP-related services by 2021.		
4.1: (Number and) % of PLHIV provided with 'prevention with positives' services	<i>Male:</i> (96,293) ²² <i>Female:</i> (213,141) ²²	90%

5. Cross-cutting issues

While the thematic areas depict the basic HIV programme areas that are directly linked to reduced risk of HIV transmission and improved outcomes for people living with HIV, the cross-cutting issues are “critical enablers” – complementary and broad strategies that increase the effective of basic programme areas. There are two categories of critical enablers: social enablers that help create the enabling environments for the implementation of the NSF, and programme enablers that facilitate the creation of demand for relevant services and help improve the performance of key interventions³³.”

Figure 11: Investment framework for 2017 – 2021 HIV response in Nigeria.



Adapted from: Schwartländer et al. (2011), and UNAIDS (2011).

5.1. Social enablers

The NSF prioritizes the need to respect human rights and mainstream gender-sensitive approaches and response in order to achieve its goals. The NSF also recognizes the need for relevant policy formulation and review to facilitate an enabling environment for improved HIV response.

5.1.1. Gender and human rights

The respect for the rights of all citizens in Nigeria is fundamental to ensuring equitable access to HIV prevention, treatment, care and support programmes. Equitable access to HIV programmes can also be enhanced through the recognition of gender differences that may serve as barriers to access of programmes and commodities, or hamper effective programming across the continuum of HIV prevention, testing, treatment, and care and support. The NSF recognizes the relative powerlessness and unequal socioeconomic status of women compared

to men; the risk that gender-based violence poses to the ability of women to negotiate safer sex, prevent HIV or mitigate the impact of AIDS; and acknowledges that differences in sexual orientation and sexual practices should not limit access of anyone to HIV programmes. It recognizes the negative impact of inadequate attention to rights and gender issues on access to HIV prevention, treatment, care and support services; and how this worsens the impact of HIV on specific population groups, especially adolescents and young women. The NSF acknowledges that the lower rate of retention in care among males living with HIV is a pertinent gender-related issue and responding to the impact on gender dynamics on the HIV response implies that barriers to access of HIV programmes by males, females and trans-genders need to be recognized and addressed.

The 2017 – 2021 NSF was therefore developed with a focus on respecting the rights of all persons regardless of age, gender, socio-economic status and sexual orientation. It also recognizes stigma and discrimination as human rights violations that pose significant challenge to effective HIV response, and thus commits to addressing stigma and discrimination against all people living with, presumed to be living with, at risk of, and affected by HIV, as a critical element in the national response. It aligns its programmes with the Guidelines for Gender Mainstreaming in the National HIV/AIDS Response and Training Manual for Capacity Building for Gender Mainstreaming in the national HIV/AIDS Response. The Framework also upholds that HIV and AIDS response “can be fast-tracked by protecting and promoting access to appropriate, high-quality, evidence-based HIV information, education and services without stigma and discrimination and with full respect for rights to privacy, confidentiality and informed consent.” This Framework therefore provides for gender-sensitive and gender-responsive programming which improves access of PLHIV, vulnerable children, and PABA to comprehensive, rights-based care; it fosters an enabling environment for PLHIV, PABA, VC, FSW, MSM and PWID to access HIV services; while strengthening interventions targeted at reducing stigma and discrimination against PLHIV, vulnerable and key populations. The Framework also promotes advocacy for strengthening implementation of the HIV and AIDS Anti-discrimination Act; and, promotes access of all persons including PLHIV, vulnerable and key populations to justice through use of community-based and institutionalized mechanisms.

5.1.2. Policy Advocacy

Policy advocacy is critical for the success of efforts promoting national ownership and sustainability of the HIV response in Nigeria, as it aims, among others, to secure the support of stakeholders and mobilize resources for the HIV and AIDS responses. This Framework recognizes advocacy for policy formulation and review as keys to creating the required enabling environment for effective HIV response. It also recognizes that the enactment of appropriate and supportive laws and development or revision of guidelines that will facilitate improved access of key, vulnerable and general populations to comprehensive and high-quality HIV prevention intervention, testing services, treatment, care, and support is required. Advocacy is also critical to the effective and continued engagement of relevant local, State, zonal and national stakeholders, including the leadership of PLHIV communities and networks of key and vulnerable populations. At the political level, policy advocacy is critical to ensuring Nigeria's fulfillment of her regional and international obligations, including obligations to the Abuja 2001 and Abuja +12 declarations for increased funding of the health system, and the obligation to the 2016 political declaration on HIV/AIDS to “Accelerate the

Fight against HIV and to End the AIDS Epidemic by 2030.” Thus, this Framework recognizes the need for review of laws and advocacy for policy formulations and revisions for all the thematic areas of the national HIV and AIDS response; affirms the need for development of an advocacy strategy that would increase public and private, local government, state and national government investment in HIV management; including the need to invest in research that promotes development of and access to HIV prevention tools, and HIV treatment, care and support services. Ensuring increased and sustained local investment is a critical element of the 2017-2021 response.

5.2. Programme Enablers

Strengthening health and community systems, and programme communication are some of the programme enablers for effective HIV response under the NSF.

5.2.1. Strengthening Health Systems

The delivery of critical HIV interventions that will impact on HIV risk, transmission, morbidity, and mortality is dependent on the effective performance of the health system. Access to services need to be expanded by scaling-up service delivery points and improving service delivery strategies in order to achieve the 90-90-90 target and the goal of ending the AIDS epidemics by 2030. Thus, the operationalization of this Framework is dependent on instituting strategies that strengthen the health system. This enabler is essential for the successful implementation of the five basic programme or thematic areas of the HIV response. The relevant areas that need to be taken to strengthen the health system are: Leadership and Governance; Human Resource for Health; Health Financing; Service Delivery; Medical products, Vaccines and Technologies and Health Information System. Table 9 summaries the elements of the six building blocks of the health system, and some of the strategic interventions required in respect of them in the context of this Framework.

Table 9: The health system building blocks, its elements, and the NSF strategic interventions

Building block	Elements	NSF strategic interventions
Leadership and Governance	<ul style="list-style-type: none"> • Strategic policy frameworks • System design • Effective oversight • Coalition building • Regulations • Accountability 	<ul style="list-style-type: none"> • Review and enforce relevant laws • Review/adapt and implement service guidelines • Strengthen coordination structure • Strengthen integrated supportive supervision • Strengthen linkages between sectors
Human Resources for Health	<ul style="list-style-type: none"> • Availability • Distribution • Quality • Performance 	<ul style="list-style-type: none"> • Training and re-training of health workers and other service providers
Service Delivery	<ul style="list-style-type: none"> • Comprehensiveness • Accessibility • Coverage • Continuity • Quality • Coordination • Accountability • Integration 	<ul style="list-style-type: none"> • Expanding access to services • Integration and linkages of services • Quality assurance • Scaling up of services
Financing	<ul style="list-style-type: none"> • Resources mobilization • Resource pooling • Expenditure allocation/tracking 	<ul style="list-style-type: none"> • Mobilization of domestic resources • Improved resource management
Medical Products, Vaccine and Technologies	<ul style="list-style-type: none"> • Policies, standards, guidelines, • Information on prices, capacity to negotiate • Procurement, supply, storage, distribution, minimizing leakage and wastages • Rationale use of medicines; adherence, decreasing resistance, patient safety 	<ul style="list-style-type: none"> • Strengthening of commodity logistics and supply chain management system • Conduct research on efficacy and effectiveness of products • Conduct research to identify how to improve access to the commodities

Health Information	<ul style="list-style-type: none"> • Data generation • Compilation • Analysis/synthesis • Communication and use 	<ul style="list-style-type: none"> • Improving HIV data systems production, analysis and dissemination to monitor coverage, quality, and utilization of services, and outcomes
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5.2.2. Community systems strengthening

Community involvement and participation are well-recognised approaches in public health for improving programme effort and outcomes. The community system is key in expanding access to HIV, improving programming in HIV, and ensuring greater accountability of results. Community systems have been defined as “community-led structures and mechanisms used by communities through which community members and community-based organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities”. Community systems strengthening (CSS) is “an approach that promotes the development of informed, capable and coordinated communities, and community-based organizations, groups and structures.” CSS programmes would need to address six core component areas namely: Enabling environments and advocacy; Community networks, linkages, partnerships and coordination; Resources and capacity building; Community activities and service delivery; Organizational and leadership strengthening; and, Monitoring and evaluation and planning.

This National HIV and AIDS Strategic Framework embraces strengthening community systems as a critical enabler for achieving the 90-90-90 target by 2020, and incorporates relevant strategic interventions in each of its thematic areas, including:

- **Enabling environments and advocacy:** The NSF strategic interventions include community engagement and advocacy for improving the policy, legal and governance environments, relating to every area of HIV prevention, treatment and care. This includes advocacy for more rigorous implementation of the HIV and AIDS Anti-discrimination Act, advocacy for review of laws creating barriers to access of HIV programmes, and advocacy for increased political support; and investment in and ownership by national, state and private organisations of the HIV response.
- **Community networks, linkages, partnerships and coordination:** Building linkages and partnerships between PLHIV networks, key populations, community-based organisations, and other community actors, and strengthening the coordination mechanisms for optimal impact.
- **Resources and capacity building:** Building the knowledge and capacity of community actors, service providers, and community-based organisations, and supporting them technically to function effectively in HIV prevention, treatment, and care services.
- **Community activities and service delivery:** Expanding access to HIV prevention, treatment, and care services at community level using relevant and context-specific formal and informal community structures including PLHIV networks, mentor mothers and traditional birth attendants; strengthening adherence counselling and support systems at community levels; and, strengthening the quality assurance mechanisms for home-based care and support services.

- **Organizational and leadership strengthening:** Strengthening formal structures such as the ward development committees, LACA, and networks for improved leadership role and performance in the HIV response, and strengthening accountability within the community systems.
- **Monitoring, evaluation, research and planning:** Generating local data to monitor and drive quality assurance of community-based services, ensuring effective participation of community actors in the monitoring and evaluation of the HIV response, and conducting research to generate evidence needed for efficient and cost-effective programming.

5.2.3. Programme Communication

Communication interventions impact HIV and AIDS response on several fronts and embraces both behaviour change communication and social change communication. Behaviour change communication promotes tailored and culturally sensitive messages, personal risk assessment, greater dialogue and an increased sense of ownership of the response by the individual and the community. Social change communication, on the other hand, involves the strategic use of advocacy, communication and social mobilization to systematically facilitate and accelerate change in the underlying determinants of HIV risk, vulnerability and impact. Nigeria's National 2014/2015 National HIV Prevention Plan advocates for the strengthening of Social Behavioural Change Communication (SBCC) to facilitate positive behaviour change at individual, community and structural levels.

Thus, communication interventions contribute towards shaping decision-making at individual and group levels, building risk reduction skills of individuals and populations, promoting appropriate HIV prevention behavior, addressing stigma and discrimination, and educating health-care providers and other care givers. Furthermore, communication efforts are key to improving both the supply and demand sides of all the HIV-related services – prevention, testing, treatment, care and support. As such, communication interventions are embedded into each of the thematic areas.

Among others, the Framework provides for the following strategic interventions, each of which embraces communication interventions: fostering an enabling environment that facilitates access of adolescents, young people and other key and vulnerable populations to a combination of appropriate HIV prevention strategies; strengthening targeted strategic behaviour change communication for general, key and vulnerable populations; expanding access of in- and out-of-school youth to family life and HIV education; and strengthening targeted demand generation programmes for HTC, eMTCT, treatment, and care and support.

