FEDERAL REPUBLIC OF NIGERIA

NATIONAL HIV AND AIDS STRATEGIC PLAN

2017-2021

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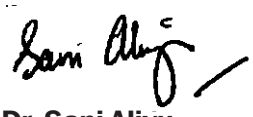
FOREWORD

Traditionally the development of HIV/AIDS strategic plans in Nigeria has followed a top down approach principally due to the Federal nature of governance and perceived capacity deficiency at sub-national levels. This approach has led to products that were non-responsive to the states' epidemic status, capacity and available resources. Thus, most state SSPs in the past were inadequately implemented due to poor local ownership and resourcing and seldom guided implementation. The development of the National Strategic Plan (NSP) 2017-2021 was a robust and collaborative process involving all the relevant stakeholders and with a bottom- up approach. The process involved strategic plans at subnational and national level that were evidence driven and promoted ownership at all levels, synergy of efforts among the different partners and built on gains made so far in the national HIV response.

The vision of the NSP 2017-2021 is "An AIDS-free Nigeria, with zero new infection, zero AIDS-related discrimination and stigma, with a broad goal to "Fast-track the national response towards ending AIDS in Nigeria by 2030". In line with the UNAIDS investment framework, the NSP 2017-2021 targets five thematic areas: (i) Prevention of HIV among General and Key Populations; (ii) HIV Testing Services; (iii) Elimination of Mother-to-Child transmission of HIV (eMTCT); (iv) HIV Treatment; and, (v) Care, Support and Adherence. The NSP also recognizes the role played by a number of cross-cutting issues and programme enablers (gender and human rights, health systems and community systems strengthening & service integration, coordination and institutional arrangement, policy, advocacy and resource mobilization, monitoring and evaluation and leadership, ownership and sustainability) that are critical to achievement of the vision, goal, objectives and targets outlined therein.

NACA recognizes and acknowledges the technical and financial support of the Federal Government of Nigeria and our donors and partners in the development of the NSP 2017-2021. Civil Society, PLHIV and the states also played an important role and this is appreciated. The Federal Government of Nigeria led by NACA remains committed to our collective vision of an AIDS-free Nigeria, with zero new infections and zero AIDS related discrimination and stigma. It is hoped that the relevant stakeholders will use the NSP 2017-2021 to guide planning and implementation of programs, interventions and activities so that our set goal, objectives and targets would have been achieved five years from now.



Dr. Sani Aliyu
Director General
NACA

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The visionary leadership of the Director- General of NACA, Dr Sani Aliyu and his Directors in ensuring access to much needed resources for the development of this document is appreciated. It is worthy to mention the support from the Country Offices of UNAIDS, WHO, UNICEF and Women in Nigeria.
This document was developed in an all-inclusive process with contributions from key sectors of the National HIV/AIDS response. The adit to this was the National HIV/AIDS Strategic Framework (2017 – 2021). The support garnered from our partners; Civil Society Networks especially NEPWHAN, CiSHAN, ASHWAN, APYN; Ministries and Agencies, SACAs and other key interest groups too numerous to itemise is duly acknowledged and appreciated.

Our profound appreciation also goes to the lead and costing consultants Professor Segun Fatusi, and Mr. Emeka Nsofor. Your passion, dedication, and commitment to contributing to the attainment of an HIV/AIDS free Nigeria is acknowledged.
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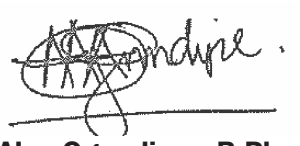
Overall appreciation goes to God Almighty for the privilege and seeing this through.



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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
CiSNHAN	Civil Society Network for 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
eMTCT	Elimination of Mother-to-Child Transmission of HIV
ENR	Enhancing National Response to HIV and AIDS in Nigeria
EID	Early Infant Diagnosis of HIV
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	International Development Partners
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 Action Committee on AIDS
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistant TB
MPPI	Minimum Prevention Package Intervention
MIPA	Meaningful Involvement of People Living with HIV and AIDS
MSM	Men who have Sex with Men
MTCT	Mother-to-child transmission of HIV
NACA	National Agency for the Control of AIDS

NACS	Nutritional Assessment, Counselling and Support
NARHS	National AIDS and Reproductive Health Surveys
NASA	National AIDS Spending Assessment
NASCP	National AIDS/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
PCRP	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 of HIV
PrEP	Pre-exposure Prophylaxis
PWID	People Who Inject Drugs
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SACAs	State Action Committees on AIDS/State Agency for the Control of AIDS
SBCC	Strategic Behavioural Change Communication
SDPs	Service Delivery Points
SKM	Strategic Knowledge and Management
SMEDAN	Small and Medium 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
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
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
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 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 mobilising the required resources to that end.

The National HIV and AIDS Strategic Framework (NSF) 2017-2021 and National HIV and AIDS Strategic Plan (NSP) 2017-2021 were developed through a highly participatory and consultative process that involved a wide cross-section of stakeholders; these strategic documents succeed the National HIV and AIDS Strategic Framework 2010-2015 and the National HIV and AIDS Strategic Plan 2010-2015.

Vision of the National Strategic Plan

The vision of the NSP is "An AIDS-free Nigeria, with zero new infection, zero AIDS-related discrimination and stigma"

Goal of the National Strategic Plan

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

Thematic Areas and Cross-Cutting Issues

The National Strategic Plan has five thematic areas: (i) Prevention of HIV among General and Key Populations; (ii) HIV Testing Services; (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 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.

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 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 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.

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 population 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 **c**ontraceptive prevalence rate of 40% achieved among HIV-positive women by 2021

Target2: 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 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 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.

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.

Target3: 90% of eligible PLHIV receive co-trimoxazole prophylaxis by 2021.

Target4: 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. Institutionalise 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 access those services by 2021.

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

Target4: 90% of PLHIV access -positive health, dignity and prevention 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 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. 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 institutionalised 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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1.1. 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 mobilising the required resources to that end.

This National HIV and AIDS Strategic Plan is designed to guide the national response to HIV and AIDS from 2017 though 2021. It builds on the achievements of the previous national frameworks and plans. Prior to the development of the 2017-2021 Framework and Plan, the national HIV and AIDS response was previously 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 2017-2021 strategic framework and plan 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.” The 2017-2021 framework and plan also recognize 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 $4^{o}16'$ and $13^{o}53'$ to the north of the equator and longitudes $2^{o}40'$ and $14^{o}41'$ 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 not recognized as such. 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 implementing many 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%. With an estimated population of slightly above 182 million in 2015, the United Nations ranked 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: 62% of the population are in 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: this signifies 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, and the health beliefs and health-seeking behaviour 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, and male circumcision. On the other hand, practices such as widowhood rites, female genital mutilation (FGM), denial of access of women to inheritance, encouragement of multiple sexual partners for males, and mariage of 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 age 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 the 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 the armed clashes between the nomadic Fulani herdsmen and indigenous farming communities, and the 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 HIV-risky sexual behaviour such as selling of sex by young girls. Boko Haram has resulted in the worst humanitarian challenge in Nigeria's history with about 15 million people affected since 2009, and over two million people internally displaced. About seven million people are estimated to require humanitarian assistance in 2016. Natural disasters that result in displacement of populations also have implications for HIV incidence.

1.3. NSP 2017-2021 development process

The NSP 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 NSP development process consisted of five key stages: (i) Preparatory stage; (ii) Framing of the national response priorities and strategies; (iii) Finalisation of the drafting of the NSF and approval; and, (iv) Development and costing of the State and sectoral HIV response plans; and, (v) Consolidation of the State and Sectoral HIV response plans and finalization of the NSP

The Preparatory Stage: Technically, the development of the NSF and NSP started in 2015 with the preparatory processes. As part of that effort, the Strategic Knowledge and 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 evaluation and end-of-term evaluation of the 2010-2015 National HIV/AIDS Strategic Plan (NSP).

The Policy Department developed a roadmap for

the NSF and NSP 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 and NSP 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 epidemics 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 organisations 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 on 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.

Finalisation of the Drafting of the Strategic Framework and Approval: 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 feedbacks were received during a one-day meeting of stakeholders, which involved members of the Steering Committee, for validation of the draft NSF document. The feedbacks were used to finalise the draft NSF document, in readiness for presentation to the National AIDS Council for its approval.

Development and costing of the State and sectoral HIV response plans: The National HIV and AIDS Strategic Plan 2017-2021 (NSP) was developed using a bottom-up approach: the NSP was developed based on the consolidation of the State Strategic Plans (SSPs) and the Strategic Plans of federal-level line Ministries, Departments and Agencies (MDAs), which themselves were informed and guided by the National Strategic Framework. For the process of developing the state and sectoral strategic plans, the NSF consultants developed guidance notes to facilitate the work of the State Consultants. A costing template was also included alongside the framework and its guidance notes. The guide was shared with stakeholders for their review and comments. Feedbacks received were used in revising and finalising the guidance note. Thus, the guidance note provided a guide for all stakeholders in developing their strategic plan in a robust, evidence-driven, systematic and standard way that can easily feed into the National Strategic Plan. Based on the review and approval of the final version of the Framework and the guidance note, an orientation training was given to the state thematic and costing consultants alongside the SACA/SMoH focal officers. The state consultants then worked with state stakeholders in their various states to develop a

costed SSP, which was then forwarded to NACA. The SSPs provided a basis for interactions with relevant NACA officers and national consultants to further understandings regarding the state prioritization process and outcomes.

Consolidation of the State and Sectoral HIV response plans and finalization of the NSP: ***T***he plans submitted by states and federal level MDAs were consolidated by the lead consultant and the costing consultant into the National Strategic Plan.

1.4. Rationale for the NSP 2017-2021

The 2010-2015 National Strategic Plan gave strategic direction for the HIV response in Nigeria. Its implementation resulted in the reduction in 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 increasing access to high-quality high-impact interventions and key populations. Also, new evidence-based guidelines on the use of antiretroviral drugs for treating and preventing new HIV infection issued by the World Health Organization (WHO), and the resultant changes to the Nigeria's HIV treatment protocol in 2015 with the adoption of the "test and treat approach" and acknowledgement of the need to use ARV for HIV prevention meant that the National HIV response in Nigeria needs to take on new approaches.

The NSF and NSP 2017-2021 is the nation's attempt to build on past successes, achievement 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 needs to be addressed to achieve global and national goals. This new NSP 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 Goal, and the 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."

In addition, the new NSF and NSP provide 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.

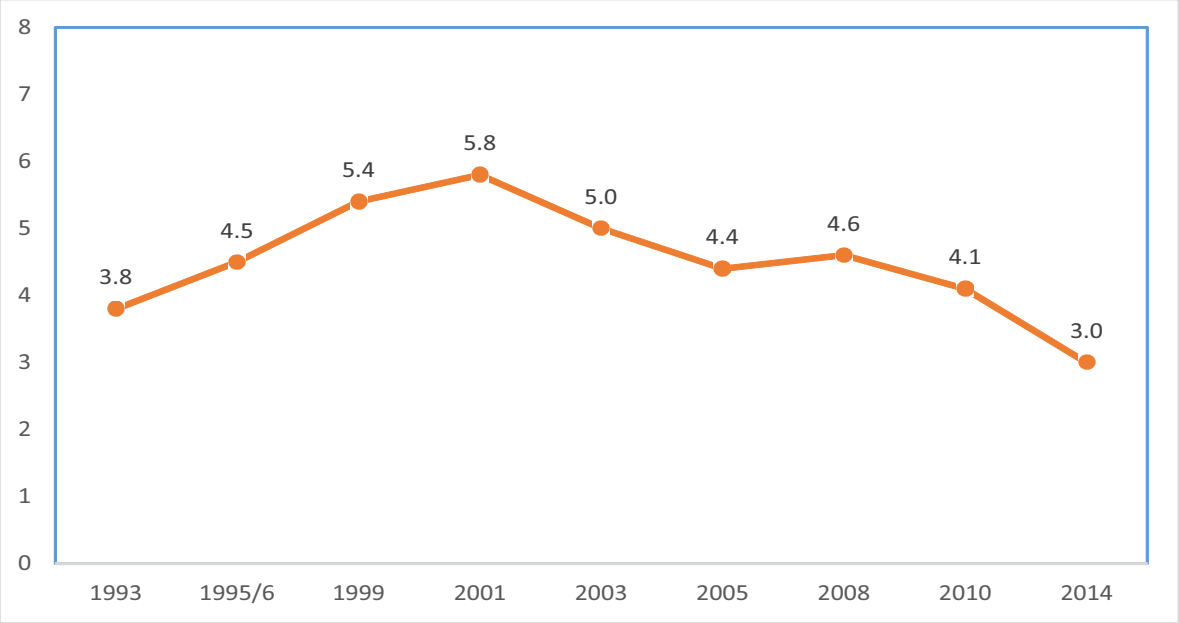
2. HIV Situation and Response in Nigeria

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 Behavioural 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 in 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 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

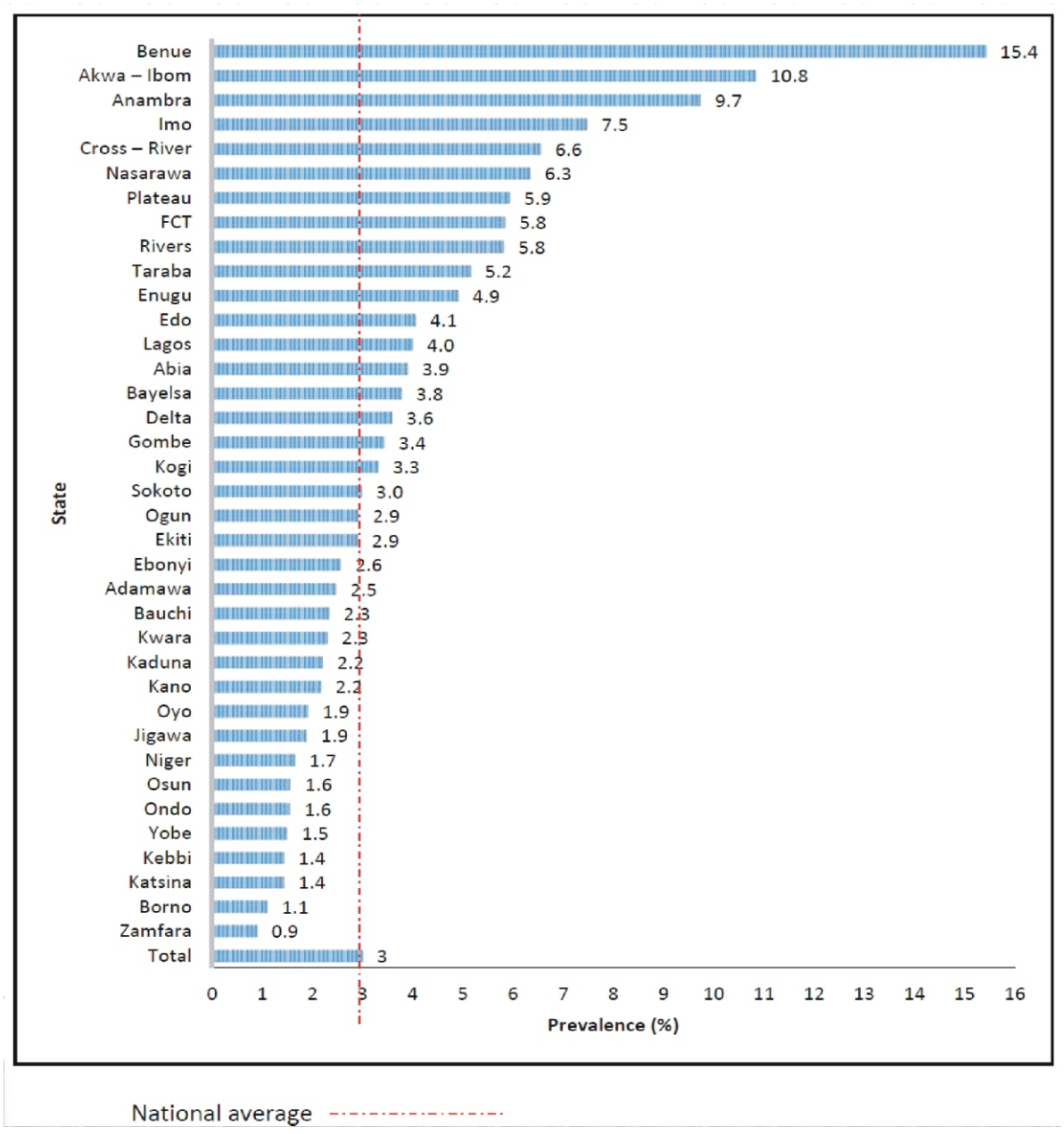


Source: FMoH, 2015.