6. Implementation Framework

6.1. Implementation structure and coordination arrangements

6.1.1. National HIV response system and structure

In line with her three-tier federal structure, Nigeria's national response involves key actors at the federal, state, and the LGA level. The national response in Nigeria is coordinated through a system involving state and non-state actors. In line with the Principle of "Three Ones", NACA is the national coordinating entity, and leads the coordination at national level. The state level has the State Agency for the Control of AIDS as the coordinating body, while the Local Agency for the Control of AIDS is the coordinating body at LGA level. At every level of governance, the HIV response is multi-sectoral, with each state agency engaged in the response in its sector in line with its specified mandate. In this regard, the Federal Ministry of Health (FMoH) – through her National AIDS and STI Control Programme (NASCP) – is responsible for coordinating the health sector component of the response, while other line ministries are responsible for coordinating other inter-related sectoral responses. In all, thirty-one Federal ministries, departments and agencies are implementing HIV/AIDS activities that are in line with their mandates. NACA interfaces principally with five domains in its coordination responsibilities: CSO, private sector, and public sector, development partners, and SACAs/LACAs.

At the national level, Technical Working Groups have been established to plan and provide technical advice on thematic areas within the national response. Civil society coordination arrangements are established in the form of Constituency Coordinating Entities (CCEs), including the Civil Society Network for HIV and AIDS in Nigeria (CiSHAN) and Network of People Living HIV/AIDS in Nigeria (NEPWHAN). The private/for-profit business sector is organised as the Nigeria Business Coalition against AIDS (NIBUCCA). The CCEs are responsible for reporting on activities of their constituency to NACA.

The national response is accountable to the National AIDS Council that meets annually with all SACAs, Sectors, and CCEs in line with the stipulations of the 2007 Act that established NACA. There is also the HIV/AIDS Committee in the National Assembly and the AIDS, Tuberculosis and Malaria Committee of the House of Representatives. These bodies all play roles as coordination and accountability structures for the national response.

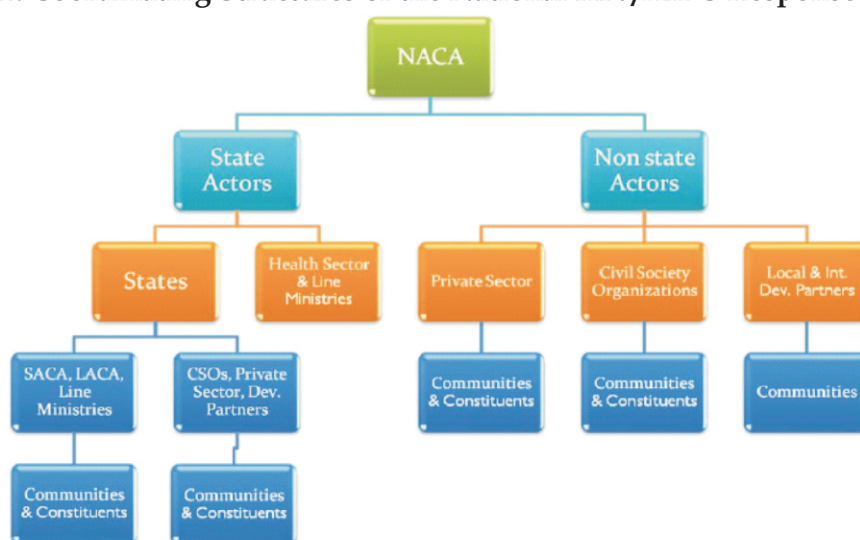
6.1.2. Mandates of NACA

The specific mandates of NACA as stipulated by the 2007 NACA Act are to:

- Coordinate and plan identified multi sectoral HIV & AIDS activities of the National response;
- Facilitate the engagement of all tiers of government on issues of HIV & AIDS;
- Advocate for the mainstreaming of HIV & AIDS interventions into all sectors of the society;
- Develop and periodically update the Strategic Framework of the National Response Programme;

- Provide leadership in the formulation of policies and sector-specific guidelines on HIV and AIDS;
- Establish mechanisms to support HIV and AIDS research in the country;
- Mobilize resources (local and foreign) and coordinate its equitable application for HIV and AIDS activities;
- Develop its own capacity and facilitate the development of other stakeholders' capacity;
- Provide linkages with the global community on HIV and AIDS; and
- Monitor and evaluate all HIV and AIDS activities.

Figure 12: Coordinating Structures of the National HIV/AIDS Response



Source: NACA, 2014³⁸.

6.1.3. National Response Planning and Implementation in the context of the NSF

Whereas NACA has spearheaded the collaborative development of the NSF, the responsibility of developing specific sectoral and state strategic plans is that of the implementing entities (federal sectoral agencies and states). The National Strategic Plan (NSP) will be developed using a bottom-up approach. The NSF provides the foundation for the development of the NSP, and a guidance note (see Annex 1) has been developed to facilitate the development of the sectoral and state response plans in a robust and systematic way, utilizing a standardized approach that will facilitate the aggregations of the various plans into the NSP at a later date. The objectives set in the NSF are the overarching national objectives, which can be suitably adapted by all the other response entities. The national targets, on the other hand, provide a national focus and will serve as guides for the states and sectors in setting their targets. Targets at the state level will be determined by the profile of the epidemic, the outcomes of past response efforts, available resources and state priorities as explained in the guidance note. The NSP would be developed through an aggregation of the State and Sectoral Strategic Plans. The implementation of the NSP will be in line with the mandate of the various entities involved in the national response and as broadly described in section 6.1.1.

6.2. Programme Resourcing

Achieving the 90-90-90 target of the NSP necessitates that the HIV prevention, treatment, and care programme needs to be scaled up significantly. This has significant resource (human, financial, institutional, material and policy) implications. Similarly, the test and treat approach, and adoption of PrEP for HIV prophylaxis will also increase the resource needs of HIV treatment. Thus, the resources required for the full implementation of NSF 2017-2021 will significantly be higher than that required for the 2010-2015 NSF. Overall, however, the approach adopted by Nigeria and the targets set are highly cost-effective, as early treatment enhances both health and economic gain. Furthermore, the investment approach adopted by this NSF implies that evidence-based approaches that are cost-effective will be used for the programme design and implementation for high yielding impacts. As such, there is the need to mobilize the resources required for the full implementation of the NSF. There is also a need for greater investment in research that would generate evidence for continuous cost-effective programming. In addition, there is the need for efficient and transparent application of resources.

So far, the national HIV response has been largely donor-driven and donor-dependent. This poses considerable challenge to the sustainability of the response particularly in the face of global financial challenges and reducing level of international development assistance. With the uncertain funding landscape at international and global level, the resourcing of the NSF 2017-2021 would require significantly increased public sector funding – to a target of at least 50% of the required resources. A robust advocacy effort is required in this regard, targeted at key stakeholders at both the executive and legislative arms of government at the federal, state, and LGA levels. As the first step, the government of Nigeria needs to honor her existing commitment of 15% budgetary allocation to health (Abuja 2001 and Abuja+12 declaration) and the allocation of 1% of consolidated revenue fund to PHC (Basic Health Care Provision Fund) to facilitate effective decentralization of HIV services. In addition, government needs to explore alternative domestic funding sources and diversify resource mobilization efforts to include cost recovery mechanism and taxes. Increased mobilization of resources from the private sector is also required in support of the NSF 2017-2021.

6.3. Monitoring and Evaluation System

The Monitoring and Evaluation System encompasses three broad groups of activities – monitoring, evaluation, and research.

6.3.1. Monitoring and evaluation of the national HIV and AIDS response

The monitoring and evaluation (M&E) strategy is designed to coordinate and support all stakeholders to regularly and systematically track progress in the implementation of the NSF and the priority initiatives of the NSP. M&E is also required to objectively and effectively assess the performance of stakeholders in accordance with the agreed objectives and performance indicators over the NSP implementation period. It is therefore important to have a comprehensive national reporting mechanism that captures both health and non-health sector data on HIV and AIDS interventions from all actors. All stakeholders need to be made aware of and educated on the use of the reporting tools, timelines and systems. The DHIS2 reporting system needs to be further strengthened and coverage expanded significantly to fully embrace all public facilities, private facilities and community-based service delivery system to enhance the national reporting.

The national systems and structures for data generation, compilation, gender-responsive analysis/synthesis, compilation, dissemination and use all need to be strengthened. The multi-sectoral Monitoring and Evaluation Technical Working Group is a great resource to provide M&E technical and quality assurance support for the national HIV and AIDS response: the Group needs to facilitate regular review and validation of routine HIV/AIDS related data generated.

NACA in collaboration with the relevant stakeholders will develop a National M&E Plan for HIV and AIDS that is linked to the NSF, which in line with the “Three Ones” principle will be used by all partners to track progress made in the implementation of the NSF/NSP 2017-2021 and monitor the effectiveness of the HIV response at national and sub-national levels. The M&E plan will provide detailed description of standard national indicators with baseline figures and targets, data sources for the indicators, data collection and reporting tools, data flow as well as the roles and responsibilities of key stakeholders in implementing the M&E Plan. The M&E Plan will also describe how data generated by the national M&E system will be disseminated and used. Similarly, at the state level, SACAs with support from state level stakeholders will develop state-level M&E plans that are linked to the National M&E Plan and responds to their State HIV and AID Strategic Plans to measure progress in the state HIV and AIDS response.

NACA, SACA and LACA will develop annual work plans to define annual milestones to enable the response strategically and systematically achieve its overall objectives and targets. Joint national and state annual reviews of the HIV and AIDS strategic plans are required to help ensure all stakeholders, states and the country are on track to achieve set targets. A mid-term evaluation will be carried out in 2019 to enable the country identify successes and gaps with the HIV responses. The mid-term evaluation will also provide an opportunity for reviewing the strategic direction of the national and state responses and make relevant adjustments. In addition, an end-of-term evaluation of the national HIV and AIDS response, embracing the federal, state and LGA levels, will be conducted in 2021 to assess the outcomes and impact of activities proposed in the NSP, State and Sectoral Strategic Plans.

6.3.2. Research

The national HIV and AIDS response is evidence-informed. Adequate resources – human, financial and material – should be provided to generate relevant evidence that can be used to improve knowledge of the trends of the epidemic, the drivers of the epidemic, the coverage and quality of interventions, and enhance the effectiveness and efficiency of programming in each of the thematic areas of the NSF, as well as the cross-cutting issues. Resources also need to be invested in the design and implementation of local and collaborative HIV prevention and treatment clinical trials that will increase access of Nigerians to effective and efficient prevention and treatment products. Resources also need to be mobilised to support the conduct of locally relevant, multi-centre studies that would help to identify effective strategies and tools for HIV and AIDS management. The national HIV research policy and agenda need to be revised to support the generation of evidence to ensure efficient and cost-effective HIV prevention, treatment, care and support programming. In this regard, a wide variety of relevant research shall be encouraged, including basic research, implementation research, clinical trials, social science research and systematic reviews.

The research programmes should, among others, identify cost-effective mechanisms to promote reduction of risky behaviour among key and vulnerable populations, and to enhance

prevention-for-positives programmes. Translational and implementation research are needed to improve the application and use of effective, new biomedical HIV prevention tools and strategies.

Multiple platforms should be created and supported for the dissemination and use of research findings. Systems also need to be created to facilitate the prompt translation of the research findings into policies and programmes in ways that ensure that the HIV response is fast-tracked to achieve the national targets in a cost-effective way, and contribute appropriately to global progress.

Annex 1:

Guidance Note for the Development of Sectoral and State

HIV and AIDS Strategic Plan 2017-2021

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1. Introduction

1.1. Background

The National HIV and AIDS Strategic Framework 2017-2021 succeeds and builds on the achievements of the National HIV and AIDS Strategic Framework 2010-2015 and the National HIV and AIDS Strategic Plan 2010-2015, and provides a crucial platform for Nigeria's national HIV and AIDS response. Furthermore, the NSF constitutes the foundation for developing the National HIV and AIDS Strategic Plan.

A strategic plan sets the direction for the future for an entity or programme. The National Strategic Plan, therefore, is a document that articulates the strategic direction for the HIV response of a nation, state, or sector. It highlights the goal(s) to be achieved, and the strategies, priority actions that will lead to the accomplishment of the goals, and institutional framework needed to achieve the goals, among others. Strategic planning is about making deliberate decisions about the pathway into the future.

The Strategic Framework and the Strategic Plan are intrinsically linked, and together constitute the product of a strategic planning process. The Plan is an extension of the Framework: the Framework provides the pillar upon which the Plan is erected. The Framework provides the structure, while the Plan provides the “specifics” of what needs to be done to get to the goal that the Framework defines.

In the Nigerian context, given the federal structure of the country, the constitutional provision that places health on the concurrent legislative list, and the mandates of the various entities involved in the national HIV response, the National Agency for the Control of AIDS (NACA) developed the National Strategic Framework (NSF) as the coordinating entity for the HIV response. The process of developing the Framework was highly participatory, involving a cross-section of stakeholders, from Federal and State government Agencies, Civil Society Organizations, Networks of People Living with HIV, the academia, and international development partners. The National Strategic Plan (NSP), on the other hand, will be developed using a bottom-up approach with States and the various sectors involved in the national HIV response taking the responsibility for developing their HIV response plan. An aggregation of the various State and sectoral plans would result in the NSP.

‘What makes an HIV/AIDS strategy “strategic” is that it takes into account the underlying determinants of the epidemic and how they affect different social groups, and then carefully selects approaches and actions that will address each group to achieve specified results’.
GAMET, World Bank

1.2. Purpose of the National Strategic Plan

The purpose of the NSP is to provide an orientation for all stakeholders on the goal of the national HIV response; provide guidance for the stakeholders and implementing entities regarding the strategic direction of the HIV response in a defined future period (usually about five years); and, a rallying point for harnessing stakeholders commitments, capacities and resources.

1.3. How to use this guide

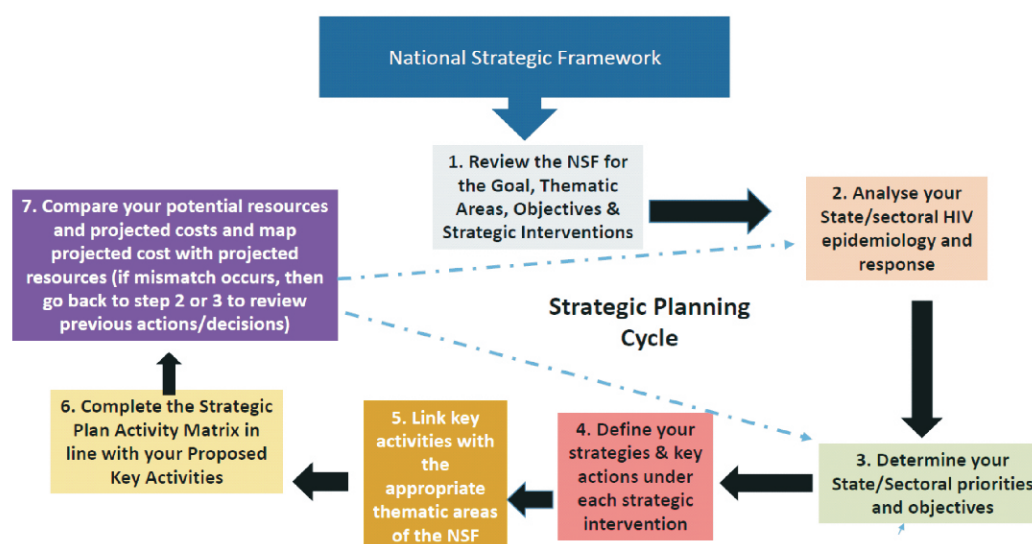
This guide has been developed primarily for State-level as well as Federal level sectoral stakeholders in the field of HIV programming, for the purpose of providing them step-by-step guidance for the development of their HIV strategic plan. Users should read through this document thoroughly before the strategic planning process starts, and use it as a constant reference document throughout the process of developing the Strategic Plan.

2. Strategic Plan Development

A consultative approach should be used in the development of the Strategic Plan, while a core group should be constituted into a Strategic Planning Team that would drive the process, and take charge of the delivery of the desired output. The Team should consist of individuals with relevant knowledge and skills. Care should be taken to ensure that there is a good mix of critical skills in the team, and ensure each thematic area has a stakeholder represented on the team. Also, all major interests/groups within the HIV response field should participate in developing the strategic plan.

The main steps in the strategic plan formulation are illustrated in Figure 1 and described below. It is important to note, as the diagram shows, that rather than being a list of sequential steps or strictly linear process, the development of the plan is iterative in nature, and certain steps may need to be repeated before the final plan is achieved.

Figure 1: The process of delivering the state/sectoral HIV strategic plan⁴



Step I: Review the National Strategic Framework

The National Strategic Framework is the foundation upon which the strategic plans would be developed. Thus, the first step in the process of developing the plan is to be familiar with the key elements of the National Strategic Framework. As such, members of the Strategic Planning Team at the state or sectoral level should carefully read and review the NSF document, and be very familiar with its goal, the thematic areas, objectives, targets, and strategic interventions, among others.

³Some of the desired qualities for the membership of the Strategic Planning Team include: Capacity and authority to make decisions and manage the planning process; Knowledge of how government functions; Ability to manage stakeholder consultations; Ability to coordinate multi-sectoral and private sector inputs; Ability to coordinate community and civil society inputs; Knowledge of the HIV/AIDS situation (epidemiological, social behavioral, legal elements); Program development and management experience; Results-based planning, monitoring and evaluation expertise; Financial management skills (expenditures, budgeting, costing)(UNAIDS (1998): Guide to the strategic planning process for a national response to HIV/AIDS)

⁴ The steps involved in the development of the NSP are iterative in nature.

Step 2: Analyze the State/Sectoral HIV Epidemiology

While the NSF provides the pillars for the framing of the strategic plan document, each strategic plan is to be context-specific. In this regard, the details of the Strategic Plan should be determined by the dynamics of the HIV epidemic and response in the individual state or sector. Two steps are fundamental in this respect:

A. “Know your epidemic”:

Undertake a thorough review of the HIV situation in your state or sector. The questions to answer include the following:

- *What:* What is the prevalence of HIV in the state (or the population that the sector is related to), and ensure appropriate disaggregation (e.g. by sex, by geography - rural and urban areas, socio-economic groups, key populations “versus” general population). What factors shape the spread of the HIV epidemic in the various communities? What are the predominant modes of transmission? What are the drivers of HIV in the State?
- *Who:* Who are the people most affected, and why?
- *Where:* Where are the highest concentrations of the HIV infection in the state?
- *Why:* Why is the epidemic scenario in the state what it is? What explains it? Why is the prevalence higher among some groups or areas compared to others?

B. “Know your response.”

Review the state of your response, with a focus on understanding the following: What progress has been made, and what are the associated factors? What has worked well? What services and interventions were provided/implemented? To what extent has the response improved the access of the key, vulnerable, and general populations to essential services? What has not worked as well? What bottlenecks exist to impede the access of all relevant groups and populations to the needed HIV services? Where are the gaps in the previous response? What are the lessons learned from the implementation of the immediate past HIV strategic plan?

A SWOT analysis may be helpful in further interrogating this issue:

- *Strengths:* What advantages does your state/sector response have? What does your state or sector do well with regards to the HIV and AIDS response?
- *Weaknesses:* What are your challenges and limitations? What could be improved? What should be avoided?
- *Opportunities:* What good opportunities can you identify on the national, state and local front (e.g. policies, laws, guidelines, new funding potentials, changing population profiles, new service models)? What interesting trends are you aware of that you can take advantage of?
- *Threats:* What obstacles do you face that are rooted in factors external to your state/sector (e.g. policies, laws, guidelines, negative changes in external funding landscape)?

⁵ “Strengths” and “weaknesses” are regarded as internal to your State or organization, while “opportunities” and “threats” generally relate to factors external to your state or organization.

Ideally, a synthesis of the HIV epidemiology and response analysis should have been prepared ahead, detailing the facts on the situation of the epidemic and the response. In the absence of that, the Strategic Planning Team and stakeholders should jointly undertake a rapid assessment. This can be done in a workshop setting. The workshop should consist of stakeholders with relevant knowledge and expertise. Care should be taken to ensure that all key institutions and groups that play key role in the sector/state response are represented. The first two days of the of a 5-day strategic planning workshop can focus on a rapid assessment of the HIV situation and response in the state/sector. The workshop should generate answers to the questions raised on the status of the epidemic. Provision of relevant documents and evidence is critical to effective epidemiology and response analysis. You can obtain the evidence from both primary data (new data collected specifically for the task at hand) and secondary data (data collected previously by some other people/organisation, perhaps for a different purpose). It is critical that the epidemiology and resource analysis, and indeed the entire strategic planning process, be evidence-driven.

Part of the analysis at this stage should also include examination of the health systems' capacity (human, infrastructure, administrative, logistics and finance) deployed in the past response as well as analysis and projection of the funds that will be available in the new 5-year response period (This will be discussed further under sub-section 3.4 of this guidance note).

Step 3: Determine the Priority Areas for the State/Sectoral Response

With the background of the analysis that has been carried out, consensus should be built by the Strategic Planning Team on the priority challenges with the HIV response that needs to be addressed in the new Strategic Plan. The team should use existing evidence and an objective approach to determine the challenges that needs to be prioritised for action (See the annex for some examples).

Step 4: Determine the Key Activities to Address the Priority Actions Identified

For each priority area of focus, identify key activities for action. The baseline data for the priority issues/key activities should be identified and documented, and consensus built on key targets to be achieved by the state/sector over the next five years. In identifying the key activities and the targets for the key activities, the strategic planning team (SPT)/stakeholders should bear in mind the national aspiration as expressed in the overarching goal of the NSF. The NSF's overarching goal is "to fast-track the national response towards ending AIDS in Nigeria in 2030". The immediate five-year outcome of the NSF is to achieve the "90-90-90" target.

Step 5: Link the Key Activities to the Appropriate NSF Thematic Areas.

Consider your priorities and key activities in the context of the thematic areas of the NSF. For example, if one of your priorities is to improve access of people living with HIV in your state to ART, then the thematic area is that of "HIV Treatment" (NSF sub-section 4.4). On the other hand, if your priority is primarily to use antiretroviral for prevention (for example, in the context of pre-exposure prophylaxis or post-exposure prophylaxis), the thematic area is "prevention" (NSF sub-section 4.1).

⁶ Secondary data include surveys such as Nigeria Demographic and Health Survey [NDHS], National HIV/AIDS and Reproductive Health Survey [NARHS], and Integrated Behavioural and Biological Surveillance Survey [IBBSS].