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%), River (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 cl inics 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).

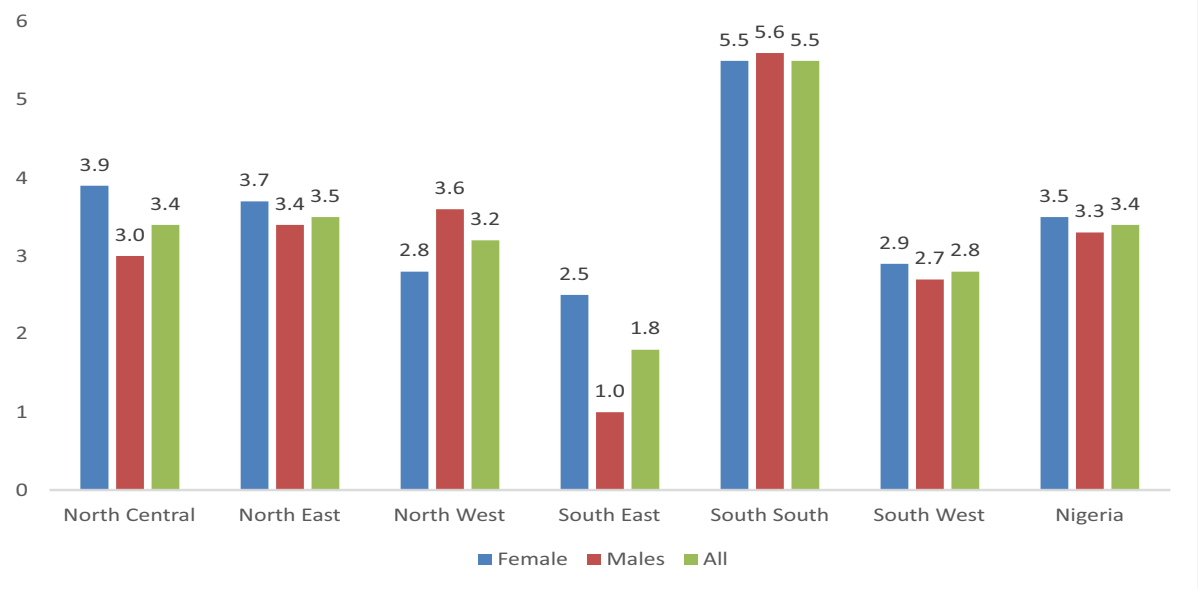
Table 1: HIV prevalence among pregnant women attending sentinel ante -natal clinics by zones: Nigeria, 2014

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).

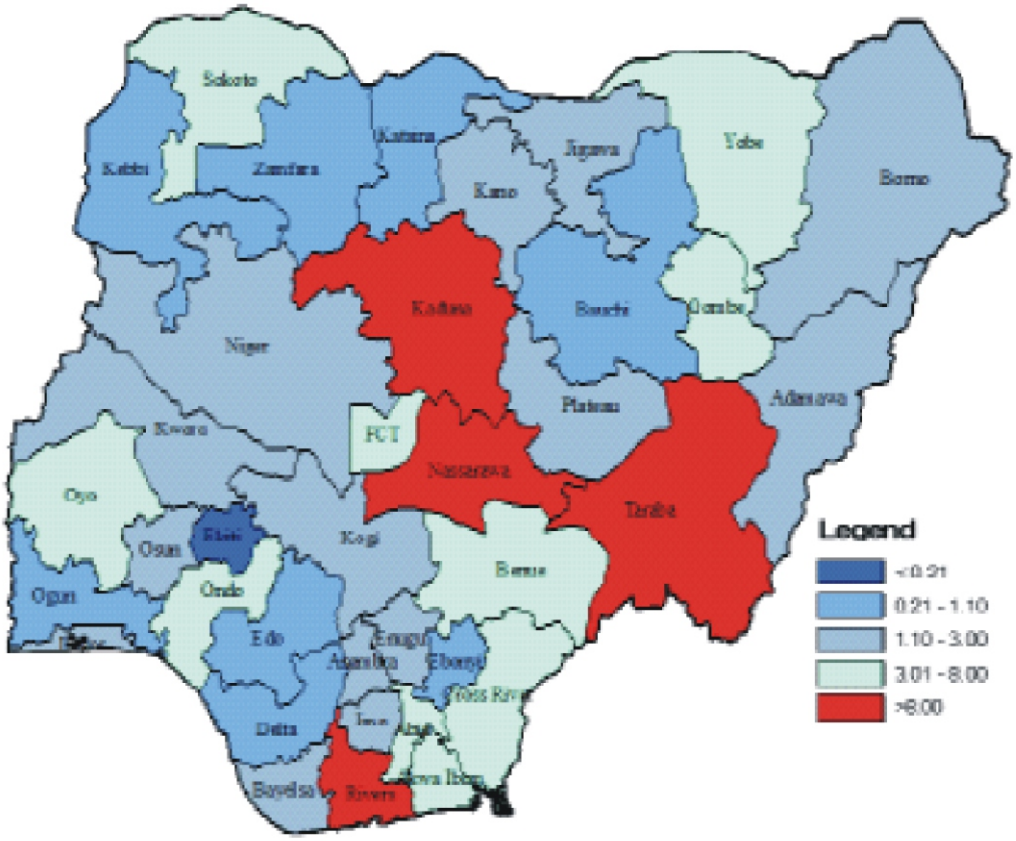
Figure 3: HIV prevalence among the general population by zone and sex: Nigeria, 2012



Source: FMoH, 2013.

At the State level, the 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, 11states and the FCT had HIV prevalence rates higher than the national average of 3.4%.

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



Source: FMoH, 2013.

The HIV prevalence was highest among those 35-39 years old (4.4%) and lowest among those 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 2: HIV prevalence according to selected characteristics; Nigeria, 2012

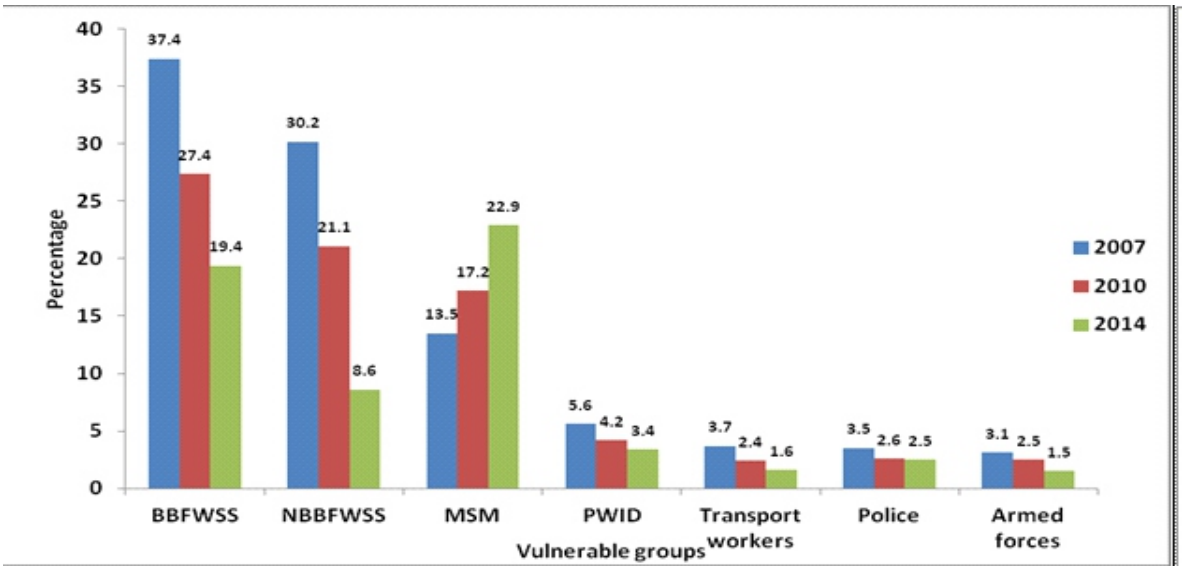
Characteristics	HIV prevalence rate	95% CI
Location		
Urban	3.2	2.8 -- 3.6
Rural	3.6	3.3 -- 3.9
Education		
No Formal Education	2.5	2.1 -- 2.9
Qur'anic only	2.4	1.7 -- 3.3
Primary	3.9	3.3 -- 4.5
Secondary	3.9	3.5 -- 4.3
Higher	3.5	2.9 -- 4.2
Marital Status		
Currently Married sexual	3.5	3.3 -- 3.8
Never 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 2009study on the mode of transmission of HIV in Nigeria (MOT)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 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%), BBFSS (9.4%), NBBFSS (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).

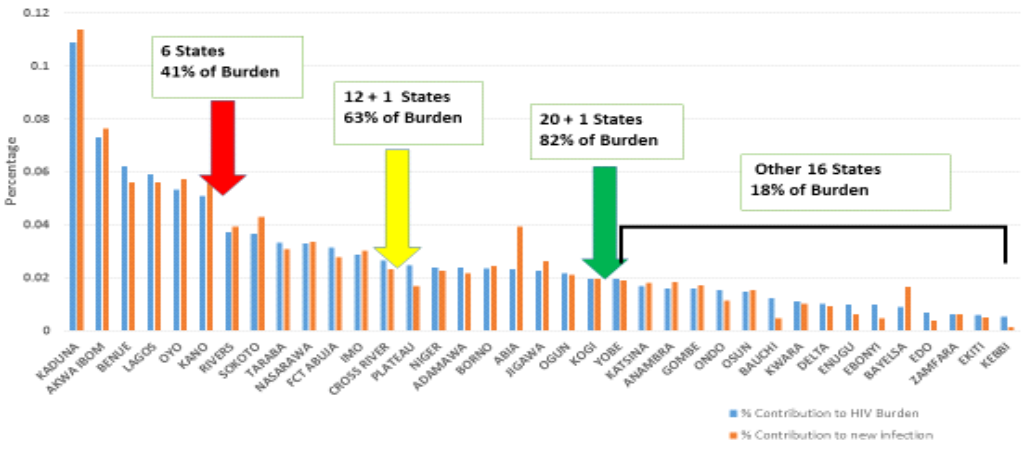
Figure 5: Trends in HIV prevalence among key and vulnerable populations: Nigeria, 2007 - 2014



Source: FMOH, 2013

As shown by the UNAIDS modeling, 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 2013.

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 HIV-risky sexual behaviours 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 risk behaviours 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 behaviour 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.

Table 3: Factors that predispose to HIV transmission in Nigeria

Route of transmission	Local practices/behaviour or conditions	Epidemiological implication
Sexual route	-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	-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 of 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	-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	-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)	-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	-Increase the risk of mother to child transmission of HIV
Inoculation through skin practices, blood-letting procedures	- 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	- 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.

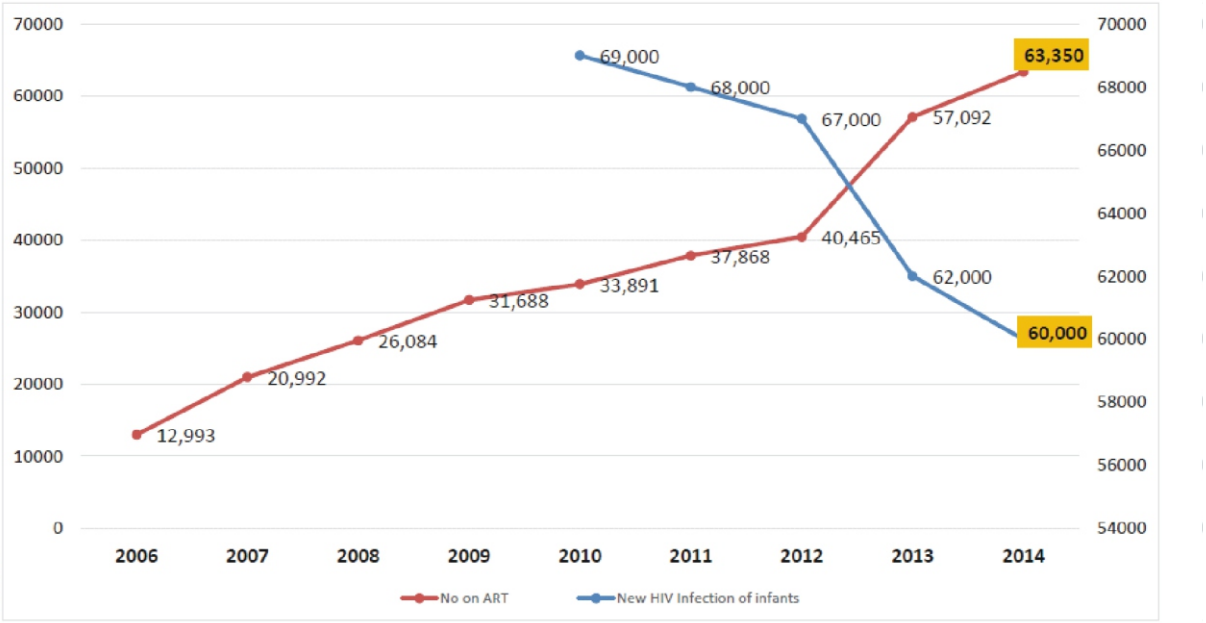
At the end of 2015, an estimated 3,037,363 people were living with HIV in Nigeria, including 238,504 children aged 0-14 years and 1,639,593 women age 15 years and above. The end-of-term evaluation report of the National HIV and AIDS Strategic Plan 2010-2015and other data sources provide an insight into 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.