Step 6: Complete the Strategic Plan Activity Matrix in line with your Proposed Key Activities

The strategic plan matrix are in the form of Excel Sheets. One sheet has been provided for each thematic area of the strategic plan. The strategic plan matrix has been organized to capture the following information; (a) the Strategic Objective per thematic area; (b) Targets to be achieved per Strategic objective; (c) Strategic Intervention per Target; and (d) Key Activities. Other information to be defined as part of the process includes the target population, levels and timelines for implementation of each activity.

While updating the activity column of the matrix for each Strategic Intervention, bear in mind that some key actions have been identified beforehand *as a guide* (based on the knowledge of the HIV prevention and control field and the national response actions in Nigeria). Further details about these suggested key actions are in the annex. If any of the suggested key actions fits into your state/sectoral intentions, then appropriately complete details required in the row. In case you come up with other actions outside the suggested ones, please put such actions on the blank lines provided (one action on each row), and complete the required details. Please, ensure that you keep the list of new actions to the few essential ones.

National HIV/AIDS Programme-2017-2021 Strategic Plan

Targets	Strategic Intervention	Activities	Target Population	Level of Implementation	Timeline					Cost Assumptions per Activity	Key Responsible Entity	Total Cost by Year					Total Cost
					2017 FY	2018 FY	2019 FY	2020 FY	2021 FY			2017 FY	2018 FY	2019 FY	2020 FY	2021 FY	
Prevention and BCC																	
Strategic Objectives:																	
Target 2: 90-90-90 ⁷ status achieved by 2020	Intervention 2.1: Equal Coverage of ART	1.1.1 Training health workers in 2 LGAs	Adolescent & young Person	State level	✓	✓	✓			11m/30 HIV "3 days" 3 LGAs 1m/1 Rm 2000 "5days" R/GA → Stationary for 30 yrs @ \$20 each and lunch for 30 per LGAs @ \$500 each	CCN, SHAN	900	1,770	9,300,000	6,800,000	10,200,000	28,200,000
		1.1.2			✓	✓	✓					0	0	0	0	0	0
		1.1.3										0	0	0	0	0	0
		1.1.4										0	0	0	0	0	0
		1.1.5										0	0	0	0	0	0
	Intervention 2.2:	2.2.1										0	0	0	0	0	0
		2.2.2										0	0	0	0	0	0
		2.2.3										0	0	0	0	0	0
		2.2.4										0	0	0	0	0	0
		2.2.5										0	0	0	0	0	0
	Intervention 2.3:	3.3.1										0	0	0	0	0	0
		3.3.2										0	0	0	0	0	0
		3.3.3										0	0	0	0	0	0

Step 7: Undertake Resource Mapping and Costing of Proposed Interventions/Actions, and match Projected Cost with Projected Resources

It is useful to note the strategic plan matrix for each thematic area is linked to a costing sheet. As key actions are developed for the strategic interventions, likely cost assumptions (tasks or sub-activities) required to achieve the activity should be defined. Detailed costing sheets based on “activity based costing approach” has been provided to articulate the year-on-year cost of the assumptions.

Map potential resources and cost your proposed actions. Your resource mapping should involve:

- Estimation of your resource envelope: What is the projected revenue that you will have over the next five years, and from what sources? How do you plan to mobilise resources, and from what sources?
- Determination of the cost of your proposed actions: costing should be undertaken using the costing template provided by NACA/NST team.

⁷ The 90-90-90 targets specify that: “by 2020, 90% of all people living with HIV will know their HIV status; by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; by 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.”

Following this, compare your anticipated resources with the projected cost. On that basis, determine which of the following two steps you will take next:

- i. Move forward to complete the Strategic Plan matrices, if there is a good match between the projected revenue and the projected cost, by (i) transferring the cost generated from the costing template to the appropriate cells in the Activity Matrix; and (ii) add the indicator for that activity.
- ii. If there is a significant mismatch between your anticipated resources and costs, then you need to go back and review your priorities guided by the epidemic and response situation, and the strength and weaknesses of your proposed activities to determine the most cost-effective and necessary ones. This “investment approach” demands that you rigorously interrogate the question of what approach can give you the best returns for your investment and finite resources. For example, rather than carry out a particular intervention across the entire state, can it be focussed on specific high burden areas, or specific key population group to reduce the cost of the intervention, and increase the cost-effectiveness of the gains?

The strategic planning process will need to go on iteratively until a good match is achieved between projected revenue and cost, and the Strategic Matrix completed as indicated in option (i) above.

3. Suggested List of Key Activities for Thematic Areas

3.1. Thematic Area I: HIV Prevention among General and Key Populations

Strategic Objective: To significantly reduce the incidence of new HIV infections by 2021.

Target 1: 90% of the general population have access to HIV prevention interventions by 2021.

Strategic Interventions

1.1. Foster a supportive environment for adolescents, youth and other vulnerable populations to access HIV prevention services.

Key Activities

- 1.1.1. DEVELOP AND OR REVISE POLICIES AND REGULATIONS: Adapt, review, produce, disseminate and operationalize available national policies, regulations, protocols and laws regarding provision and access to target populations to friendly HIV prevention services.
- 1.1.2. PROVIDE UP-TO-DATE PROTOCOLS AND GUIDELINES TO SERVICE FACILITIES: Adapt, review, produce, disseminate and operationalize available protocols on friendly HIV prevention service provision for different populations.
- 1.1.3. BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, mentor and provide supportive supervision for provision of friendly HIV prevention services to vulnerable populations and adolescents.
- 1.1.4. FACILITATE ESTABLISHMENT OF FRIENDLY HIV PREVENTION ONE-STOP SERVICE MODELS: Establish friendly service sites providing comprehensive and flexible services using one-stop-shop model
- 1.1.5. FACILITATE COMMUNITY ENGAGEMENT, PARTICIPATION AND MOBILISATION: Improve community participation, support and uptake of HIV prevention services through engagement of existing and new community structures.
- 1.1.6. MOBILISE RESOURCES: Identify sources of funding, strategize to mobilize resources for provision of friendly HIV prevention services.
- 1.1.7. SUPPORT RESEARCH ACTIVITIES: Conduct operational, implementation and other forms of research to identify strategies that best support improved access to HIV prevention services.
- 1.1.8. SUPPORT INTEGRATION AND BUILD LINKAGES BETWEEN SERVICES:

Strengthen the referral and linkages between HIV prevention and other health and social sector services.

1.2. Expand access of in- and out-of-school youths to family life and HIV education

Key Activities

- 1.2.1. REVIEW PROGRAMME IMPLEMENTATION: Review policies, guidelines and coordinating structures to create enabling environment for implementation and monitoring of a sustainable FLHE programme.
- 1.2.2. BUILD CAPACITY OF IN-SCHOOL TEACHERS: Build capacity of in-school teachers to provide gender and cultural sensitive FLHE.
- 1.2.3. BUILD CAPACITY OF COMMUNITY FACILITATORS: Build the capacity of community facilitators to provide gender and cultural sensitive FLHE to out-of-school youths.

1.3. Strengthen innovative strategic behavior change communication for targeted populations.

Key Activities

- 1.3.1. UPDATE THE MAPPING AND SIZE ESTIMATION OF KEY AND VULNERABLE POPULATIONS: Revise and update existing mapping and size estimation for key populations and vulnerable population.
- 1.3.2. REVISE AND IMPLEMENT THE MINIMUM PREVENTION PACKAGE INTERVENTION: Revise and update the MPPI tools to strengthen its impact for HIV risk reduction behavior.
- 1.3.3. DEVELOP TARGETED AND APPROPRIATE HIV PREVENTION COMMUNICATION PLANS: Segment target population in line with the current state HIV epidemics for appropriate Social Behavioral Change Communication (SBCC) messaging.
- 1.3.4. PROMOTE WORKPLACE PROGRAMMES: Establish workplace programmes to support workers of organized private sectors to access HIV prevention services

1.4. Strengthen condom and lubricant programming for general population, including sexually-active young persons.

Key Activities

- 1.4.1. CONDUCT CONDOM NEEDS ASSESSMENT: Conduct a study on condom needs assessment to identify barriers and how to address barriers to access and use of condoms and lubricants.
- 1.4.2. EXPAND ACCESS TO CONDOM AND LUBRICANTS USE: Support innovative approaches to expand access to condoms and lubricants through social and retail marketing.
- 1.4.3. INTENSIFY COMMUNICATION AND EDUCATION ACTIVITIES:

Promote public communication on access and use of HIV prevention strategies and tools using gender and culture appropriate community based strategies.

- 1.4.4. **STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT:** Support commodity supplies forecasting and quantification of HIV prevention commodities including improving the availability of a variety of male and female condoms and lubricants at community and facility level, preventing stock outs and reducing wastage.

1.5. Strengthen non-HIV sexually transmitted infection management programmes.

Key Activities

- 1.5.1. **BUILD CAPACITY OF SERVICE PROVIDERS:** Train, retrain, mentor and provide supportive supervision for management of non-HIV sexually transmitted infection.
- 1.5.2. **DEVELOP APPROPRIATE TOOLS TO IMPROVE STI MANAGEMENT:** Integrate color coded syndromic management of STIs into drop-in centers (DiC) and OSS
- 1.5.3. **PROVIDE UP-TO-DATE PROTOCOLS AND GUIDELINES TO SERVICE FACILITIES:** Adapt, review, produce, disseminate and operationalize available protocols on non-HIV sexually transmitted infection management for different populations:
- 1.5.4. **STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT:** Support commodity supplies forecasting and quantification for non-HIV sexually transmitted infection drugs.
- 1.5.5. **INTENSIFY COMMUNICATION AND EDUCATION ACTIVITIES:** Promote public communication on gender and culture sensitive and appropriate non-HIV sexually transmitted infection.
- 1.5.6. **SUPPORT INTEGRATION AND BUILD LINKAGES BETWEEN SERVICES:** Establish systems for integrating and linking HIV-negative persons to non-HIV sexually transmitted infection; integrate non-HIV sexually transmitted infection into ART and routine HIV prevention services.

Target 2: 90% of key and vulnerable populations adopt HIV risk reduction behavior and access to HIV prevention prophylaxis by 2021

Strategic Interventions

Foster a supportive environment to facilitate access and uptake of appropriate HIV prevention services by key and vulnerable populations.

Key Activities

- 2.1.1. **DEVELOP AND OR REVISE POLICIES AND REGULATIONS:** Adapt, review, produce, disseminate and operationalize available national policies, regulations, protocols and laws to support provision of key and vulnerable population-friendly HIV prevention services.

- 2.1.2. PROVIDE UP-TO-DATE PROTOCOLS AND GUIDELINES TO SERVICE FACILITIES: Adapt, review, produce, disseminate and operationalize available protocols on key and vulnerable population friendly HIV prevention services.
- 2.1.3. ADVOCATE FOR THE REVIEW/REPEAL OF RELEVANT LAWS, AND THE ENFORCEMENT OF SUPPORTIVE LEGAL PROVISIONS: Support organisations to advocate for the revision and repeal of laws, policies and programmes that hinder access of key and vulnerable population to HIV prevention services.
- 2.1.4. BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, mentor and provide supportive supervision for provision of key and vulnerable population-friendly HIV prevention services.
- 2.1.5. FACILITATE ESTABLISHMENT OF KEY POPULATION-FRIENDLY HIV PREVENTION ONE-STOP SERVICE MODELS: Establish key and vulnerable population-friendly service sites providing comprehensive and flexible services using one-stop-shop model.
- 2.1.6. INTENSIFY COMMUNICATION AND EDUCATION ACTIVITIES: Promote public communication on access and use of HIV prevention strategies and tools using key and vulnerable population-friendly strategies.
- 2.1.7. FACILITATE COMMUNITY ENGAGEMENT, PARTICIPATION AND MOBILISATION: Improve community participation, support and uptake of HIV prevention services through engagement of existing and new community structures led by key populations.
- 2.1.8. MOBILISE RESOURCES: Identify sources of funding, strategize to mobilize resources for provision of key and vulnerable population friendly HIV prevention services.
- 2.1.9. SUPPORT INTEGRATION AND BUILD LINKAGES BETWEEN SERVICES: Strengthen the referral and linkages between HIV prevention services and other health and social sector services needed by key and vulnerable populations.
- 2.1.10. SUPPORT RESEARCH ACTIVITIES: Conduct operational, implementation and other forms of research to identify strategies that best support improved access of key and vulnerable populations to HIV prevention services.