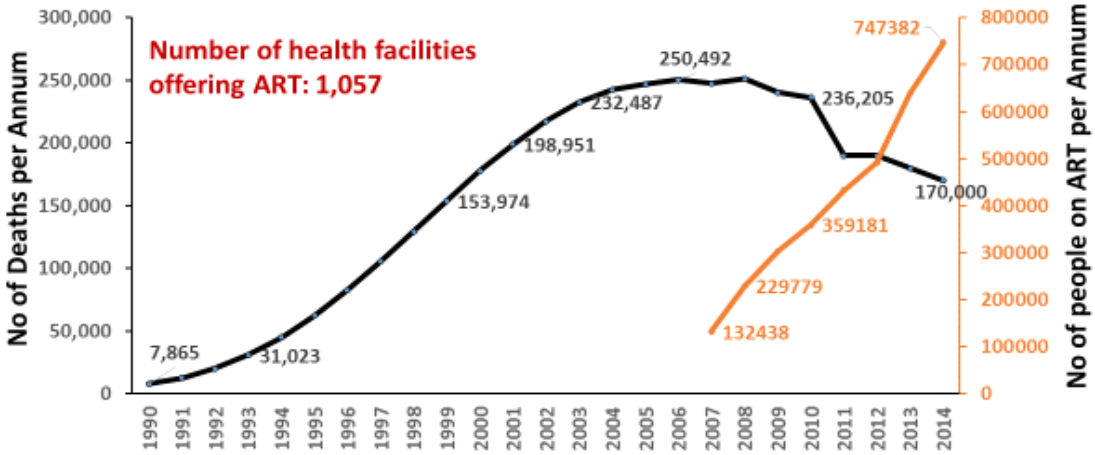
Figure 7: HIV-positive pregnant women on ART and new HIV casesaverted among infants: Nigeria, 2006-14



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 8: 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, 202,434 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 enforcement 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, and the development of the 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 had 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 through which all partners engaged in the HIV response are coordinated 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 systems are 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 HIV response.

Monitoring and evaluation systems: Data collected at the national and state levels are analysed 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. Development Context

The NSF and NSP are developed in the context of the following:

1. *The 1999 Constitution of the Federal Republic of Nigeria*: 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 delineate the roles and responsibilities of the various level of government and other stakeholders in the health arena, as well as their relationships; and the 2016 Health Policy that 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 Operationalisation of the Continental Policy Framework for Sexual And Reproductive Health and Rights, which prioritises, 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 (of African Union Member States of commitments 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 of which Nigeria fully subscribes to.

3.2. Guiding Principles

The provisions of the NSP and 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 with 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-based and gender-sensitive*: 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. *Optimisation 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 NSP.

3.3. Vision

The vision of this NSP is "An AIDS-free Nigeria, with zero new infection, zero AIDS-related discrimination and stigma"

3.4. Goal

The goal of the NSP is to "Fast-track the national response towards ending AIDS in Nigeria by 2030"

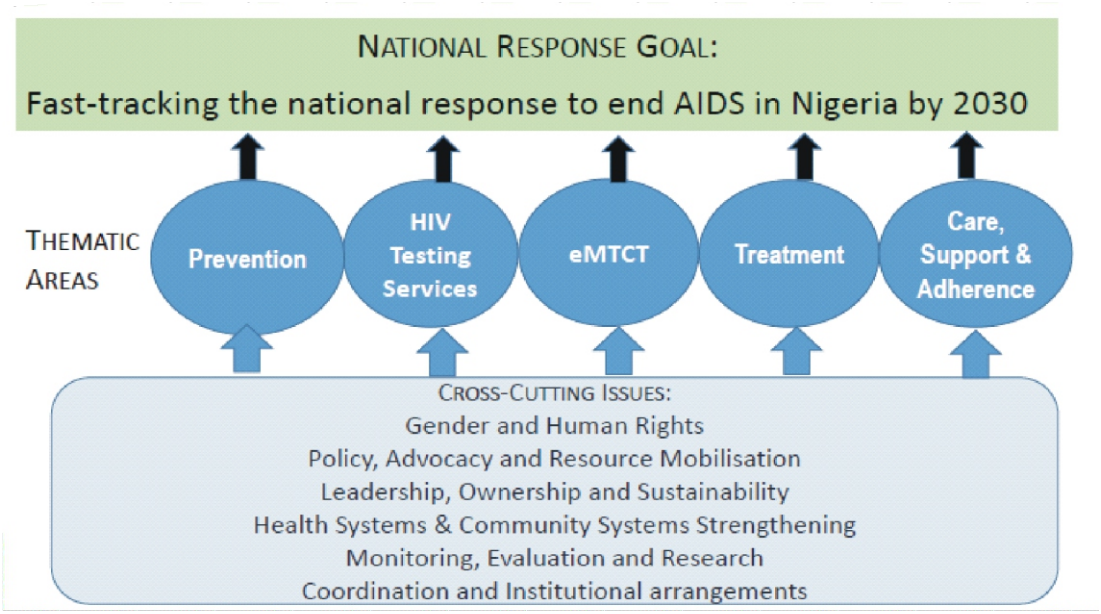
3.5. Thematic Areas

The thematic areas of the NSP 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 NSP has five thematic areas:

1. Prevention of HIV among General and Key Population
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.

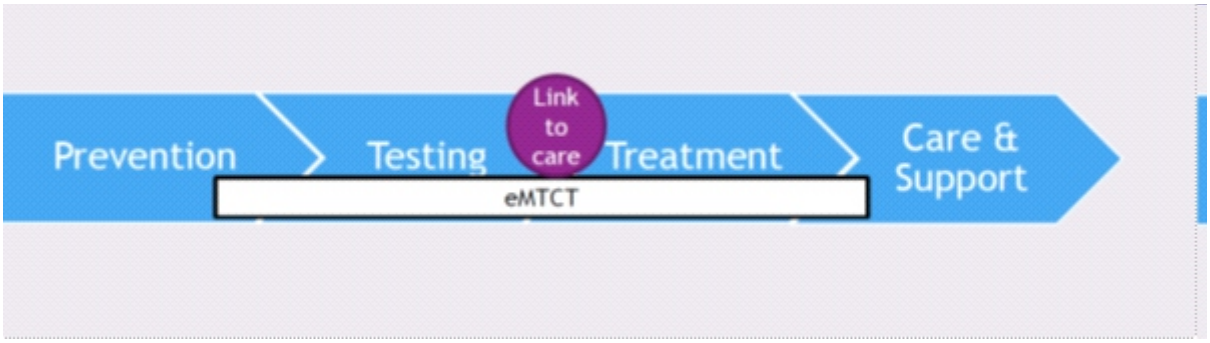
Figure 9: National Goal and Linkage with Thematic Areas and Cross-cutting Issues



4. Objectives, Targets, and Strategic Interventions

The objectives of the NSP 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



4.1.1. 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 HIV-risky sexual behaviours, unsafe blood and blood products, use of non-sterile needles in people who inject drugs (PWID), and mother-to-child transmission. This Plan 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 Plan recognises 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 behaviour change. The Plan 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 (ii) 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 access safe injection practices by 2021.

1.1.4. 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 using.
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. Major Activities

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

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

Major Activities

- *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 client-centered and friendly HIV prevention services.
- *Provide Up-to-Date Protocols and Guidelines to Service Facilities and Promote their Utilisation*: Adapt, review, produce, disseminate and operationalize available protocols on client-centered and friendly HIV prevention service provision for different populations.
- *Build the Capacity of Service Providers*: Train and retrain service provider, promote mentoring and provide supportive supervision for provision of client-centered friendly HIV prevention services to vulnerable populations and adolescents.
- *Facilitate the Establishment of friendly HIV Prevention One-Stop Service Model*: Establish friendly service sites providing comprehensive and flexible services using one-stop shop model
- *Facilitate Community Engagement, Participation and Mobilisation*: Improve community participation, support and uptake of HIV prevention services through engagement of existing and new community structures.
- *Mobilise Resources*: Develop and effectively implement a resource mobilisation plan to generate increased domestic funds from public, private (private-for-profit, non-profit and development-focused foundations) and community institutions to support the provision of friendly HIV prevention services to adolescents, youth and other vulnerable population; also mobilise international development assistance in support of the services
- *Support Research Activities*: Conduct operational, implementation and other forms of research to identify strategies that best support improved access to HIV prevention services.
- *Support Integration and Build Linkages between Services*: Strengthen the referral and linkages between HIV prevention and other health and social sector services.

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

Major Activities

- *Review Programme Implementation for Improved Performance*: Review policies, guidelines and coordinating structures to create enabling environment for implementation and monitoring of a sustainable FLHE programme.
- *Build the Capacity of In-School Teachers*: Build capacity of in-school teachers to provide gender and cultural sensitive FLHE.

- *Build the Capacity of Community Facilitators and Community Resource Persons*: Build the capacity of community facilitators and community resource persons to provide gender and cultural sensitive FLHE to out-of-school youths.

4.1.5.3. Strengthen innovative strategic behaviour change communication for targeted populations.

Major Activities

- *Update the Mapping and Size Estimation of Key and Vulnerable Populations*: Conduct relevant research to revise and update existing mapping and size estimation for key populations and vulnerable population.
- *Revise and Implement the Minimum Prevention Package Intervention*: Revise and update the MPPI tools to strengthen its impact for HIV risk reduction behaviour.
- *Develop Targeted and Appropriate HIV Prevention Communication Plans:* Segment target population in line with the current state HIV epidemics for appropriate Social Behavioural Change Communication (SBCC) messaging.
- *Promote Workplace Programmes*: Establish workplace programmes to support workers of organized private sectors to access HIV prevention services

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

Major Activities

- *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.
- *Expand Access to Condom and Lubricants Use*: Support innovative approaches to expand access to condoms and lubricants through social and retail marketing.
- *Intensify Communication and Education Activities*: Promote public communication and health education on access and use of HIV prevention strategies and tools using gender and culture appropriate community based strategies.
- *Strengthen Logistics and Supply Chain Management*: Support commodity supplies forecasting and quantification of HIV prevention commodities to improve, among others, the availability of a variety of male and female condoms and lubricants at community and facility level, as well as prevent stock-outs and reduce wastages.

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

Major Activities

- *Build the Capacity of Service Providers*: Train and retrain service providers, promote mentoring and provide supportive supervision for management of non-HIV sexually transmitted infection.
- *Develop Appropriate Tools to Improve STI Management:* Integrate color-coded syndromic management of STIs and other user-friendly management tools into drop-in centres (DiC) and OSS.
- *Provide Up-To-Date Protocols and Guidelines to Service Facilities and Promote their Utilisation*: Adapt, review,

produce, disseminate and operationalize available protocols on non-HIV sexually transmitted infection management for different populations:

- *Strengthen Logistics and Supply Chain Management*: Support commodity supplies forecasting and quantification for drugs for non-HIV sexually transmitted infections.
- *Intensify Communication and Education Activities*: Promote public communication and SBCC on gender and culture sensitive and appropriate non-HIV sexually transmitted infection.
- *Support Integration and Build Linkages between Services*: Establish systems for integrating and linking HIV-negative persons to non-HIV sexually transmitted infections; 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 behaviour and access to HIV prevention prophylaxis by 2021

Strategic Interventions

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

Major Activities

- *Develop and/or Revise Relevant 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.
- *Provide Up-To-Date Protocols and Guidelines to Service Facilities and Promote Utilisation*: Adapt, review, produce, disseminate and operationalize available protocols on key and vulnerable population friendly HIV prevention services.
- *Advocate for the Review/Repeal of Relevant Laws, and the Enforcement of Supportive Legal Provisions*: Support organisations to advocate for the revision and repellent of laws, policies and programmes that hinder access of key and vulnerable population to HIV prevention services.
- *Build the Capacity of Service Providers*: Train and retrain service providers, promote mentoring and provide supportive supervision for provision of key and vulnerable population friendly HIV prevention services.
- Facilitate the Establishment of Key Population Friendly HIV Prevention One-Stop Service Model: Establish key and vulnerable population friendly service sites providing comprehensive and flexible services using one-stop shop model.
- *Intensify Communication and Education Activities*: Promote public communication and education on access and use of HIV prevention strategies and tools using key and vulnerable population friendly strategies.
- *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.
- *Mobilise Resources*: Develop and effectively implement a resource

mobilisation plan to generate increased domestic funds from public, private (private-for-profit, non-profit and development-focused foundations) and community institutions to support the provision of friendly HIV prevention services to key and vulnerable population; also mobilise international development assistance in support of the services

- *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.
- *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.

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

Major Activities

- *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 delivering and impact of combination prevention services.
- 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.
- *Sustain and Improve Logistics and Supply Chain Management*: Improve the procurement and distribution of HIV-related commodities such as condom, lubricants, family planning, STI drugs, and ARVs.

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

Major Activities

- *Build and Improve Linkages with Community Structures*: establish an effective system to coordinate activities and linkages between institutions, facility services and community based HIV prevention service providers.
- *Sensitise Stakeholders*: Sensitise stakeholders about existing platforms for sharing information and linking facility and community based HIV services.
- *Facilitate Data Demand and Utilisation*: Obtain data for monitoring, evaluation and programme implementation

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

Major Activities

- *Formulate, Review or Adapt Relevant Service Guidelines*: Develop and /or review standard operation procedures for DiC, OSS and other HIV prevention services delivery model
- *Build the capacity of community service providers*: Train, retrain, mentor and provide supportive supervisory visits for community based service delivery providers by LACA.
- *Improve the Quality of HIV Prevention Services*: Institute measures to improve the quality of HIV prevention services delivered in community and facilitate

based services using of NIGQUAL system.

- *Institute Quality Assurance Processes*: Ensure that quality assurance mechanisms are in place to monitor patient satisfaction, adherence to guidelines, and other quality-related issues.

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

Major Activities

- *Conduct Condom Needs Assessment: Conduct a study on condom needs assessment to identify barriers to access and utilization* of condoms and lubricants, as well as approaches to address identified barriers.
- *Expand Access to Condom and Lubricants Use*: Support innovative approaches to expand access to condoms and lubricants through social and retail marketing.
- *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.
- *Strengthen Logistics and Supply Chain Management*: Support commodity supplies, forecasting and quantification of HIV prevention commodities including improvement of the availability of a variety of male and female condoms and lubricants at community and facility level, and prevention of stock-outs and reduction of wastages

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

Strategic Interventions

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

Key Activities

- *Build the Capacity of Service Providers*: Train and re-train service providers, as well as mentor and provide supportive supervision for service providers to provide ARV based HIV prevention services using approved national guidelines
- *Provide Up-to-Date Protocols to Service Sites*: Adapt, review, produce, disseminate and operationalize available protocols on ARV use for HIV prevention.
- *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.
- *Strengthen Logistics and Supply Chain Management*: Institute procurement and distribution management for ARV based HIV prevention programmes that limits the possible challenges associated with stick-outs.