2.2. Expand HIV prevention service delivery model(s) that facilitate access of key and vulnerable populations to the minimum prevention package interventions.

Key Activities

- 2.2.1. REVISE THE IMPLEMENTATION OF THE MPPI AND THE NATIONAL PREVENTION PLAN: Revise the national HIV prevention plan and the minimum prevention package intervention to strengthen the delivery and impact of combination prevention services.
- 2.2.2. INTEGRATE SERVICES AND PROMOTE ONE-STOP SERVICE MODEL: Develop a one-stop shop (OSS) to promote access to HIV prevention services,

HTS and HIV treatment.

- 2.2.3. SUSTAIN AND IMPROVE LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Increase procurement and distribution of commodities such as condom, lubricants, family planning, STI drugs, and ART drugs.

2.3. Strengthen facility and community based HIV prevention interventions and service delivery.

Key Activities

- 2.3.1. BUILD AND IMPROVE LINKAGES WITH COMMUNITY STRUCTURES: Set up an effective system to coordinate activities and linkages between institutions, facility services and community-based HIV prevention service providers.
- 2.3.2. SENSITIZE STAKEHOLDERS: Sensitize stakeholders about existing platforms for sharing information and linking facility and community based HIV services.
- 2.3.3. FACILITATE DATA DEMAND AND UTILIZATION: Obtain data for monitoring, evaluation and programme implementation

2.4. Review and implement practice guidelines for community health workers.

Key Activities

- 2.4.1. FORMULATE, REVIEW OR ADAPT SERVICE GUIDELINES: Develop and /or review standard operation procedures for DiC, OSS and other HIV prevention service delivery model
- 2.4.2. BUILD CAPACITY OF COMMUNITY-BASED SERVICE PROVIDERS. Train, retrain, mentor and provide supportive supervisory visits for community based service delivery providers by LACA.
- 2.4.3. IMPROVE QUALITY OF HIV PREVENTION SERVICES: Institute measures to improve the quality of HIV prevention services delivered in community and facility-based services using NIGQUAL system.
- 2.4.4. INSTITUTE QUALITY ASSURANCE PROCESSES: Ensure that quality assurance mechanisms are in place to monitor patient satisfaction, adherence to guidelines, and other quality-related issues.

2.5. Strengthen condom and lubricant programming and promotion for key and vulnerable populations.

Key Activities

- 2.5.1. CONDUCT CONDOM NEEDS ASSESSMENT: Conduct a study on condom needs to identify barriers and how to address barriers to access and use of condoms and lubricants.

- 2.5.2. EXPAND ACCESS TO CONDOM AND LUBRICANTS USE: Support innovative approaches to expand access to condoms and lubricants through social and retail marketing.
- 2.5.3. INTENSIFY COMMUNICATION AND EDUCATION ACTIVITIES: Promote public communication for access and use of HIV prevention strategies and tools using gender and culture appropriate community based strategies.
- 2.5.4. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Support commodity supplies forecasting and quantification of HIV prevention commodities including improving the availability of a variety of male and female condoms and lubricants at community and facility level, prevent stock outs and reduce wastage.

Target 3: 90% of key and vulnerable populations have access to desired HIV prophylaxis by 2021

Strategic Interventions

Strengthen the capacity of health care facilities and other service delivery model(s) to provide HIV prophylaxis (TasP, PrEP, PEP).

Key Activities

- 3.1.1. BUILD CAPACITY OF SERVICE PROVIDERS: Train, re-train, mentor and provide supportive supervision for service providers to provide ARV based HIV prevention services using approved national guidelines
- 3.1.2. PROVIDE UP-TO-DATE PROTOCOLS TO SERVICE SITES: Adapt, review, produce, disseminate and operationalize available protocols on ARV use for HIV prevention.
- 3.1.3. INVOLVE KEY POPULATIONS IN THE DESIGN OF TARGETED SERVICES AND PREVENTION INTERVENTIONS: Involve key populations as liaison and navigators to mobilize and ensure retention of key populations within the system.
- 3.1.4. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Institute procurement and distribution management for ARV based HIV prevention programmes that limits the possible challenges associated with stock-outs.

Target 4: 90% of the general, key and vulnerable population access safe injection practices by 2021.

Strategic Interventions

4.1. Strengthen infection prevention in health care facilities and the community

Key Activities

- 4.1.1. ESTABLISH FUNCTIONAL INFECTION CONTROL COMMITTEES:
- 4.1.2. REVISE AVAILABLE POLICIES, GUIDELINES AND STANDARDS OF INJECTION SAFETY PRACTICES: Revise and disseminate the National Policy on HealthCare Waste Management, National Policy on Infection Prevention and Control, as well as injection safety and healthcare waste management guidelines and standard operating procedures to all health care facilities
- 4.1.3. PROVIDE FACILITIES WITH TOOLS, EQUIPMENT AND MATERIALS FOR SAFE INJECTION PRACTICES: Provide adequate stock of essential injection safety commodities, waste management materials, personal protective equipment, and HIV post-exposure prophylaxis.
- 4.1.4. BUILD CAPACITY OF HEALTH CARE WORKERS: Train. Retrain, monitor and provide supportive supervision for health workers on injection safety practices, waste segregation and proper disposal of medical wastes
- 4.1.5. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Institute procurement and distribution management to prevent stock-outs of injection safety and waste management materials.

4.2. Improve access to harm reduction strategies for PWIDs.

Key Activities

- 4.2.1. DEVELOP AND OR REVISE POLICIES AND GUIDELINES FOR IMPLEMENTING HARM REDUCTION STRATEGIES: Review policies where available or develop and adapt available policies to facilitate enabling environment for implementing harm reduction packages for PWIDs.
- 4.2.2. INTENSIFY COMMUNICATION AND EDUCATION ACTIVITIES: Provide PWID specific targeted information, education and communication messages for safe sex behavior, and to prevent re-use and sharing of needles and syringes.
- 4.2.3. BUILD CAPACITY OF SERVICE PROVIDERS TO REDUCE HIV RISK TAKING BEHAVIOUR BY PWIDs: Train, retrain, mentor, and provide supportive supervision for service providers for harm reduction strategies for PWID at facility and community levels.
- 4.2.4. ESTABLISH ONE-STOP-SHOP MODEL FOR SERVICE DELIVERY TO PWIDs: Establish one-stop-shop service delivery models to provide all the components of harm reduction in a comprehensive, flexible and friendly environment for PWID.

Target 5: 100% of Nigerians have access to safe blood and blood products by 2021

Strategic Interventions

Improve quality management systems for all blood banks.

Key Activities

- 5.1.1. PROMOTE THE IMPLEMENTATION OF NATIONAL STANDARDS: Implement standards specified by NBTS/national policy on screening including 'emergency screening targets of less than 20% of blood transfused
- 5.1.2. INSTITUTE QUALITY ASSURANCE SYSTEM FOR SAFE BLOOD TRANSFUSION: Implement relevant national policies and guidelines to ensure donors, and blood are screened in line with the guidelines.
- 5.1.3. BUILD CAPACITY of SERVICE PROVIDERS: Train, retrain, mentor and provide supportive supervision for service providers on phlebotomy, donor recruitment, laboratory screening blood banking and haemovigilance.

5.2. Improve access to safe blood and blood products.

Key Activities

- 5.2.1. CONDUCT BLOOD DRIVE: Conduct blood drive or campaign to mobilize voluntary and non-remunerated blood donors.
- 5.2.2. INCREASE THE NUMBER OF BLOOD BANKS AND BLOOD CENTRES: Support health tertiary and secondary public and private health facilities to provide safe blood and blood products.
- 5.2.3. LINK NEW BLOOD BANKS TO NATIONAL BLOOD TRANSFUSION CENTRES: Link all health facilities through the hub-and-spoke health care model to national blood transfusion centers for access to safe blood and blood products.

3.2. Thematic Area II: HIV Testing Services

Strategic Objective: To increase access to HIV testing services so as to enable 90% of people living with HIV to know their status and be linked to relevant services.

Target 1: 100% of key populations, 100% of children (age 1 – 9 years) born to HIV-positive mothers, 80% of vulnerable population and 60% of general population access HTS by 2021.

Strategic Interventions

1.1. Foster an enabling environment for improved access to HTS

Key Activities

- 1.1.1. DEVELOP ADVOCACY PLAN AND UNDERTAKE ADVOCACY ACTIVITIES: Advocacy to key stakeholders for improved funding of HTS and biological surveillance for HIV co-infections, revision of relevant

laws, and policies including policies guiding surveillance activities in HIV setting and expansion of services.

- 1.1.2. DEVELOP AND OR REVISE POLICIES AND REGULATIONS: Adapt, review, produce, disseminate and operationalize available national policies, regulations and laws regarding provision and access to HTS and biological surveillance of HIV co-infections.
- 1.1.3. PROVIDE UP-TO-DATE PROTOCOLS & GUIDELINES TO SERVICE FACILITIES: Adapt, review, produce, disseminate and operationalize available protocols on HTS and biological surveillance of HIV co-infections.
- 1.1.4. BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, mentor and supervise healthcare providers in public and private facilities on the implementation of the national policies, protocols and guidelines.
- 1.1.5. MOBILIZE RESOURCES: Identify sources of funding, strategize to mobilize resources for free HTS.
- 1.1.6. SUPPORT RESEARCH ACTIVITIES: Conduct operational, implementation and other forms of research to identify strategies that best support improved access of key and vulnerable populations to HTS.

1.2. Expand coverage of HTS services.

Key Activities

- 1.2.1. MAP EXISTING HTS AND IDENTIFY NEW SITES FOR SERVICE EXPANSION: Map existing HTS sites to assess coverage, identify areas of need/gaps in coverage; identify new sites to expand HIV testing services.
- 1.2.2. EQUIP FACILITIES: Equip new service delivery points.
- 1.2.3. TRAIN SERVICE PROVIDERS: Train and re-train service providers on task shifting and task sharing to enhance HTS delivery.
- 1.2.4. DELIVER SERVICE: Identify and implement appropriate community- and facility- based service delivery approaches.

1.3. Strengthen community systems to support testing and re-testing of key and vulnerable population.

Key Activities

- 1.3.1. FACILITATE COMMUNITY ENGAGEMENT, PARTICIPATION AND MOBILIZATION: Improve community participation, support and uptake of HTS through engagement of existing and new community structures.
- 1.3.2. BUILD CAPACITY OF SERVICE PROVIDERS: Identify, select lay providers, train, retrain, mentor and supervise the provision of HTS in the community.
- 1.3.3. DELIVER SERVICE: Implement the test for Triage and/or other appropriate community-based HTS delivery approaches.

1.4. Strengthen targeted HTS demand generation programmes.

Key Activities

- 1.4.1. DEVELOP DEMAND GENERATION PLAN: Develop plans to guide demand generation activities in hot spots for key and vulnerable populations in high burden areas.
- 1.4.2. GENERATE DEMAND: Use culturally sensitive and audience specific strategies to increase interest in and uptake of HTS especially by adolescents and young people.
- 1.4.3. INCREASE COMMUNITY MOBILISATION: Integrate HTS into prevention services provided to different segments of the population.
- 1.4.4. INTENSIFY COMMUNICATION AND EDUCATION ACTIVITIES: Promote public communication on HTS using gender appropriate community based strategies.

1.5. Promote integration of, and strengthen referral and linkage systems between HTS, other HIV management services, blood transfusion service, and other health-related services.

Key Activities

- 1.5.1. ENGAGE KEY AND VULNERABLE POPULATIONS: Integrate HTS and screening for HIV co-infections into key and vulnerable population's HIV and other health care activities delivered through various service delivery models.
- 1.5.2. SUPPORT INTEGRATION AND BUILD LINKAGES BETWEEN SERVICES: Establish systems for integrating and linking HIV-negatives to prevention services and HIV-positives to treatment, care and other support services.
- 1.5.3. IMPROVE ACCESS TO SAFE BLOOD SERVICES: Build the capacity of service providers for safe blood-related practices (phlebotomy, donor recruitment, laboratory screening, appropriate clinical use of blood and haemo-vigilance); promote blood drive and voluntary non-remunerated blood donation; link HIV treatment center and other health facilities to National Blood Transfusion Services (NBTS) for screening transfusion-transmittable infections (TTIs) and enhance access to safe blood; and, institute/strengthen quality assurance system for safe blood transfusion.
- 1.5.4. TRACK PATIENTS: Institute mechanisms to monitor and follow up all clients referred to care following access to HTS.

⁸A community-based HIV testing approach involving trained and supported lay providers conducting a single HIV rapid diagnostic test (RDT). The lay providers then promptly link individuals with reactive test results to a facility for further HIV testing and to an assessment for treatment. Individuals with non-reactive test results are informed of their results, referred and linked to appropriate HIV prevention services and recommended for re-testing according to recent or on-going national HIV risk guidelines

Target 2: 95% of pregnant women access HTS by 2021

Strategic Interventions

2.1. Expand coverage of HTS services for pregnant women.

Key Activities

- 2.1.1. SUPPORT INTEGRATION AND ESTABLISH NEW SERVICE POINTS: Expand access of pregnant women to HTS at all ANC sites and other sites where pregnant women access care services.
- 2.1.2. BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, mentor and supervise HTS providers for provision of high quality, gender- and human rights-responsive HTS/eMTCT.
- 2.1.3. DELIVER SERVICE: Conduct HIV testing in line with the national guidelines, implement couple and partner HIV testing strategy for all pregnant women and their partners, implement re-testing in the third trimester, during labor or shortly after delivery, because of the high risk of acquiring HIV infection during pregnancy.
- 2.1.4. SUPPORT INTEGRATION AND IMPROVE REFERRALS/LINKAGE FOR MANAGEMENT OF CO-INFECTIONS: Establish systems for integrating and linking HIV-positive pregnant women to services for the management of HIV co-infections

2.2. Strengthen community systems for demand generation for HTS services targeted at pregnant women.

Key Activities

- 2.2.1. DEVELOP DEMAND GENERATION PLAN: Develop plans to guide demand generation activities for HTS focused on identifying HIV-positive pregnant women.
- 2.2.2. INCREASE COMMUNITY MOBILISATION: Conduct community-based outreach targeted at pregnant women.
- 2.2.3. INTENSIFY COMMUNICATION AND EDUCATION ACTIVITIES: Engage lay providers as HTS personnel at community level.

Target 3: 90% of people tested for HIV screened for TB, syphilis, hepatitis B, and hepatitis C.

Strategic Interventions

3.1 Integrate screening for HIV co-infections into HTS activities.

Key Activities

- 3.1.1. BUILD CAPACITY OF SERVICE PROVIDERS: Increase awareness and build capacity of service providers for screening of HIV co-infections especially among key and vulnerable populations.

- 3.1.2. DELIVER SERVICE: Ensure quality assured laboratory screening for syphilis, hepatitis B, hepatitis C and clinical screening for TB.

3.2. Strengthen service linkages and referrals for screening to diagnose HIV co-infections.

Key Activities

- 3.2.1. IMPROVE REFERRALS: Set up referral system to ensure that referrals for laboratory screening for syphilis, hepatitis B, and hepatitis C are done.
- 3.2.2. SUPPORT INTEGRATION AND BUILD LINKAGES BETWEEN SERVICES: Establish systems for linking persons with diagnosed infections to appropriate management and facilitate integration of HTS into all routine health care programmes.

Target 4: 90% of HTS sites establish and maintain quality control measures.

Strategic Interventions

4.1 Strengthen the quality management systems for all HIV testing sites.

Key Activities

- 4.1.1 PROVIDE UP-TO-DATE PROTOCOLS & GUIDELINES TO SERVICE PROVIDERS: Adapt, review, produce, disseminate and operationalize available national HIV testing policy, guidelines and protocols linked to the national laboratory policy and strategic plan.
- 4.1.2 BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, and mentor HTS providers for provision of high quality, gender- and human rights-responsive HTS; and support service providers to prevent burnout.
- 4.1.3 INSTITUTE SUPPORTIVE SUPERVISION: Implement adequate supportive supervision of HIV testing providers.
- 4.1.4 ESTABLISH QUALITY ASSURANCE COORDINATION TEAM: Implement quality assurance cycle that assures optimal HIV testing and HIV co-infection screening results are generated.
- 4.1.5 INSTITUTE QUALITY ASSURANCE PROCESSES: Implement the quality management system in all testing sites.

4.2 Improve the logistics and supply chain management for HTS testing and co-infections screening commodities.

Key Activities

- 4.2.1 IMPROVE FORECASTING AND QUANTIFICATION: Develop and implement accurate forecasting, quantification and procurement systems to avoid stock-out of test kits and consumables.
- 4.2.2 LINK SERVICES TO QUALITY-ASSURED DIAGNOSTICS: Ensure access to quality-assured diagnostics that have had post-market validation in-country.
- 4.2.3 IMPROVE COMMODITY DISTRIBUTION MECHANISMS: Develop and implement appropriate distribution mechanisms to prevent stock out.

3.3. Thematic Area III: Eliminate Mother-to-Child Transmission of HIV

Strategic Objective: To eliminate mother-to-child transmission of HIV in Nigeria by 2021

Target 1: 40% of HIV-positive women use modern contraceptive by 2021

Strategic interventions

1.1 Promote integration and strengthen linkages between sexual and reproductive health services and HIV services at all level.

Key Activities

- 1.1.1. FORMULATE, REVIEW OR ADAPT HEALTH SERVICES INTEGRATION POLICIES: Establish policies on integration of sexual and reproductive health services and HIV services at all levels.
- 1.1.2. INTEGRATE SERVICES: Ensure one-stop access to ANC, eMTCT, MNCH and family planning services.
- 1.1.3. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Support commodity supplies and logistics for integration of eMTCT into ANC, family planning and MNCH services.
- 1.1.4. INSTITUTE SUPPORTIVE SUPERVISION: Implement adequate supportive supervision for providers of eMTCT services.

1.2. Strengthen contraceptive demand generation programmes for HIV positive women.

Key Activities

- 1.2.1. INTENSIFY COMMUNICATION AND EDUCATION ACTIVITIES: Conduct activities to increase awareness on importance of family planning among PLHIV; and integrate HIV care into ongoing programmes that increases demand for use of contraceptives.
- 1.2.2. FACILITATE COMMUNITY ENGAGEMENT, PARTICIPATION AND MOBILIZATION: Sensitize and elicit the support of husband/sex partners, family, community leaders, religious leaders and policy makers for eMTCT.

1.3. Improve access of HIV-positive women to family planning services.

Key Activities

- 1.3.1. INCREASE FAMILY PLANNING SERVICE DELIVERY POINTS: Increase family planning services delivery points in health facilities and in the community.
- 1.3.2. BUILD CAPACITY OF FAMILY PLANNING PROVIDERS: Train, re-train and mentor family planning service providers to provide quality of family planning services for HIV positive mothers.

Target 2: 95% of HIV positive pregnant and breastfeeding mothers receive antiretroviral therapy by 2021.

Strategic interventions

2.1. Expand access of HIV positive pregnant and breastfeeding mothers to antiretroviral therapy services.

Key Activities

- 2.1.1. INTENSIFY COMMUNICATION AND EDUCATION ACTIVITIES: Conduct public education programmes to promote utilization of antenatal care, delivery, and postnatal services provided by skilled personnel.
- 2.1.2. INCREASE eMTCT SERVICE DELIVERY POINTS: Integrate eMTCT services into services delivery packages of primary, private, and community-based health facilities.
- 2.1.3. SUPPORT INTEGRATION, LINKAGES AND REFERRAL FOR eMTCT: Establish functional “Hub and spoke” referral system where they do not exist, and sustain the system where it exists to improve availability of PMTCT services at PHC and private facilities.
- 2.1.4. BUILD CAPACITY OF HEALTH CARE PROVIDERS: Build the capacity of health care workers to provide ART to pregnant and breastfeeding women to HIV positive pregnant women.
- 2.1.5. DELIVER SERVICES: Implement the “test and treat” policy and the Option B+ antiretroviral strategy that ensures in accordance with national policy and guidelines
- 2.1.6. IMPROVE AND SUSTAIN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Support commodity supplies and logistics for provision of integrated eMTCT services and prevent stock-out of commodities.

2.2. Strengthen community systems for improved access of HIV positive pregnant and breastfeeding mothers to antiretroviral therapy.

Key Activities

- 2.2.1. MOBLISE COMMUNITY SUPPORT AND PARTICIPATION: Support CSO and Ward Development Committees to create public support for PMTCT access, and linkages of pregnant and breastfeeding women to eMTCT services
- 2.2.2. SUPPORT COMMUNITY SYSTEMS TO ENHANCE ACCESS TO ANTIRETROVIRAL THERAPY: Engage men, families, community and religious leaders to support and encourage women to seek eMTCT services; and support community systems and structures that promote access of HIV positive pregnant women to ART refills.

2.3. Ensure supportive environment for HIV positive pregnant and breastfeeding mothers to access antiretroviral therapy.

Key Activities

- 2.3.1. REVISE AND IMPLEMENT POLICIES AND GUIDELINES TO IMPROVE ACCESS TO eMTCT SERVICES: Formulate and or implement policies that support the access of pregnant and breastfeeding women to ART.
- 2.3.2. ELIMINATE STIGMA AND DISCRIMINATION BY SERVICE PROVIDERS: Train, re-training and institute corrective and punitive measures for health care workers to eliminate stigmatization and discrimination of HIV-positive pregnant women.
- 2.3.3. MOBILIZE RESOURCES FOR eMTCT SERVICE PROVISION: Develop an advocacy plan to guide the process of resource mobilization from public, private and community institution for the scale up of eMTCT service provision.
- 2.3.4. SUPPORT RESEARCH ACTIVITIES: Conduct operational, implementation and other forms of research to identify strategies that best support access of different populations to eMTCT services.