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

Strategic Interventions

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

Major Activities

- *Establish Functional Infection Control Committees*: establish functional infection committees at all health facilities to foster optimal infection control practices
- *Revise, Distribute and Operationalise Policies, Guidelines and Standards Operating Procedures Relating to Infection Control*: 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
- *Provide Facilities with Tools, Equipment and Materials for Safe Injection and Infection Control Practices*: Provide adequate stock of essential injection safety commodities, waste management materials, personal protective equipment, and HIV post-exposure prophylaxis.
- *Build the 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
- *Strengthen Logistics and Supply Chain Management*: Institute procurement and distribution management to prevent stick-outs of injection safety and waste management materials.

4.1.5.13. Improve access to harm reductions strategies for PWIDs.

Major Activities

- *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.
- *Intensify Communication and Education Activities*: Provide PWID specific targeted information, education and communication messages for safe sex behaviours, and to prevent reuse and sharing of needle and syringe reuse.
- *Build Capacity of Service Providers on Reduce HIV Risk-Taking Behaviours by PWIDs*: Train, retrain, mentor, and provide supportive supervision for service providers on harm reduction strategies for PWID at facility and community levels.
- *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

4.1.5.13 Improve quality management systems for all blood banks.

Major Activities

- *Promote the Implementation of National Standards for Safe Blood Transfusion*: Implement standards specified by NBTS/national policy on screening including 'emergency screening targets of less than 20% of blood transfused
- *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.

- *Build the Capacity of Service Providers*: Train, retrain, mentor and provide supportive supervision for service providers on phlebotomy, donor recruitment, laboratory screening blood banking and haemo-vigilance.

4.1.5.15. Improve access to and safe blood and blood products.

Major Activities

- *Vigorously Promote Blood Drive Programmes*: Promote blood drive agenda vigorously and strengthen campaign efforts for voluntary and non-remunerated blood donors.
- *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.
- *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 centres for improved access to safe blood and blood products.

4.1.6. Targets and Indicators for Thematic Area

***T*able 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 on HIV transmission and prevention	25% (2012)[18]	90%
1.2: % of young people (15 – 24 years) with comprehensive knowledge on 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)[4]	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) [1]	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 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 expose 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%

4.1.7. Results Framework for Thematic Area

Objectives	Outcome Indicators	Baseline-Value (National)	Mid-term (End of 2019)	End of program (2021)	MOV	Comments
OBJECTIVE To significantly reduce the incidence of new HIV infections by 2021.	By the year 2021, at least 90% of the general population has access to HIV prevention interventions.	25%		90%	FMoH & NACA Reports	Disaggregate by: Age groups Sex HF Level/LGA/State LGA
	By the year 2021, at least 90% of key and vulnerable populations adopt HIV risk reduction behaviour	26%		90%	FMoH & NACA Reports	Disaggregate by: Age groups (⩽18mths; 19mths-5yrs; 6-9yrs; 10-14yrs) Sex HF Level/LGA/state
	By the year 2012, at least 90% of key and vulnerable populations have access to desired HIV prophylaxis	Not Available		90%	FMoH & NACA Reports	
	By the year 2021, 100% of Nigerians have access to safe blood and blood products	Not Available		100%	FMoH & NACA Reports	
	By 2021, at least 90% of the general, key and vulnerable populations access safe injection practices	Not Available		90%	FMoH & NACA Reports	

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 Organisation 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.

The 2017-2021 Framework and Plan aim 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 Plan 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.

2.2.2. 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

Target1: 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 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.

4.2.5. Major Activities

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

4.2.5.1. Foster an enabling environment for improved access to HTS

Major Activities

- *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
- *Develop and/or Revise Policies and Regulations Regarding Provision of HTS*: 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.
- *Provide Up-to-Date Protocols and Guidelines to Service Facilities on HTS and Biological Surveillance of HIV Co-Infections*: Adapt, review, produce, disseminate and operationalize available protocols on HTS and biological surveillance of HIV co-infections.
- *Build the 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.
- *Mobilise Resources in support of HTS*: Develop and effectively implement a resource mobilisation plan to generate increased domestic funds from public, private (private-for-profit, non-profit and development-focused foundations) and community institutions to support the expansion of HTS and implementation of free HTS; also mobilise international development assistance in support of the services
- *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.

4.2.5.2.Expand coverage of HTS services.

Major Activities

- *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.
- *Equip Facilities with relevant facilities for HTS*: Equip new service delivery points with relevant facilities for HTS
- *Train Service Providers*: Train and re-train service providers on task shifting and task sharing to enhance HTS delivery.
- *Expand HTS Service Deliveries*: Identify and implement appropriate community and facility based service delivery approaches.

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

Major Activities

- *Facilitate Community Engagement, Participation and Mobilisation*: Improve community participation, support and uptake of HTS through engagement of existing and new community structures.
- *Build the Capacity of Service Providers*: Identify, select lay providers, train, retrain, mentor and supervise the provision of HTS in the community.
- *Expand HTS Service Delivery Mechanisms and Outlets at the Community Level*: Implement the test for Triage and/or other appropriate community based HTS delivery approaches.

4.2.5.4. Strengthen targeted HTS demand generation programmes.

Major Activities

- *Develop Demand Generation Plan for HTS*: Develop plans to guide demand generation activities in hot spots for key and vulnerable populations and in high burden and priority areas.
- *Implement Demand Generation Plan to Improve the Uptake of HTS*: Use culturally sensitive and audience specific strategies increase interest in and uptake of HTS particularly among priority populations.
- *Promote Community Mobilisation for Improved Uptake of HTS*: Integrate HTS into prevention services provided to different segments of the population.
- Intensify Communication And Education Activities: Promote public education and communication on HTS using gender-appropriate community-based strategies.

4.2.5.5. Promote integration of, and strengthen referrals and linkages systems between HTS, other HIV management services, blood transfusion service, and other health-related services.

Major Activities

- *Support Integration and Build Linkages Between Services:* Integrate HTS and screening for HIV co-infections into key population and vulnerable population HIV and other health care activities delivered through various service delivery models.
- *Improve Access to Safe Blood Services*: Build the capacity of service providers on safe blood-related practices (phlebotomy, donor

[3]A 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

recruitment, laboratory screening, appropriate clinical use of blood and haemovigilance); promote blood drive and voluntary non-remunerated blood donation; link HIV treatment centre and other health facilities to National Blood Transfusion Services (NBTS) for screening for transfusion transmittable infections (TTIs) and enhance access to safe blood; and, institute/strengthen quality assurance system for safe blood transfusion

- *Track Patients*: Institute mechanisms to monitor and follow up all clients referred to care following access to HTS.

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

Strategic Interventions

4.2.5.6. Expand coverage of HTS services for pregnant women.

Major Activities

- *Support Integration of Services 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.
- *Build the Capacity of Service Providers*: Train, retrain, mentor and supervise HTS providers for provision of high quality, gender and human rights responsive HTS/eMTCT.
- *Expand HTS Service Delivery for Pregnant Women and their Partners*: Conduct HIV testing in line with the national guidelines, implement couple and partner HIV testing strategy for all pregnant women and their partners, implement retesting in the third trimester, or during labour or shortly after delivery, because of the high risk of acquiring HIV infection during pregnancy.
- *Support Integration and Improve Referrals/Linkage for Management of Co-Infections*: Establish systems for integrating and linking HIV positive pregnant women for management of HIV co-infections

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

Major Activities

- *Develop Demand Generation Plan*: Develop plans to guide demand generation activities for HTS focused on identifying HIV-positive pregnant women.
- *Increase Community Mobilisation*: Conduct community-based outreach targeted at pregnant women.
- *Intensify Communication And Education Activities*: Engage lay providers for HTS service delivery at community level.

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

Strategic Interventions

Integrate screening for HIV co-infections into HTS activities

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Major Activities

- *Build the Capacity of Service Providers*: Increase awareness and build capacity of service providers on screen for HIV co-infections especially among key and vulnerable populations.

- *Deliver Relevant Laboratory Screening Services*: Ensure quality assured laboratory screening for syphilis, hepatitis B, and hepatitis C and clinical screening for TB.

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

Major Activities

- *Improve Referrals*: Set up referral system to ensure that referrals for laboratory screening for syphilis, hepatitis B, and hepatitis C are done.
- *Support Integration And Build Linkages Between Services*: Establish systems for linking persons with diagnosed infections for 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

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

Major Activities

- Provide Up-to-Date Protocols and 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.
- *Build the 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.
- *Institute Supportive Supervision*: Implement adequate supportive supervision of HIV testing providers.
- *Establish Quality Assurance Coordination Team*: Implement quality assurance cycle that assures optimal HIV testing and HIV co-infection screening results are generated.
- *Institute Quality Assurance Processes*: Implement the quality management system in all testing sites.

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

Major Activities

- *Improve Forecasting and Quantification of Commodities*: Develop and implement accurate forecasting, quantification and procurement systems to avoid stock-outs of test kits and consumables.
- *Link Services to Quality-Assured Diagnostics*: Ensure access to quality-assured diagnostics that have had post-market validation in-country.
- *Improve Commodity Distribution Mechanisms*: Develop and implement appropriate distribution mechanisms to prevent stock out.

4.2.6. 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 for HIV and received their 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	*Children <15years*: (17,675) (1.7%) - Males: (9,123) (0.86%) - Females: (8,552) (0.81%) *Adult >15 years:* 246,801 (3.7%) - Females: (152,535) (2.3%) - Males: (94266) (1.4%) (2015)[23]	90%
1.3: % of FWSS, MSM, PWID who tested for HIV and received their test results within the last 12 months	FSW: 97.1% MSM:97.0% PWID: 93.5% (2014)[17]	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%

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

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 centres with instituted quality improvement	To be determined	90%

4.2.7. Results Framework for Thematic Area

Objectives	Outcome Indicators	Baseline-Value (National)	Mid-term (End of 2019)	End of program (2021)	MOV	Comments
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.	By the year 2021, 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	26% (2012) 97% Not Available Not Available		60% 100% 100% 80%	FMoH & NACA Reports	Disaggregate by: Age groups Sex HF Level/LGA/State LGA
	By the year 2021, at least 95% of pregnant women access HTS	44%		95%	FMoH & NACA Reports	Disaggregate by: Age groups (⩽18mths; 19mths-5yrs; 6-9yrs; 10-14yrs) Sex HF Level/LGA/state
	By the year 2021, at least 90% of people tested for HIV screened for TB, syphilis, hepatitis B, and hepatitis C	Not Available		90%	FMoH & NACA Reports	
	By the year 2021, at least 90% of HTS sites establish and maintain quality control measures	Not Available		90%	FMoH & NACA Reports	

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 Plan 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 Plan 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 Plan 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 **c**ontraceptive prevalence rate of 40%achieved among HIV-positive women by 2021.

Target2: 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 infant.
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. Major Activities

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

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

Major Activities

- *Formulate or Review Policies and Guidelines Relating to Integration of HIV and AIDS Services and Sexual and Reproductive Health Services, including Family Planning*: Review policies on integration of sexual and reproductive health services and HIV services at all levels.
- *Integrate Services*: Ensure one-stop access to ANC, eMTCT, MNCH and family planning services.
- *Strengthen Logistics and Supply Chain Management*: Support commodity supplies and logistics for integration of eMTCT into ANC, family planning and MNCH services.
- *Strengthen Supportive Supervision*: Strengthen and implement adequate supportive supervision for providers of eMTCT services.

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

Major Activities

- *Intensify Communication and Education Activities*: Conduct communication and education activities to increase awareness on importance of family planning among PLHIV; and integrate HIV care into ongoing programmes aimed at increasing the demands for contraceptives.
- *Facilitate Community Engagement, Participation and Mobilisation*: Sensitise and elicit the support of husband/sex partners, family, community leaders, religious leaders and policy maker for eMTCT.

4.3.5.3. Improve access of to HIV positive women to family planning services.

Major Activities

- *Increase Family Planning Service Delivery Points*: Increase family planning services delivery points in Health facilities and in the community.
- *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.
- *Promote the use of total market approach for family planning commodity provision*: promote effective partnership between the public and private sector in the coordination and implementation of a total market approach for provision of family planning commodity
- *Strengthen Family Planning Logistics and Supply Chain Management*: Support commodity supplies and logistics for integration of eMTCT into ANC, family planning and MNCH services

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

Strategic interventions

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

Major Activities

- *Intensify Communication and Education Activities*: Conduct public education and communication programmes to promote utilisation of antenatal care, delivery, and postnatal services provided by skilled personnel.
- *Increase eMTCT Service Delivery Points*: Integrate eMTCT services into services delivery packages of primary health facilities, private health facilities, and community based facilities.
- 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 level and private facilities.
- *Build the 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.
- *Expand HIV Service Delivery for HIV Positive Pregnant and Breastfeeding Women*: Implement the "test and treat" policy and the Option B+ antiretroviral strategy that ensures in accordance with national policy and guidelines
- *Improve and Sustain Logistics and Supply Chain Management*: Support commodity supplies and logistics for provision of integration eMTCT services and prevent stock-out of commodities.

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

Major Activities

- *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
- *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.

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

Major Activities

- *Revise and Implement Policies and Guidelines to Improve Access to eMTCT Services*: Formulate and or implement policies that supports the access of pregnant and breastfeeding women to ART.
- *Eliminate Stigma and Discrimination from Service Providers*: Train, re-training and institute corrective and punitive measures for health care workers that will eliminate stigmatization and discrimination of HIV positive pregnant women.
- *Mobilise Resources for eMTCT Service Provision*: Develop and effectively implement a resource mobilisation plan to generate increased domestic funds from public, private (private-for-profit, non-profit and development-focused foundations) and community institutions to support the scale up of eMTCT-related services; also mobilise international development assistance in support of the services
- Develop and effectively implement a resource mobilisation plan to generate increased domestic funds from public, private and community institutions to support.
- *Support Research Activities*: Conduct operational, implementation and other forms of research to identify strategies that best support access of different populations to eMTCT services.

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

Major Activities

- *Improve Quality of eMTCT Services*: Implement actions to improve the quality of eMTCT services delivered in community and facility-based services using of NIGQUAL system.
- *Institute Quality Assurance Processes*: Ensure that quality assurance mechanisms are in place to monitor patient satisfaction, adherence to guidelines, and other quality-related issues.
- *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

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

Major Activities

- *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.

- *Follow up HIV Exposed Infants to Ensure the 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.
- *Build the Capacity of Health Care Providers*: Train, retrain, mentor and supervise health care workers to ensure access of HIV exposed infants to ARV prophylaxis.
- *Strengthen Logistics and Supply Chain Management*: Improve logistics management system to ensure constant availability of paediatric antiretroviral and avoid stock-out.

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

Major Activities

- *Support Community Participation, Support and Mobilisation*: 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.
- *Build the Capacity of Community and Lay Service Providers*: Train, retrain, mentor and provide supportive supervision for care providers to ensure HIV exposed infants access 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

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

Major Activities

- *Increase Access of HIV-Exposed Infants to EID Service*: Establish EID services in all secondary health care service centres to which eMTCT sites are linked. Facilitate point of care EID service delivery at all eMTCT sites.
- *Build the Capacity of Laboratories to Provide EID Services:* Train and use appropriate technology that can reduce the turn-around time for EID results.
- *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.
- *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

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

Major Activities

- *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.

- *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.
- *Build the Capacity of Health Care Providers*: Train, retrain, mentor and supervise health care workers to ensure access of HIV exposed infants to co-trimoxazole.
- *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

4.3.5.12. Expand access of HIV exposed babies to HIV serological test.

Major Activities

- *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.
- F*ollow 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.
- *Build the Capacity oOf Health Care Providers*: Train, retrain, mentor and supervise health care workers to support HIV exposed infants to access HIV serological tests.
- *Strenghten Logistics and Supply Chain Management:* Support commodity supplies and logistics to support HIV exposed infants to access HIV serological tests at 18 months.

4.3.6. 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 received 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%
Target3: 95% of all HIV-exposed infants receive antiretroviral prophylaxis by 2021		
3.1: % of infants born to HIV positive women who received ARV prophylaxis	15.44% (2015)	95%
3.2:% of facilities offering ART for HIV-exposed infants with quality assurance mechanisms	To be determined	95%
Target4: 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%
Target5: 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%

4.3.7. Results Framework for Thematic Area

Objectives	Outcome Indicators	Baseline-Value (National)	Mid-term (End of 2019)	End of program (2021)	MOV	Comments
OBJECTIVE To eliminate mother-to-child transmission of HIV in Nigeria by 2021	By the year 2021, at least Modern **c**ontraceptive prevalence rate of 40%achieved among HIV-positive women	Not Available		40%	FMoH & NACA Reports	
	By the year 2021, at least 95% of all HIV positive pregnant and breastfeeding mothers receive antiretroviral therapy	30%		90%	FMoH & NACA Reports	
	By the year 2021, at least 95% of all HIV-exposed infants receive antiretroviral prophylaxis.	15.44%		95%	FMoH & NACA Reports	
	By the year 2021, at least 95% of all HIV-exposed infants have early infant diagnosis within 2 months of birth	9%		95%	FMoH & NACA Reports	
	By the year 2021, at least 95% of all HIV exposed infants receive co-trimoxazole prophylaxis within 2 months of birth	10.26%		95%	FMoH & NACA Reports	
	By the year 2021, at least 90% of HIV exposed babies have access to HIV serological test by the age of 18 months	Not Available		90%	FMoH & NACA Reports	

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 Plan 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 Plan 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 the 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.

Target3: 90% of eligible PLHIV receive co-trimoxazole prophylaxis by 2021.

Target4: 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. Institutionalise 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.

4.4.5. Major Activities

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

4.4.5.1. Ensure supportive environment for delivery of ART services.

Major Activities

- *Develop Advocacy Plan:* Develop an advocacy plan to guide the process for increasing public and private institutional support for ART.
- *Revise and Implement Service-Related Policies and Guidelines*: Adapt, review, produce and disseminate relevant policies and guidelines; and operationalize relevant policies and guidelines.
- *Build the Capacity of Service Providers in ART Service Delivery***:** Train, retrain, mentor and provide supportive supervision for service providers in public and private facilities on implementation of relevant ART policies and guidelines and provision of quality services.
- *Strengthen Advocacy to Key Stakeholders for Improved Programme Funding*: Strengthen advocacy efforts targeted at key stakeholders for increased and sustained funding of ART service delivery from government, as well as to increase domestic funding from non-governmental sources including private-for-profit and non-profit sectors
- *Mobilise Resources in Support of ART and Related Services*: Develop and effectively implement a resource mobilisation plan to generate increased domestic funds from public, private (private-for-profit, non-profit and development-focused foundations) and community institutions to support to support the scale up of ART services; also mobilise international development assistance in support of the services
- *Support Research Activities*: Conduct operational, implementation and other forms of research to identify strategies that best support access of different populations to ART services.

4.4.5.2. Expand coverage of ART services.

Major Activities

- *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.
- *Identity New ART Service Delivery Sites*: Increase the number of secondary and comprehensive primary health care centres, private healthcare facilities, and community-based service organisations that can provide ART services in close proximity to areas of need including camps for internally displaced persons.
- *Support Integration, Linkages and Referral for Improved Access to ART Services*: Strengthen efforts at decentralization and integration of ART

service delivery programme, and improve service linkage and referrals to improve access to ART services;

- *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 mobilisation of ARV stocks to prevent stock-outs in all ART facilities.
- *Build Capacity of Service Providers*: Train, retrain, mentor and provide supportive supervision to healthcare workers providing ART services in public, private and community-based health care institutions; and Ensure availability of guidelines, protocols and SOPs at service delivery points.
- *Improve ART Service Delivery*: Institute support for implementation of the test and treat progamme at all ART sites.

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

Strategic Interventions

4.4.5.3. Strengthen health care services to support differentiated care

Major Activities

- *Develop/Revise and Implement Service Policies and Guidelines Relating to Provision of Differentiated Care:* Ensure that National Integrated Guidelines for ARV use address the differential ART needs of adults, adolescents and children.
- *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.
- *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, and use innovative approaches to improve the availability of, and access to community and facility-based targeted service delivery points
- *Support Integration, Linkages and Referral for Differentiated Care*: Initiate and advance efforts to improve integration, linkages and referrals to support the practice of differentiated care, and expand access to differentiated care.

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

Major Activities

- *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
- *Establish Community-Based Adherence Support Mechanisms*: Set up age-, population- and culturally-appropriate mechanisms in the community to support medication adherence for stable patients who require fewer clinic visits.
- *Set up Rapid Re-Entry Programmes*: Fast-track the location of PLHIV missing

drug pick up appointments and reabsorb into ART programmes

4.4.5.5. Strengthen quality assurance mechanisms for ART related services.

Major Activities

- *Provide Up-to-Date Protocols and Guidelines to Service Providers*: Adapt, review, produce, disseminate and operationalize available national ART policy, guidelines and protocols.
- *Build the Capacity of Service Providers*: Train, retrain, and mentor ART providers for provision of high quality, gender and human rights responsive ART services.
- *Strengthen Supportive Supervision*: Implement adequate supportive supervision for ART service provider.
- *Establish/Strengthen Quality Assurance Mechanism and Coordination:* Establish effective coordination mechanisms and implement quality assurance cycle that assures optimal ART services and client satisfaction.
- *Institute Quality Assurance Processes*: Implement the quality management system in all ART sites using the HIVQUAL.
- *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.

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

Major Activities

- *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
- *Strengthen Existing and Establish New Viral Load Testing Centres*: Strategically expand diagnostic capacity to reach areas of poor coverage
- *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.
- *Strengthen Logistics and Supply Chain Management*: Support commodity supplies and logistics to support HIV exposed infants to access HIV serological tests at 18 months.
- *Build the Capacity of Service Providers*: Train, retrain, mentor and provide supportive supervision for staff on viral load assessment and its use for patients' care.

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

Strategic Interventions

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

Major Activities

- *Build Capacity of Service Providers*: Train, retrain, mentor and provide supportive supervision to healthcare workers on the use of co-trimoxazole prophylaxis in adults and children living with HIV.
- *Educate PLHIV on Co-trimoxazole Prophylaxis*: Support the implementation of health education and health promotion programmes by health care workers and Support Group to improve the knowledge, uptake and

optimal use of co-trimoxazole prophylaxis by PLHIV.

- *Strengthen Logistics and Supply Chain Management*: Improve logistics management system to ensure uninterrupted availability of co-trimoxazole at ART facilities.

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

Strategic Interventions

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

Major Activities

- *Support Service Integration and Improve Service Linkages and Referrals***:** Increase the number of patient-centred "one-stop shops" where HIV and TB services are integrated; fast track the establishment of ART service delivery in existing DOTS Centres, and integrate TB service delivery at ART sites.
- *Build the Capacity of Service Providers*: Train, retrain, mentor and provide supportive supervision to health care workers in the provision of ART and TB services, use of GeneXpert MTB/Rif, management of TB in HIV positive children, and management of HIV positive pregnant women and patients with HIV co-infection.
- *Strengthen Logistics and Supply Chain Management*: Support commodity supplies and logistics to support HIV and TB co-infection management.
- *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.

4.4.6. 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)[3] [30]	90%
1.3: % of ART sites with stock out of ARV within the past 3 months	TBD	0%
Target2: 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 12months: 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%
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	12.2% (2014)	100%

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

4.4.7. Results Framework for Thematic Area

Objectives	Outcome Indicators	Baseline-Value (National)	Mid-term (End of 2019)	End of program (2021)	MOV	Comments
OBJECTIVE For all diagnosed PLHIV receive quality HIV treatment services, and at least 90% of those on ARV achieve sustained virological suppression	By the year 2021, at least 90% of diagnosed PLHIV are on ART	23%		90%	FMoH & NACA Reports	
	By the year 2021, at least 90% of diagnosed PLHIV on treatment are retained in care.	12.7%		90%	FMoH & NACA Reports	
	By the year 2021, at least 90% of eligible PLHIV receive co-trimoxazole prophylaxis	76.3.%		90%	FMoH & NACA Reports	
	By the year 2021, All PLHIV diagnosed with TB have access to TB services	68%		100%	FMoH & NACA Reports	

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 infection[1]. 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 their retention 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 organisations, and the engagement of PLHIV in the delivery of care for their peers.

This NSP 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 Plan 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 Plan 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

Target4: 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. 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 institutionalised 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. Major Activities

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

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

Major Activities

- *Map and Increase Community-Based Care and Support Service Sites*: Establish new community based care and support services.
- *Improve the Coverage of Targeted SBCC for PLHIV*: Organise targeted SBCC to promote PLHIV's awareness and utilization of community based care and support services through SBCC
- *Build the 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.
- *Provide Resources to PLHIV Support Groups and Networks for Home-Based Care*: Advocate for and mobilize resources for home-based care services as integral component of HIV management for people living with HIV; provide financial, technical, managerial and other forms of supports to PLHIV support groups and networks to expand and improve the quality of home-based care

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

Major Activities

- *Provide Up-to-Date Guidelines and Protocols for Community-Based Services*: Revise the existing protocols on home-based care in partnership with PLHIV networks and other relevant stakeholders to improve the quality of community-based services
- *Build the Capacity of PLHIV and Networks to Monitor and Supervise Community-Based Care Services*: Build the capacity of PLHIV groups and networks to institute mechanisms for effective monitoring and supervision of community-based HIV care services.
- *Monitor and Supervise Community-Based Services*: Empower PLHIV groups and networks to monitor and supervise community-based services, and to communicate findings to appropriate authorities as an integral part of non-health sector response

4.5.5.3. Strengthen the adherence counseling system at facilities.

Major Activities

- *Select and Train Facility-Based and Community Adherence Counsellors*: Build capacity of PLHIV and community health workers to serve as adherence counselors, and implement relevant innovative approaches including the mentor mothers approaches (using women have successfully gone through PMTCT to serve as mentor mothers)
- *Monitor and Supervise Activities of Adherence Counsellors*: Train, equip and support health care workers and other personnel at programme coordination (such as LACA personnel), facility and community levels to monitor and provide supportive supervision to adherence counselors

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

Strategic Interventions

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

Major Activities

- *Review/Establish and Re-Orientate Response Coordination Structures*: Review the performance of existing coordination structures, and develop evidence-based approaches to strengthen and improve the effectiveness of the coordination structures for care and support of vulnerable children
- *Organise Regular, Periodic Multi-Sectoral Coordination and Programme Meetings for Effective Coordination*: Provide required resources and engage with stakeholders for effective inter-sectoral, and multi-sectoral coordination
- *Increase Service Points for Care and Support for Vulnerable Children*: increase and support community-based organisations engaged in the care and support of vulnerable children
- *Strengthen the linkage between Vulnerable Children's Care and Support Organizations and Healthcare Facilities*: Facilitate the linkage of all organizations working with vulnerable children to

health care facilities through the hub-and-spoke structure

- *Integrate Quality Assurance Mechanisms Into Care and Services for Vulnerable Children*: Build and strengthen the quality assurance mechanisms for home-based care and support services

4.5.5.5. Strengthen community based systems to mobilise resources and implement care and support services for vulnerable children in line with the national care and support guidelines.

Major Activities

- *Conduct Organisational Capacity Assessments Regarding Service Provision for Vulnerable Children*: Assess the institutional capacity of organisations engaged in provision of services for vulnerable children (through the use of instruments such as the NHOCAT and PADEF) to identify areas for organizational capacity strengthening
- *Provide Technical Support for Civil Service Organisations for Improved Programme Operations*: Support Civil Society Organisations to address gaps identified in the process of capacity assessment and improve operational capacity
- *Build the Capacity of Civil Society Operatives*: Train, retrain, mentor and provide supportive supervision for Civil Society Organisations engaged in HIV care and support programming for PLHIV.
- *Facilitate the Access of CSOs to Relevant and Needed Resources*: Support CSO to access relevant human, institutional and financial resources to improve the implementation of care and support services to vulnerable children.

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

Strategic Interventions

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

Major Activities

- *Orientate Legal Officers and Law Enforcement Agencies on the HIV and AIDS Anti-discrimination Act*: Support legal agencies on implementation of the HIV and AIDS Anti-discrimination Act
- *Sensitise and Solicit for the Support of Key Stakeholders and Community Leaders at every level on the HIV and AIDS Anti-discrimination Act*: Conduct advocacy, awareness, sensitization and education programmes targeted at key stakeholders and community leaders across all states and governance levels in Nigeria on the HIV and AIDS Anti-discrimination Act.
- *Advocate for Passage and/or Enforcement the HIV and AIDS Anti-Discrimination Act:* Organise advocacy efforts to relevant stakeholders toward the passage and/or enforcement of HIV and AIDS Anti-discrimination Act in all states in Nigeria.
- *Educate the General Population About the HIV and AIDS Anti-Discrimination Act* : Conduct awareness, sensitization and education programmes for community members on HIV-related stigma and its effect, and the HIV and AIDS Anti-discrimination Act; integrate information on HIV and AIDS-related

stigma and the HIV and AIDS Anti-discrimination Act into the Family Life and HIV Education programme.