2.4. Ensure quality assurance mechanism in all facilities providing PMTCT services for mothers and babies.

Key Activities

- 2.4.1. IMPROVE QUALITY OF eMTCT SERVICES: Institute measures to improve the quality of eMTCT services delivered in community and facility-based services using NIGQUAL system.
- 2.4.2. INSTITUTE QUALITY ASSURANCE PROCESSES: Ensure that quality assurance mechanisms are in place to monitor patient satisfaction, adherence to guidelines, and other quality-related issues.
- 2.4.3. SUPPORT RESEARCH ACTIVITIES: Conduct operational, implementation and other forms of research to identify strategies that best support improved access of HIV positive women to eMTCT services.

Target 3: 95% of all HIV exposed infants receive antiretroviral prophylaxis by 2021.

Strategic Interventions

3.1. Expand the access of HIV exposed infants to antiretroviral prophylaxis.

Key Activities

- 3.1.1. INCREASE ACCESS OF HIV-EXPOSED INFANTS TO ARV PROPHYLAXIS: Support all HIV-positive women to have access to antiretroviral prophylaxis for use by exposed infants in line with the national guidelines.

- 3.1.2. FOLLOW UP HIV-EXPOSED INFANTS TO ENSURE USE OF ARV PROPHYLAXIS: Institute appropriate mechanisms to follow-up and track defaulting mother-infant pairs and ensure access to ARV prophylaxis for exposed infants.
- 3.1.3. BUILD CAPACITY OF HEALTH CARE PROVIDERS: Train, retrain, mentor and supervise health care workers to ensure access of HIV exposed infants to ARV prophylaxis.
- 3.1.4. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Improve logistics management system to ensure constant availability of pediatric antiretrovirals and avoid stock-out.

3.2. Strengthen community systems to support access of HIV exposed infants to needed services.

Key Activities

- 3.2.1. SUPPORT COMMUNITY PARTICIPATION, SUPPORT AND MOBILIZATION: Support activities of the Ward Development Committees, CBO, FBO and other community structures to link mothers and their babies for EID services, serological tests, ARV prophylaxis and co-trimoxazole access.
- 3.2.2. BUILD CAPACITY OF COMMUNITY AND LAY SERVICE PROVIDERS: Train, retrain, mentor and provide supportive supervision for care providers to ensure HIV-exposed infants have access to EID service, serological tests, ARV prophylaxis and co-trimoxazole access

Target 4: 95% of all HIV exposed infants have early infant diagnosis (EID) within 2 months of age by 2021.

Strategic Interventions

4.1. Expand access to early infant diagnosis (EID) services.

Key Activities

- 4.1.1. INCREASE ACCESS OF HIV-EXPOSED INFANTS TO EID SERVICE: Establish EID services in all secondary health care service centers to which eMTCT sites are linked. Facilitate point of care EID service delivery at all eMTCT sites.
- 4.1.2. BUILD CAPACITY OF LABORATORIES TO PROVIDE EID SERVICES: Train and use appropriate technology to reduce the turn-around time for EID results.
- 4.1.3. FOLLOW UP HIV-EXPOSED INFANTS TO ENSURE UPTAKE OF EID: Institute appropriate mechanisms to follow-up and track defaulting mother-infant pairs and ensure access to EID services.
- 4.1.4. INSTITUTE QUALITY ASSURANCE PROCESSES: Ensure that quality assurance mechanisms are in place to monitor adherence to guidelines, and other quality-related issues for EID services.

Target 5: 95% of all HIV-exposed infants receive co-trimoxazole prophylaxis within 2 months of birth by 2021.

Strategic Interventions

5.1. Expand access of all HIV-exposed infants to co-trimoxazole prophylaxis within 2 months of birth

Key Activities

- 5.1.1. INCREASE ACCESS OF HIV-EXPOSED INFANTS TO CO-TRIMOXAZOLE: Support all HIV-exposed children to have access to co-trimoxazole at all eMTCT site in line with the national guidelines.
- 5.1.2. FOLLOW UP HIV-EXPOSED INFANTS TO ENSURE USE OF CO-TRIMOXAZOLE: Institute appropriate mechanisms to follow-up and track defaulting mother-infant pairs and ensure access to co-trimoxazole for exposed infants.
- 5.1.3. BUILD CAPACITY OF HEALTH CARE PROVIDERS: Train, retrain, mentor and supervise health care workers to ensure access of HIV exposed infants to co-trimoxazole.
- 5.1.4. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Improve logistics management system to ensure constant availability of co-trimoxazole for children.

Target 6: 90% of HIV-exposed babies have access to HIV serological test by the age of 18 months by 2021

Strategic Interventions

6.1. Expand access of HIV-exposed babies to HIV serological test.

Key Activities

- 6.1.1. INCREASE ACCESS OF HIV-EXPOSED INFANTS TO HIV SEROLOGICAL TEST: Support all HIV-exposed children to have access to HIV serological tests at 18 months at all eMTCT site in line with the national guidelines.
- 6.1.2. FOLLOW UP HIV-EXPOSED INFANTS TO ENSURE UPTAKE OF HIV SEROLOGICAL TESTS: Institute appropriate mechanisms to follow-up and track defaulting mother-infant pairs and ensure access to HIV serological tests for exposed infants.
- 6.1.3. BUILD CAPACITY OF HEALTH CARE PROVIDERS: Train, retrain, mentor and supervise health care workers to support HIV-exposed infants to access HIV serological tests.
- 6.1.4. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Support commodity supplies and logistics to provide HIV-exposed infants to access HIV serological tests at 18 months.

3.4. Thematic Area IV: HIV Treatment

Strategic Objective: All diagnosed PLHIV receive quality HIV treatment services to ensure sustained virological suppression

TARGET 1: 90% of diagnosed PLHIV are on ART by 2021.

Strategic Interventions

1.1. Ensure supportive environment for delivery of ART services.

Key Activities

- 1.1.1. DEVELOP ADVOCACY PLAN: Develop an advocacy plan to guide the process for increasing public and private institutional support for ART.
- 1.1.2. ADVOCACY TO KEY STAKEHOLDERS: or increased and sustained funding of ART service delivery.
- 1.1.3. REVISE AND IMPLEMENT SERVICE RELATED POLICIES AND GUIDELINES: Adapt, review, produce and disseminate relevant policies and guidelines; and operationalize relevant policies and guidelines.
- 1.1.4. BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, mentor and provide supportive supervision for service providers in public and private facilities for implementation of relevant ART policies and guidelines and provision of quality services.
- 1.1.5. MOBILIZE RESOURCES FOR ART SERVICE PROVISION: Develop an advocacy plan to guide the process of resource mobilization from public, private and community institutions for the scale up of ART service provision.
- 1.1.6. SUPPORT RESEARCH ACTIVITIES: Conduct operational, implementation and other forms of research to identify strategies that best support access of different populations to ART services.

1.2. Expand coverage of ART services.

Key Activities

- 1.2.1. MAP EXISTING AND POTENTIAL ART SERVICE SITES: Map existing sites to assess coverage and gaps in service delivery; and identify new sites for expansion of ART Service delivery.
- 1.2.2. IDENTITY NEW ART SERVICE DELIVERY SITES: Increase the number of secondary and comprehensive primary health care centers, private health care centers and community based service organizations that can provide ART services in close proximity to areas of need including camps for internally displaced persons.
- 1.2.3. SUPPORT INTEGRATION, LINKAGES AND REFERRAL FOR ART ACCESS: Integrate ART service delivery into routine health care service delivery institutions; strengthen efforts at decentralization and integration of ART service delivery programmes.

- 1.2.4. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Improve logistics management system to ensure constant availability of ARVs, operation of laboratory support services for viral load assessment; and effective mobilization of ARV stocks to prevent stock-outs in all ART facilities.
- 1.2.5. BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, mentor and provide supportive supervision for staff providing ART services in public, private and community-based health care institutions; and ensure availability of guidelines, protocols and SOPs at service delivery points.
- 1.2.6. DELIVER SERVICE: Institute support for implementation of the test and treat programme at all ART sites.

TARGET 2: 90% of diagnosed PLHIV on treatment are retained in care by 2021

Strategic Interventions

2.1. Strengthen health care services to support differentiated care

Key Activities

- 2.1.1. REVISE AND IMPLEMENT SERVICE POLICIES AND GUIDELINES THAT FACILITATE ACCESS OF PEOPLE LIVING WITH HIV TO DIFFERENTIATED CARE: Ensure that National Integrated Guidelines for ARV use address the differential ART needs of adults, adolescents and children.
- 2.1.2. BUILD CAPACITY OF STAKEHOLDERS TO IMPLEMENT DIFFERENTIATED CARE SERVICE DELIVERY MODELS: Train, retrain, mentor and provide supportive supervision for stakeholders on provision of differentiated care for people living with HIV.
- 2.1.3. ESTABLISH COMMUNITY AND FACILITY BASED TARGETED SERVICE DELIVERY POINTS: Establish adolescent clinics to support transition between child and adult care and family care clinics to reduce frequency of clinic visits for PLHIV.
- 2.1.4. SUPPORT INTEGRATION, LINKAGES AND REFERRAL FOR ART ACCESS: Integrate ART service delivery into existing integrated population-specific care programmes; and strengthen referral and linkage systems between care centers.

2.2. Improve adherence counselling and tracking mechanisms for PLHIV accessing facility-based services.

Key Activities

- 2.2.1. BUILD CAPACITY FOR ADHERENCE COUNSELLING AND SUPPORT: Train, retrain, mentor and provide supportive supervision for counselors and ART service providers to support PLHIV to adhere to

drug use and clinic visits; Strengthen disclosure education and support for parents/ guardians of HIV-positive adolescents.

2.2.2. ESTABLISH COMMUNITY-BASED ADHERENCE SUPPORT

MECHANISMS: Set up age, population and culturally appropriate mechanisms in the community that would support medication adherence for stable patients who require fewer clinic visits.

2.2.3. SET UP RAPID RE-ENTRY PROGRAMMES: Fast track the location of PLHIV missing drug pick up appointments and reabsorb into ART programmes;

2.3. Strengthen quality assurance mechanisms for ART related services.

Key Activities

2.3.1. PROVIDE UP-TO-DATE PROTOCOLS & GUIDELINES TO SERVICE PROVIDERS: Adapt, review, produce, disseminate and operationalize available national ART policy, guidelines and protocols.

2.3.2. BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, and mentor ART providers for provision of high quality, gender and human rights responsive ART services.

2.3.3. INSTITUTE SUPPORTIVE SUPERVISION: Implement adequate supportive supervision for ART service providers.

2.3.4. ESTABLISH QUALITY ASSURANCE COORDINATION TEAM: Implement quality assurance cycle that assures optimal ART services and client satisfaction.

2.3.5. INSTITUTE QUALITY ASSURANCE PROCESSES: Implement the quality management system in all ART sites using the HIVQUAL.

2.3.6. SUPPORT RESEARCH ACTIVITIES: Conduct operational, implementation and other forms of research to identify strategies that best support improved access of HIV positive clients to ART services.

2.4. Expand access of PLHIV to viral load assessment services.

Key Activities

2.4.1. USE EXISTING POINT-OF-CARE EQUIPMENT TO FACILITATE VIRAL LOAD ASSESSMENT: Use existing point-of-care equipment to conduct viral load assessment in a cost effective manner.

2.4.2. STRENGTHEN EXISTING AND ESTABLISH NEW VIRAL LOAD TESTING CENTRES: Strategically expand diagnostic capacity to reach areas of poor coverage

2.4.3. SUPPORT SERVICE INTEGRATION AND IMPROVE SERVICE LINKAGES AND REFERRALS: Support the use of existing laboratory facilities with capacity for viral load assessment to expand to conduct virological testing to reduce turn-around time.