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

Major Activities

- *Build the Capacity of Service Providers*: Train and retrain health workers and other service providers on relevant codes of conduct and respect for human dignity
- *Institute Appropriate Sanctions and Other Relevant Measures for Health Care Providers Engaged in Stigmatisation and Discrimination*: Advocate for health care institution and related regulatory agencies to institute appropriate sanctions and other relevant measures for health care providers who stigmatise and discriminate against PLHIV; and, educate PLHIV of existing avenues to seek redress and support regarding stigma and discrimination.

4.5.5.8. Develop and implement behaviour change communication targeted at reducing stigma and discrimination against HIV and AIDS.

Major Activities

- *Develop Communication Plan and Materials to Address HIV and AIDS-Related Stigma and Discrimination*: Develop implementation plans at various levels to address HIV and AIDS-related stigma and discrimination, and review existing anti-stigma communication efforts and materials for improved result.
- *Educate the General Public and Community Members*: Conduct awareness, sensitization and educational programmes to improve the knowledge of the general public and community members and mobilise their action for prevention of HIV stigma and discrimination.

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

Major Activities

- *Educate PLHIV and PABA*: Educate PLHIV and PABA about HIV and AIDS Anti-discrimination Act and how to seek justice.
- *Advocate for the Establishment and/or Strengthening of Legal Aid Groups*: Advocate for improved efforts of the existing legal aid groups and the establishment of more groups to enhance the access of PLHIV and PABA to justice.
- *Support the Operations of Community-Based Mediation/Conflict Resolution Mechanisms*: Partner with, and provide support to the Ministry of Justice to improve mechanisms for 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

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

Major Activities

- *Provide Sexual and Reproductive Health*

Education to PLHIV: Integrate sexual and reproductive health education into ongoing facility- and community-based education programmes for PLHIV.

- *Support Integration, Referral and Linkages to Family Planning Services*: Integrate contraceptive access services to PLHIV treatment, care and support programmes; and facilitate access of PLHIV to family planning services through appropriate linkages and referrals.

4.5.5.11. Integrate nutritional counselling and support into routine care for PLHIV.

- *Provide Nutritional Education to PLHIV in Routine Care Setting*: Integrate nutritional education into ongoing facility and community based HIV care programmes for PLHIV.
- *Intensify Regular Nutritional Assessment And Counselling For PLHIV*: Screen PLHIV for nutritional status as part of the routine assessment.
- *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.

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

- *Provide Mental Health and Psychological Assessment for PLHIV in Routine Care Setting*: Integrate mental health and psychological assessment into ongoing facility and community based HIV care programmes for PLHIV; and, integrate mental health care and management into routine PLHIV treatment, care and support programmes
- *Provide Mental Health and Psychological Support and Counselling to PLHIV*: Train relevant health workers and community stakeholders to prove mental health and psychological support for PLHIV; expand mental health and counselling services for PLHIV; and integrate mental health assessment and interventions into routine assessment and care processes.
- *Support Integration, Referral and Linkages of Services*: Facilitate the access of PLHIV to mental health services through appropriate linkages and referrals.

4.5.6. 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 display 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 age 5-9 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	*Male:* (96,293)[22] *Female:* (213,141)[22]	90%

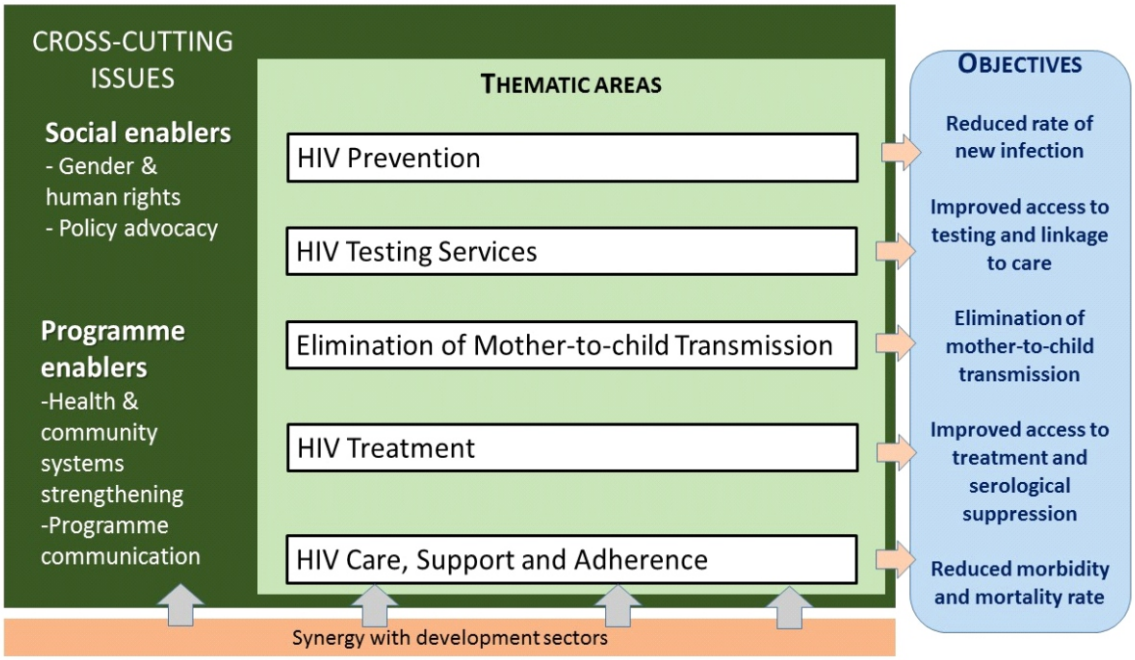
4.5.7. Results Framework for Thematic Area

Objectives	Outcome Indicators	Baseline-Value (National)	Mid-term (End of 2019)	End of program (2021)	MOV	Comments
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.	By the year 2021, at least 90% of PLHIV access quality care and support services	19.3%		90%	FMoH & NACA Reports	
	By the year 2021, at least 90% of vulnerable children enlisted for care and support services access those services	53.8%		90%	FMoH & NACA Reports	
	By the year 2021, at least 90% of males and females age 5-49 years display non-discriminatory attitudes towards PLHIV and PABA	72%		90%	FMoH & NACA Reports	
	By the year 2021, at least 90% of PLHIV access positive health, dignity and prevention related services	Not Available		90%	FMoH & NACA Reports	

5. Cross-cutting issues

While the thematic areas depicts 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 helps create the enabling environments for the implementation of the NSP, and programme enablers that facilitate the creation of demand for relevant services and help improve the performance of key interventions[33]."

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 NSP prioritises the need to respect human rights and mainstream gender-sensitive approaches and response to be able to achieve its goals. The NSP also recognises 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 to the programmes and commodities, and hampers effective programming across the continuum of HIV prevention, testing, treatment, and care and support. The NSP recognizes the relative powerlessness and unequal socioeconomic status of women when compared to men; the risk gender-based violence pose 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 inadequate attention to rights and gender issues has 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 NSP 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 to HIV programmes by males, females and transgenders need to be recognized and addressed.

The 2017–2021 NSP was therefore developed with an eye to respect the rights of all persons irrespective 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 Plan and its Framework also uphold the principle 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 Plan therefore provides for gender-sensitive and gender-responsive programming which improves access of PLHIV, vulnerable children, and PABA to comprehensive rights-based care; fosters an enabling environment for PLHIV, PABA, VC, FSW, MSM and PWID to access HIV services; strengthening interventions targeted at reducing stigma and discrimination against PLHIV, vulnerable and key populations; promotes advocacy to strengthened implementation of the HIV and AIDS Anti-discrimination Act; and, promoting the access of all persons including PLHIV, vulnerable and key populations to justice through use of community-based and institutionalised mechanisms.

5.1.2. Policy advocacy

Policy advocacy is critical to efforts to promote national ownership and sustainability of the HIV response in Nigeria, as it aims, among others, to secure the support of stakeholders and mobilise resources for the HIV and AIDS responses. This Plan recognizes advocacy for policy formulation and review as key 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 population 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 ensure Nigeria's fulfillment of her regional and international obligations, including the obligations towards 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 Plan recognizes that 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; and affirms the need for development of an advocacy 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

Health systems strengthening, community systems strengthening, and programme communication are some of the programme enablers for effective HIV response under the NSP.

5.2.1. Health systems strengthening

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 of service delivery points and improving service delivery strategies to be able to achieve the 90-90-90 target and the goal of ending the AIDS epidemics by 2030. Thus, the operationalization of this Plan is dependent on instituting strategies that strengthens 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 Plan.

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

Building block	Elements	Strategic interventions
Leadership and governance	• Strategic policy frameworks • System design • Effective oversight • Coalition building • Regulations • Accountability	• 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	• Availability • Distribution • Quality • Performance	• Training and re-training of health workers and other service providers
Service Delivery	• Comprehensiveness • Accessibility • Coverage • Continuity • Quality • Coordination • Accountability • Integration	• Expanding access to services • Integration and linkages of services • Quality assurance • Scaling up of services
Financing	• Resources mobilization • Resource pooling • Expenditure allocation/tracking	• Mobilisation of domestic resources • Improved resource management
Medical Products, Vaccine and Technologies	• 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	• 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	• Data generation • Compilation • Analysis/synthesis • Communication and use	• Improving HIV data systems production, analysis and dissemination to monitor coverage, quality, and utilisation of services, and outcomes

5.2.2. Community systems strengthening

Community involvement and participation are well-recognised approaches in public health for improving programme efforts 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 components 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.

The 2017-2021 NSF and NSP embrace community systems strengthening 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 NSP 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 national, state and private organisation investment in and ownership 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 needed evidence 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 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, informing appropriate HIV prevention behaviour, 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 Plan 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 youths 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 that regards, 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

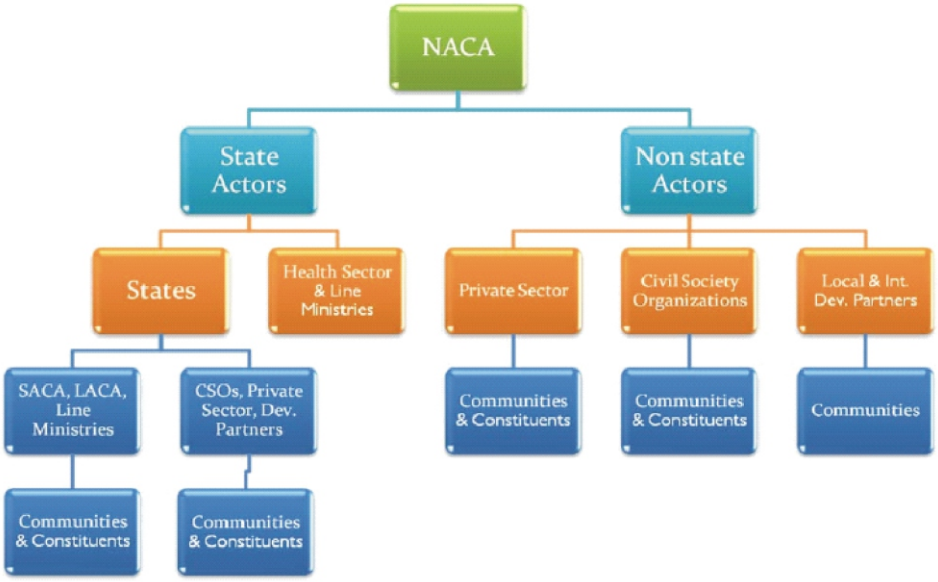
The specific mandates of NACA as stipulated by the 2007 NACA Act are to:

- 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, 2014[38].

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) was developed using a bottom-up approach. The NSF provided the foundation for the development of the NSP, and a guidance note was developed to facilitate the development of the sectoral and state response plans in a robust and systematic way, utilizing a standardised approach that will facilitate the aggregations of the various plans into the NSP at a later date. The national targets provided a national focus and served as guides for the states and sectors in setting their targets. Targets at

the state level were 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 eveolved 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 by the Public and Private Sectors

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 resources (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 NSP 2017-2021 will significantly be higher than that required for the 2010-2015 NSP. Overall, however, the approach adopted by Nigeria and the targets set are highly cost-effective; early treatment enhances both health and economic gain. Furthermore, the investment approach embraced for this NSP 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 mobilise the resources required for the full implementation of the NSP. Also, there is need for greater investment in research that would generate evidence for continuous cost-effective programming. Furthermore, 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 domestic funding – to a target of at least 50% of the required resources – and will combine efforts from the government, private sectors (both for-profit and non-profit) and communities.

6.2.1. Public Sector

The domestic funding needs to be spearheaded by the government, who is also expected to provide the greater proportion of the needed funds.

Strategic interventions

A. ***Advocacy to Key Stakeholders for Increased Government Funding of the Health Sector and HIV Programing:*** Organise strategic advocacy efforts to target key stakeholders at both the executive and legislative arms of government at the federal, state, and LGA levels to honour existing commitments, including: 15% budgetary allocation to health (Abuja 2001 and Abuja+12 declaration); allocation of 1% of consolidated revenue fund to PHC (Basic Health Care Provision Fund) to facilitate effective decentralization of HIV services; and the 59th National Council of Health

resolution that 0.5 – 1% of the monthly federal allocation to states be earmarked for financing the implementation of HIV sustainability roadmap.

B. *Explore innovative funding approaches for improved funding of HIV and AIDS Programme:* Explore innovative funding mechanisms such as National AIDS Trust funds (with contributions from government, private sector and other partners); total market approach for HIV service delivery (in partnership with the private sector), dedicated matching grant funding model with states and other actors, and taxation of health-related products;.

C. *Develop and Promote the Implementation of HIV and AIDS Resource Mobilisation Plan:* Develop HIV and AIDS Resource mobilization plan at federal and state levels, develop capacity for the implementation of resource mobilization plan and strategies

6.2.2. Private Sector

The private sector – including private health care providers, private for-profit businesses, private non-for-profit organisations, private training institutions – constitute an active and important partner in Nigeria's HIV responses. While the proportion of funds contributed by the private sector to the national HIV expenditure is low (<5% in 2014 according to NASA), the sector provide critical resources in other areas, such as human and technical resources – through service delivery provision, advocacy efforts, donation of products, and participation in technical activities such as development of guidelines and participation in technical groups. There is the need to sustain the resource currently being made available from the private sector, and to increase the sector's contribution to the overall national expenditure in the period of this Strategic Plan. Actions that stakeholder can take, most of which relate equally to the private sector operatives particularly in the area of HIV prevention in the workplace, service delivery by the private sector the context of this NAP has been outlined in Sections 4 and 5. In addition, a few key and specific actions are outlined below.

Strategic interventions

A. *Promotion of Enabling Environment for Enhanced Private Sector's Contribution to the National HIV and AIDS Response:*

- *Develop and Execute Private Sector-Focused Plan:* the government in consultation with the leadership of organized private sector and labour movement should develop a specific private-sector focused implementation plan for enhanced engagement of private sectors in HIV and AIDS response
- *Enhanced Private Sector-Focused Advocacy*: Development and implementation of targeted advocacy to key stakeholders within the private sector for increased support and contribution to the implementation of the NSP; Organisation of an annual government-private sector forum on HIV and AIDS; Annual forum for national recognition and celebration of private sector champions in the field of HIV programming
- *Advocacy for Tax Policies and*

Incentives for HIV-Related Corporate Social Responsibility Interventions: Promote and encourage corporate social responsibility in the area of HIV and AIDS programming through advocacy for friendly tax policies and incentives

B. Strengthening the Platform for HIV and AIDS Service Delivery by the Private Sector:

- *Promotion of Workplace HIV and AIDS Programmes:* Promotion of HIV and AIDS workplace that are in accordance with the national response agenda and guidelines to expand access to prevention, as well as treatment and care and support services
- *Strengthened Linkages between public and private sector service delivery systems*: Build linkages and strengthen referrals between on-site workplace programmes and public sector facilities; and between private sector health facilities and public sector facilities
- Enforce Private Sector Reporting of Service Data in Line with the National Health Act: Promote the enforcement of the National Health Act regarding the reporting and submission of private service providers to relevant state and national authorities

C. Strengthening the Framework and Channels for Formal Engagement of the Public Sector in HIV and AIDS Responses

- *Promote Partnership and Joint Activities with Private Sector Networks:* Engage in active partnership with the Nigerian Business Coalition Against AIDS (NIBUCAA)
- Foster other formal channels and opportunity for private sector engagement with government: Create channels and foster opportunities for diverse private sector entities to engage government and provide feedback on its HIV/AIDS policies, programs, and services
- *Ensure Private Sector Representation and Effective Participation in National Policy-Making and Technical-Related Bodies*: Provide for private sector representation in all national policy- and technical guiding bodies, and liaise with the private sector for effective representation in such bodies

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 generations, compilations, gender-responsive analysis/synthesis, compilation, dissemination and use also 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 the HIV and AIDS response activities proposed in the NSP and 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 evidences that can be used to improve knowledge of the trends of the epidemics, the drivers of the epidemics, 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 HIV risk behaviours 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.

7. Financial Resources; Costing and Budget

An understanding of the Nigeria HIVAIDS Strategic Plan (NSP II) costs and resources available for its implementation are both vital preconditions to ensuring realistic levels of ambition with respect to the targets and implementation of the strategy. Also, this will facilitate the leveraging and prioritization of planned investments and the design of appropriate measures to finance the resource gaps that may emerge.

7.1. Overview of the costing approach in assumption and limitations

Financial estimates of the Nigeria HIVAIDS Strategic Plan (201 – 2021) was calculated as the aggregate cost of the strategic plans from the 36 States, FCT, and Federal level line Ministries. This costing approach ensures alignment with the multi-sectoral response framework for addressing the HIV epidemic. Also, it guarantees compliance with the constitutional provision that places health on the concurrent legislative list, empowering the 36 States and FCT to make decisions on health within the context of the national framework.

Guided by this understanding, the 36 states, FCT, and line Ministries articulated costed activities for their five-year plan, across the five priority thematic areas of the national framework. The five thematic priorities are; prevention, HIV testing Services (HTS), eMTCT, Treatment, and Care and Support. Although these priorities constitute the core HIV service areas, investments proposed under each of the five priorities covered both the programme demands and components of health system strengthening. Health systems component addressed under each priority area include infrastructure, logistics for HIV medicines and supplies, health information management, governance including community participation and human resource improvement.

Activities of the five thematic priorities were costed using an activity-based costing model deployed in excel. The iterative costing process involved the following steps: (1.) capacitation of the state technical consultants on the application of the tool; (2.) Stakeholders consultative planning and costing meeting; (3.) Cost data quality assurance; and, (4.) harmonization/ aggregation of costs from the 36 States, FCT, and Line Ministries into the Nigeria HIVAIDS 2017-2021 Strategic Plan.

Assumptions considered in arriving at the total Cost of the National Strategy include the 2016 population projection of 191,557,037 and currency of ₦353 to the dollar. The assumption also posits that HIV services under the Strategy will be delivered in existing health infrastructure and by the current providers. For HIV commodities, such as ART, HIV RTK, and other supplies, however, the desired quantities to guarantee the attainment of the 90- 90-90 targets by 2021 have been included in the plan for each of the 36 states and FCT.

Identified setback to the desired output of costing process include the inability of States, and FCT Strategic Plans to adequately integrate HIV service

demands into the overall systems planning framework. Similarly, the paucity of HIV service data affected the estimation of treatment costs across many states and FCT. In addressing this gap, the NSP treatment coverage was modeled separately as part of the harmonization process. More so, the widespread attempts to address all HIV issues within the five-year duration of the Strategy contributed to driving the total cost quite high. Another limitation to the cost is the absence of submissions of line ministries at the point of aggregating the national HIVAIDS Strategic Plan cost. It is equally, important to highlight the dearth of inputs from Lines Ministries. At the point of aggregating the national HIVAIDS strategy costs, inputs from the Ministries of Health, Education, Women Affairs and Social Development, Youth, Transport, Labour, and Justice, as well as the Armed Forces and the Nigeria Police, were still being expected

7.2. National Cost disaggregated by Thematic/Service Delivery Areas

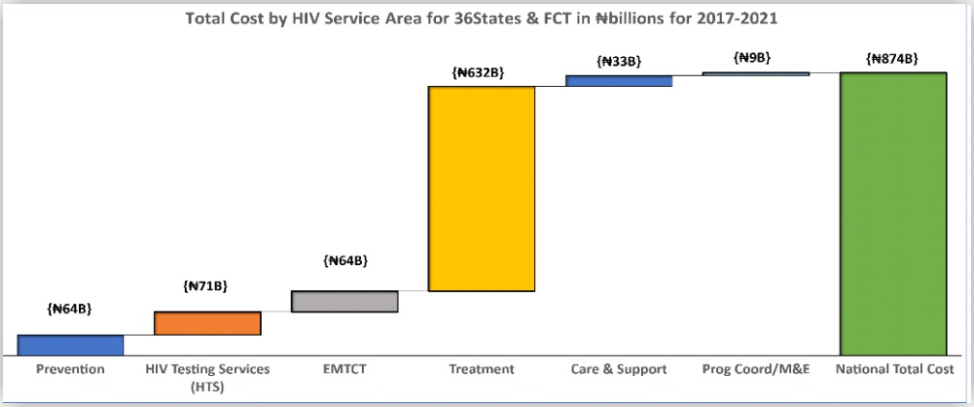


Figure 13 : Total Cost of the Nigeria HIVAIDS 2017-21 by Services Areas, in ₦Billions

7.2.1. Thematic Areas Programme Costs

The entire cost of the Nigeria HIVAIDS Strategic Plan 2017 -2021 is estimated ₦874Billion (Eight hundred and Seven-four billion Naira) (Figure 13). Analysis of the 36states and FCT costs shows that treatment accounts for 72% of the total Cost for the five-year period. Of the ₦632 billion is provided for Treatment national wide, ₦546 billion was allocated to ART services; to promote a supportive environment for ART service delivery and to expand ART coverage. Approximately ₦32Billion that is 5% of the treatment cost is allocated to ensure that PLHIV on treatment is retained. About ₦6.1Billion of the treatment cost was allocated to improve adherence counseling,

tracking mechanisms for PLHIV accessing facility-based services, and quality assurance mechanisms for ART-related services. A total of N25billion was provided to increase access of PLHIV diagnosed with TB to TB services. These allocations demonstrate government commitments to the test-and-treat policy aimed at achieving the 90-90-90 targets by 2021. By this investment, ART coverage is expected to increase from 1.02million as at 2017 to 2.85million in 2021.

Allocations for Prevention, EMTCT, and HTS across the 36 states and FCT for the period 2017 to 2021 of the Plan constituted 7%, 7%, and 8% of the total costs respectively. As a crucial investment for prevention of new infection and the reversal of HIV infection rates across 36 States and FCT, a sum of ₦64billion was projected. This fund is meant to increase access to appropriately-targeted HIV prevention services amongst the general population. Similarly, a sum of ₦17billion is allocated to ensure that key and vulnerable populations adopt HIV risk reduction behaviour and access relevant HIV prevention prophylaxis by 2021.

For eMTCT, the sum of ₦16billion, about 25% of the eMTCT total cost was targeted at actions aimed at ensuring that at least 40% of HIV-positive women use modern contraceptives. Of this, ₦8.3 Billion is committed to integration and strengthening of linkages between sexual and reproductive health services and HIV services at all level of care. A total of **₦25.4 Billion is proposed** to increase coverage of HIV positive pregnant and breastfeeding mothers receiving antiretroviral therapy to 90% by 2021 across the 36 states and FCT**.**

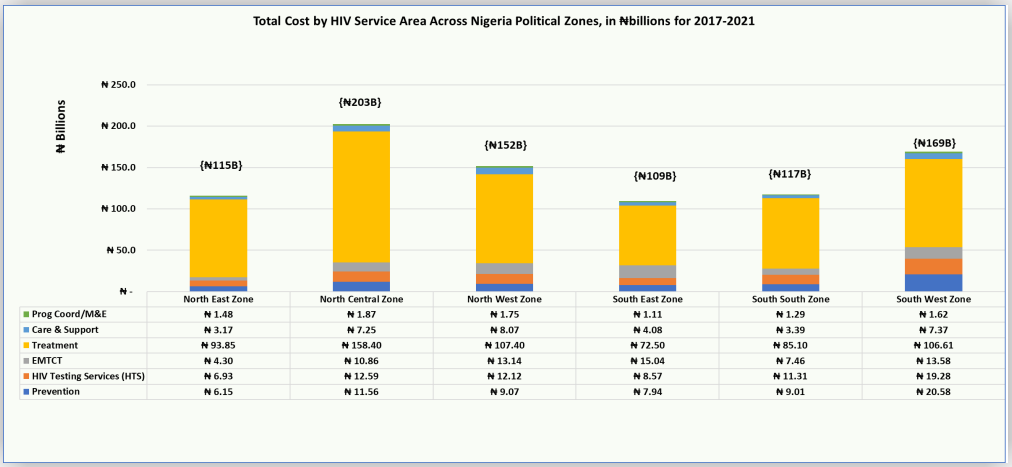
Service for care and support of the people living with HIV and affected by HIV was allocated ₦33 billion for the period of the Strategic Plan; 29% of this amount was allocated to expand access to community-based care and support services, improving the quality of home-based care and support services and adherence counseling system at facilities, while ₦10 billion was provided for OVC programming. Also, ₦6.5 billion was allocated to promote the rights of persons living with HIV and affected by HIV. Actions to be undertaken include strengthening the implementation of the HIV and AIDS anti-discrimination Act, capacitation of the health providers on relevant codes of conduct and respect for human dignity, and implementation of behavior change communication targeted at reducing HIV and AIDS-related stigma and discrimination.

7.2.2. Programme Coordination and Monitoring and Evaluation Costs

With performance targets set against the five-priority areas of the Strategy, it is imperative to strengthen coordination mechanisms and accountability systems required at both federal and State levels for their attainment. This will ensure, among others, that the strategy implementation is in alignment with the three one principles. Consequently, ₦9 billion, about 1.05% of the total cost of the plan was provided for programs coordination, and Monitoring and Evaluation. Actions covered include but not limited to operational planning, resource mobilization, stakeholders' coordination

and supervision from National to State and State to Service delivery points, implementation tracking and monitoring and evaluation.

Figure 13: Total Cost of the Nigeria HIVAIDS 2010-21 across political zones by Services Areas, in ₦Billions



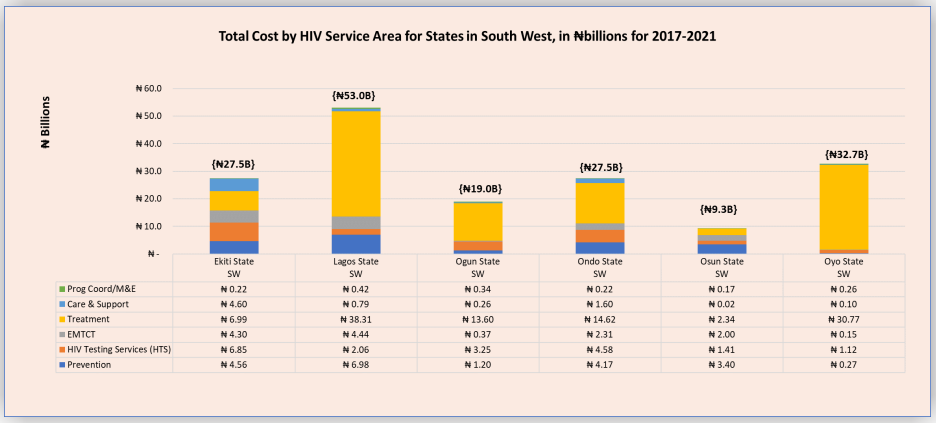
	North East Zone	North Central Zone	North West Zone	South East Zone	South South Zone	South West Zone
Prog Coord/M&E	₦ 1.48	₦ 1.87	₦ 1.75	₦ 1.11	₦ 1.29	₦ 1.62
Care & Support	₦ 3.17	₦ 7.25	₦ 8.07	₦ 4.08	₦ 3.39	₦ 7.37
Treatment	₦ 93.85	₦ 158.40	₦ 107.40	₦ 72.50	₦ 85.10	₦ 106.61
EMTCT	₦ 4.30	₦ 10.86	₦ 13.14	₦ 15.04	₦ 7.46	₦ 13.58
HIV Testing Services (HTS)	₦ 6.93	₦ 12.59	₦ 12.12	₦ 8.57	₦ 11.31	₦ 19.28
Prevention	₦ 6.15	₦ 11.56	₦ 9.07	₦ 7.94	₦ 9.01	₦ 20.58

As Figure 14 shows, cost estimate from the North-Central accounts for 23% of the total cost of the Strategic Plan, followed by South-West and North-West with 20% and 18% of the total cost of the plan respectively. On the average across the six zones, with 72% of the total cost, treatment is the service area with the most funds allocated. Allocation to prevention and HTS were 7% and 8%. Similarly, across the six zone, the provision of ART to diagnosed PLHIV accounted for 72% of the average treatment cost; with North-East recording the highest percentage of 81% and South West, the lowest at 63%, of the treatment cost.

7.3. States' Cost disaggregated by Thematic Service Delivery Areas

Figures 15 - 20 present the cost estimates for the different states in Nigeria in geopolitical zone grouping and by the percentage distribution of cost for each services area – both the costs for the thematic areas and for programme coordination and monitoring and evaluation.