2.4.4. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Support commodity supplies and logistics to support HIV-exposed

infants to access HIV serological tests at 18 months.

- 2.4.5. BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, mentor and provide supportive supervision for staff to conduct viral load assessment and apply its use for patients' care.

TARGET 3: 90% of eligible PLHIV receive co-trimoxazole prophylaxis by 2021.

Strategic Interventions

Improve access of PLHIV to co-trimoxazole prophylaxis using facility and community-based structures.

Key Activities

- 3.1.1. BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, mentor and provide supportive supervision for staff on use of co-trimoxazole prophylaxis in adults and children living with HIV.
- 3.1.2. EDUCATE PLHIV ON NEED FOR CO-TRIMOXAZOLE: Support health care workers and support group education for PLHIV on importance and use of co-trimoxazole prophylaxis.
- 3.1.3. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Improve logistics management system to ensure availability of co-trimoxazole at ART facilities.

TARGET 4: All PLHIV diagnosed with TB have access to TB services by 2021

Strategic Interventions

4.1 Expand access of all PLHIV to screening for tuberculosis and prompt treatment for positive cases.

Key Activities

- 4.1.1. SUPPORT SERVICE INTEGRATION AND IMPROVE SERVICE LINKAGES AND REFERRALS: Increase the number of patient-centered "One Stop Shops" where HIV and TB services are integrated; fast-track the establishment of ART service delivery in existing DOTS Centers; and integrate TB service delivery at ART sites.
- 4.1.2. BUILD CAPACITY OF SERVICE PROVIDERS: Train, retrain, mentor and provide supportive supervision for health care workers who provide ART and TB services on use of GeneXpert MTB/Rif, management of TB in HIV-positive children, HIV-positive pregnant women and patients with HIV co-infection.
- 4.1.3. STRENGTHEN LOGISTICS AND SUPPLY CHAIN MANAGEMENT: Support commodity supplies and logistics to support HIV and TB co-infection management.
- 4.1.4. SUPPORT SERVICE INTEGRATION AND IMPROVE SERVICE

LINKAGES AND REFERRALS: Support the use of existing Tuberculosis and ART sites for HIV/TB co-management; and facilitate effective referral and linkages between ART and TB sites.

3.5. Thematic Area V: HIV Care, Support and Adherence

Strategic Objective: To improve access of People living with HIV (PLHIV), vulnerable children, and people affected by HIV/AIDS (PABA) to **comprehensive rights-based care**.

Target 1: 90% of PLHIV access quality care and support services by 2021.

Strategic interventions

1.1. *Expand access of PLHIV to community-based care and support services*

Key Activities

- 1.1.1. MAP AND INCREASE COMMUNITY-BASED CARE AND SUPPORT SERVICE SITES: Establish new community-based care and support services.
- 1.1.2. TARGET PLHIV WITH SBCC: Organize targeted SBCC to promote PLHIV's awareness and utilization of community-based care and support services through SBSS
- 1.1.3. BUILD CAPACITY OF PLHIV AND NETWORKS FOR SERVICE DELIVERY: Train, retrain, mentor and provide supportive supervision for PLHIV and their networks to provide home-based care services.
- 1.1.4. PROVIDE RESOURCES TO PLHIV SUPPORT GROUPS AND NETWORKS FOR HOME-BASED CARE: Advocate for and mobilize resources for home-based care services as an integral component of HIV management for people living with HIV.

1.2. *Ensure quality management of community-based care and support services for people living with HIV.*

Key Activities

- 1.2.1. PROVIDE UP-TO-DATE GUIDELINES & PROTOCOLS FOR COMMUNITY-BASED SERVICES: Work with PLHIV to revise existing protocols to improve the quality of community-based services
- 1.2.2. BUILD CAPACITY OF PLHIV AND NETWORKS TO MONITOR AND SUPERVISE COMMUNITY-BASED CARE SERVICES: Build the capacity of networks to institute mechanisms for monitoring and supervision of community-based care services.
- 1.2.3. MONITOR AND SUPERVISE COMMUNITY-BASED SERVICES: Empower PLHIV networks to formally report back on outcomes of monitoring and supervision of community-based services as an integral part of non-health sector response.

1.3. Strengthen the adherence counseling system at facilities.

Key Activities

- 1.3.1. SELECT AND TRAIN FACILITY-BASED AND COMMUNITY ADHERENCE COUNSELLORS: Identify women who have gone through PMTCT to serve as mentor mothers; build capacity of PLHIV and community health workers to serve as adherence counselors
- 1.3.2. MONITOR AND SUPERVISE ACTIVITIES OF ADHERENCE COUNSELLORS: Include supervision of adherence counselors in the role of hospital care workers' supervisors and LACA supervisors

Target 2: 90% of vulnerable children enlisted for care and support services access those services by 2021.

Strategic Interventions

- 2.1. *Strengthen the coordination between relevant care and support social services to holistically address the care and support needs of vulnerable children.*

Key Activities

- 2.1.1. REVIEW/ESTABLISH AND RE-ORIENTATE RESPONSE COORDINATION STRUCTURES
- 2.1.2. ORGANISE REGULAR, PERIODIC MULTI-SECTORAL COORDINATION AND PROGRAMME MEETINGS FOR EFFECTIVE COORDINATION:
- 2.1.3. INCREASE SERVICE POINTS FOR CARE AND SUPPORT FOR VC: Increase and support CBO engaged with vulnerable children's care.
- 2.1.4. LINK ALL VULNERABLE CHILDREN'S CARE AND SUPPORT ORGANIZATIONS TO HEALTH CARE FACILITIES: Link organizations working with vulnerable children to health care facilities through the Hub-and-Spoke health care structure
- 2.1.5. BUILD QUALITY ASSURANCE ACTIVITIES INTO SERVICES: Strengthen the quality assurance mechanisms for home-based care and support services

- 2.2. *Strengthen community-based systems to mobilize resources and implement care and support services for VC in line with the national care and support guidelines.*

Key Activities

- 2.2.1. CONDUCT ORGANISATIONAL CAPACITY ASSESSMENTS FOR RELEVANT CSOs: Use the NHOCAT and PADEF to identify gaps in organizational capacity.
- 2.2.2. PROVIDE TECHNICAL SUPPORT TO CSO FOR PROGRAMME OPERATIONS: Support Civil Society Organisations to address gaps identified during capacity assessment.

- 2.2.3. BUILD CAPACITY OF CIVIL SOCIETY OPERATIVES: Train, retrain, mentor and provide supportive supervision for Civil Society Organisations engaged with in HIV care and support programming for PLHIV.
- 2.2.4. FACILITATE ACCESS OF CSO TO RESOURCES: Support CSO to access human, institutional and financial resources to implement care and support services.

Target 3: 90% of the males and females age 5-49 years display non-discriminatory attitudes towards PLHIV and PABA by 2021

Strategic Interventions

3.1. Strengthen the implementation of the HIV and AIDS Anti-discrimination Act

Key Activities

- 3.1.1. ORIENTATE LEGAL OFFICERS AND LAW ENFORCEMENT AGENCIES ON THE ANTI-STIGMA LAW: Support legal agencies on implementation of the HIV and AIDS Anti-discrimination Act
- 3.1.2. ADVOCATE FOR PASSAGE AND OR ENFORCEMENT OF ANTI-STIGMA LAW: Encourage the passage and or enforcement of anti-stigma laws in all States in Nigeria.
- 3.1.3. EDUCATE THE POPULATION ABOUT HIV AND AIDS-RELATED STIGMA: Conduct awareness, sensitization and education programmes for community members on HIV-related stigma and its effect; integrate information on HIV and AIDS-related stigma into the Family Life and HIV Education.
- 3.1.4. EDUCATE COMMUNITY MEMBERS ABOUT THE ANTI-STIGMA LAW: Conduct awareness, sensitization and education programmes for community members and other key community stakeholders and groups on the HIV and AIDS Anti-discrimination Act.

3.2. Build the capacity of health care workers and other service providers on relevant codes of conduct and respect for human dignity.

Key Activities

- 3.2.1. TRAIN SERVICE PROVIDERS: Train and retrain health workers and other service providers on relevant codes of conduct and respect for human dignity.
- 3.2.2. INSTITUTE PUNITIVE MEASURES FOR HEALTH CARE PROVIDERS WHO STIGMATIZE AND DISCRIMINATE: Advocate for health care institutions to institute punitive measures for health care providers who stigmatize PLHIV; and educate PLHIV of existing support mechanisms to address stigma and discrimination.

3.3. *Develop and implement behavior change communication targeted at reducing stigma and discrimination against persons living with HIV and AIDS.*

Key Activities

- 3.3.1. DEVELOP COMMUNICATION PLAN AND PRODUCE ANTI-STIGMA COMMUNICATION MATERIALS TO ADDRESS HIV-RELATED STIGMA AND DISCRIMINATION: Work with NACA and communication experts to revise SBCC to address stigma and discrimination in the general public.
- 3.3.2. EDUCATE COMMUNITY MEMBERS: Conduct awareness and sensitization at community level for prevention of HIV stigma and discrimination.

3.4. *Promote access to justice for PLHIV and PABA, including the use of community-based mechanisms.*

Key Activities

- 3.4.1. EDUCATE PLHIV AND PABA: Educate PLHIV and PABA about HIV and AIDS Anti-discrimination Act and how to seek justice.
- 3.4.2. ADVOCATE FOR STRENGTHENING AND ESTABLISHMENT OF LEGAL AID GROUPS: Strengthen existing and set up new legal aid groups to enhance access of PLHIV and PABA to justice.
- 3.4.3. SUPPORT THE OPERATIONS OF COMMUNITY-BASED MEDIATION/ CONFLICT RESOLUTION MECHANISMS: Work with the Ministry of Justice to support community-based resolution of cases of stigma and discrimination.

Target 4: 90% of PLHIV access Positive Health Dignity and Prevention (PHDP)-related services by 2021.

Strategic Intervention

4.1 *Integrate sexual and reproductive health and rights into routine care for PLHIV.*

Key Activities

- 4.1.1 PROVIDE SEXUAL AND REPRODUCTIVE HEALTH EDUCATION TO PLHIV: Integrate sexual and reproductive health education into ongoing facility and community based education programmes for PLHIV.
- 4.1.2 SUPPORT INTEGRATION, REFERRAL AND LINKAGES TO FAMILY PLANNING SERVICES: Integrate contraceptive access services for PLHIV treatment, care and support programmes; and facilitate access of PLHIV to family planning services through appropriate linkages and referrals.

4.2 *Integrate nutritional counselling and support into routine care for PLHIV.*

4.2.1 PROVIDE NUTRITIONAL EDUCATION TO PLHIV IN ROUTINE CARE SETTING: Integrate nutritional education into ongoing facility- and community-based HIV care programmes for PLHIV.

4.2.2 UNDERTAKE REGULAR NUTRITIONAL ASSESSMENT AND COUNSELLING FOR PLHIV: Screen PLHIV for nutritional status as part of the routine assessment.

4.2.3 SUPPORT INTEGRATION, REFERRAL AND LINKAGES TO SERVICES: Integrate nutrition care and management into routine PLHIV treatment, care and support programmes; and facilitate access of PLHIV to nutritional services through appropriate linkages and referrals.

4.3 *Integrate mental health and psycho-social services into routine care for PLHIV.*

4.3.1 PROVIDE MENTAL HEALTH AND PSYCHOLOGICAL ASSESSMENT FOR PLHIV IN ROUTINE CARE SETTING: Integrate mental health and psychological assessment into ongoing facility- and community-

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