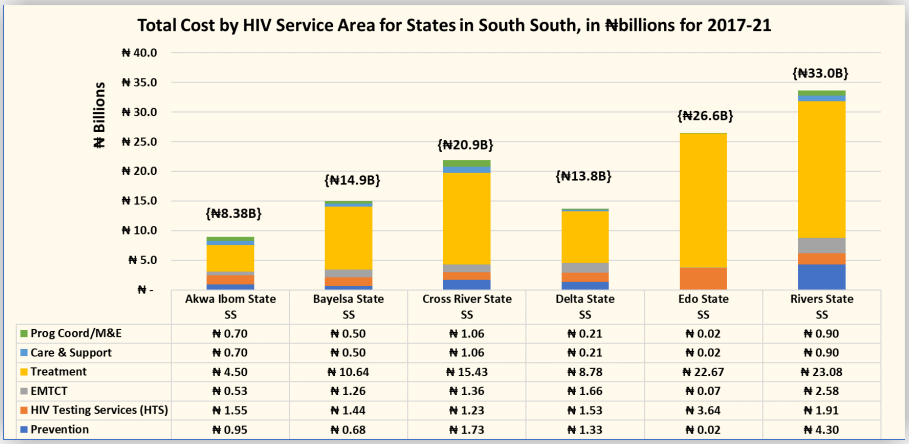
Figure 15: Total Cost of the Nigeria HIVAIDS 2010-21 for States in South West by Services Areas, in ₦Billions



	Ekiti State SW	Lagos State SW	Ogun State SW	Ondo State SW	Osun State SW	Oyo State SW
Prog Coord/M&E	₦ 0.22	₦ 0.42	₦ 0.34	₦ 0.22	₦ 0.17	₦ 0.26
Care & Support	₦ 4.60	₦ 0.79	₦ 0.26	₦ 1.60	₦ 0.02	₦ 0.10
Treatment	₦ 6.99	₦ 38.31	₦ 13.60	₦ 14.62	₦ 2.34	₦ 30.77
EMTCT	₦ 4.30	₦ 4.44	₦ 0.37	₦ 2.31	₦ 2.00	₦ 0.15
HIV Testing Services (HTS)	₦ 6.85	₦ 2.06	₦ 3.25	₦ 4.58	₦ 1.41	₦ 1.12
Prevention	₦ 4.56	₦ 6.98	₦ 1.20	₦ 4.17	₦ 3.40	₦ 0.27

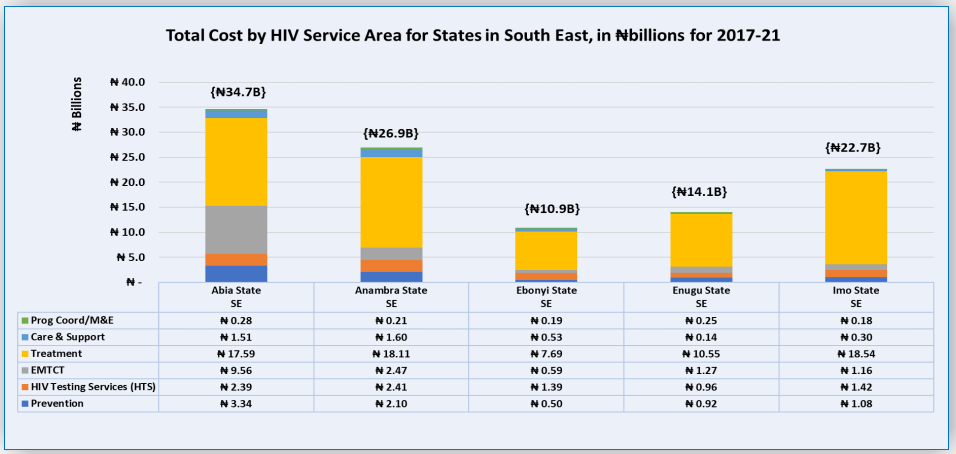
[5]Three One Principles references to One frameworks, One Coordinating Entity and One Monitoring and Evaluation System

Figure 16: Total Cost of the Nigeria HIVAIDS 2010-21 for States in South-South by Services Areas, in ₦Billions



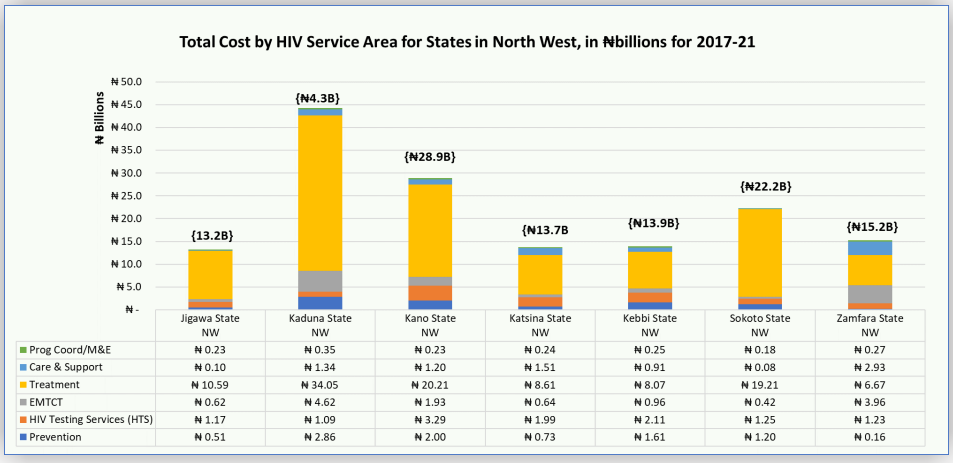
	Akwa Ibom State SS	Bayelsa State SS	Cross River State SS	Delta State SS	Edo State SS	Rivers State SS
Prog Coord/M&E	₦ 0.70	₦ 0.50	₦ 1.06	₦ 0.21	₦ 0.02	₦ 0.90
Care & Support	₦ 0.70	₦ 0.50	₦ 1.06	₦ 0.21	₦ 0.02	₦ 0.90
Treatment	₦ 4.50	₦ 10.64	₦ 15.43	₦ 8.78	₦ 22.67	₦ 23.08
EMTCT	₦ 0.53	₦ 1.26	₦ 1.36	₦ 1.66	₦ 0.07	₦ 2.58
HIV Testing Services (HTS)	₦ 1.55	₦ 1.44	₦ 1.23	₦ 1.53	₦ 3.64	₦ 1.91
Prevention	₦ 0.95	₦ 0.68	₦ 1.73	₦ 1.33	₦ 0.02	₦ 4.30

Figure 17 : Total Cost of the Nigeria HIVAIDS 2010-21 for States in South-East by Services Areas, in ₦Billions



	Abia State SE	Anambra State SE	Ebonyi State SE	Enugu State SE	Imo State SE
Prog Coord/M&E	₦ 0.28	₦ 0.21	₦ 0.19	₦ 0.25	₦ 0.18
Care & Support	₦ 1.51	₦ 1.60	₦ 0.53	₦ 0.14	₦ 0.30
Treatment	₦ 17.59	₦ 18.11	₦ 7.69	₦ 10.55	₦ 18.54
EMTCT	₦ 9.56	₦ 2.47	₦ 0.59	₦ 1.27	₦ 1.16
HIV Testing Services (HTS)	₦ 2.39	₦ 2.41	₦ 1.39	₦ 0.96	₦ 1.42
Prevention	₦ 3.34	₦ 2.10	₦ 0.50	₦ 0.92	₦ 1.08

Figure 18: Total Cost of the Nigeria HIVAIDS 2010-21 for States in North-West by Services Areas, in ₦Billions



	Jigawa State NW	Kaduna State NW	Kano State NW	Katsina State NW	Kebbi State NW	Sokoto State NW	Zamfara State NW
Prog Coord/M&E	₦ 0.23	₦ 0.35	₦ 0.23	₦ 0.24	₦ 0.25	₦ 0.18	₦ 0.27
Care & Support	₦ 0.10	₦ 1.34	₦ 1.20	₦ 1.51	₦ 0.91	₦ 0.08	₦ 2.93
Treatment	₦ 10.59	₦ 34.05	₦ 20.21	₦ 8.61	₦ 8.07	₦ 19.21	₦ 6.67
EMTCT	₦ 0.62	₦ 4.62	₦ 1.93	₦ 0.64	₦ 0.96	₦ 0.42	₦ 3.96
HIV Testing Services (HTS)	₦ 1.17	₦ 1.09	₦ 3.29	₦ 1.99	₦ 2.11	₦ 1.25	₦ 1.23
Prevention	₦ 0.51	₦ 2.86	₦ 2.00	₦ 0.73	₦ 1.61	₦ 1.20	₦ 0.16

Figure 19 : Total Cost of the Nigeria HIVAIDS 2010-21 for States in North-East by Services Areas, in ₦Billions

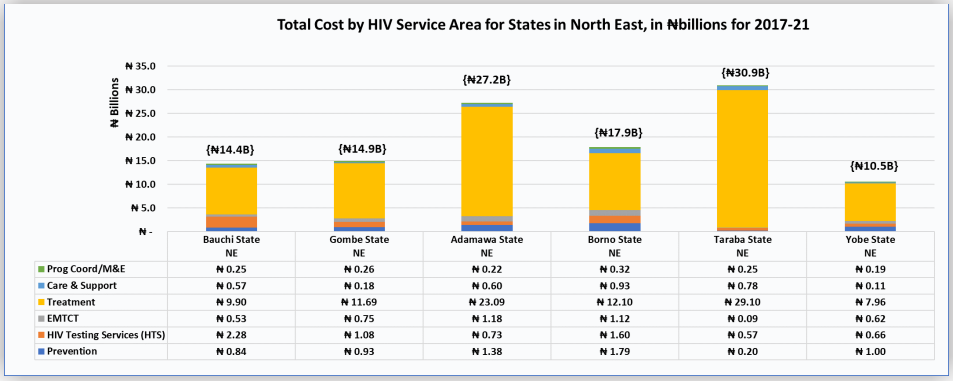
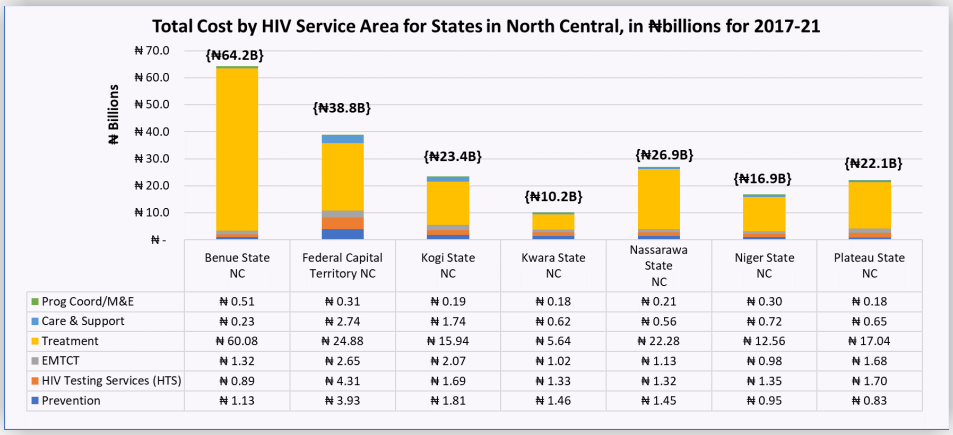


Figure 20: Total Cost of the Nigeria HIVAIDS 2010-21 for States in North-East by Services Areas, in ₦Billions



7.4. Nigeria HIV and AIDS 2010-21 Resource Gap Analysis

In the section, the Strategy is subjected to a financial sustainability analysis to compare the costs of the plan and the available funding; and, to assess the affordability of the plan given available sources. This assessment will enable Nigeria to determine whether there is need to scale down and at what point in the planning horizon this should be done. It also acts as a basis for resource mobilization. Analysis of the funding Gap was conducted using the currency of ₦353 to the dollar.

Funding for HIV and AIDS programme in Nigeria varies across an extensive range of sources and scope. While some development assistance focusses on improving the quality and coverage of specific services like prevention, HTS, and Treatment, others target empowering community systems and activities of non-state actors for the improvement of the quality of life of PLHIV or PABA HIV. More recently, significant resources have been deployed to address the high infection rate associated with key populations. In the following analysis, the emphasis is on all available resources, irrespective of the scope of its utilization. Attempts have been made to project the current commitment of the major partners supporting HIV programming in Nigeria, namely USG PEPFAR, and the World Bank. Other funding commitments captured for analysis include

budgetary subventions of Federal and State Governments to NACA and SACAs in 21 States. Funds from the Private Sector were captured as part of the HIV Trust Fund. The various sources of funds, including their commitments for 2017 and 2018, are presented in Table 10.

Beyond 2018, for this analysis, it was assumed that the major partners currently supporting HIVAIDS in Nigeria would be favourably disposed to continue, but not at the current magnitude. Guided by the recent call for increased domestic funding for the HIV programme, a year to year discount of fifty percent discount was applied to partners' allocation from 2019 to 2021; as the assumption for projecting the resources that will be available for the 2017 -2021 period.

Table 10 : Major Funding agencies/allocations compared with the cost of the HIVAIDS Response in Nigeria from 2017 to 2022

Funding Sources *in Million USD*	**2017**	**2018**	**2019**	**2020**	**2021**	**Total**	**Source**
Government of Nigeria (NACA)	$12.4m	$12.1m	$12.1m	$12.1m	$12.1m	$60.8m	*2017 Appropriation ACT & 2018 Proposal*
Government of Nigeria State FMoH (NASCP)	TBD	TBD	TBD	TBD	TBD	-	
Government of Nigeria State Budget Allocation (21 States)	$15.4m					-	*Data from 21 States budget proposals*
USG PEPFAR	$409.1m	$383.6m	-	-	-	-	*COP 2017 Approval Meeting Presentation Nigeria*
World bank			$50.0m	$150.0m	100.0m	$300.0m	*HPDP III Project Proposal*
Global Fund	TBD	TBD	TBD	TBD	TBD	-	
Private Sectors (HTF)	$06.2m	$29.4m	$14.7m	$07.3m	$03.7m	$61.3m	*HIV Trust Fund (HTF) Concept paper and 2014 NASA*
Total available	**443.2m**	**$425.1m**	**268.6m**	**$265.3m**	**$163.7m**	**$1,566m**	
National HIVAIDS Strategy 2017-2021 Cost in Dollars	$391m	$433.2m	$490.8m	$547.2m	$614.8m	$2,477m	
Funding gap (Surplus in Red)	**$52.2m**	**$8.1m**	**$222.m**	**$2829m**	**$451m**	**$911m**	
Funding gap %	13%	2%	45%	52%	73%	37%	

Result of the NSP II sustainability analysis indicates a funding gap of 37% at the end of the five years. This estimate is premised on the assumption that existing resource commitments to the national response is sustained over the period of the strategy. Given that the NSP II funding gap of $900million is expected to reduce as additional information on development assistant become available, it becomes imperative to strengthen on-going effort to map all HIV programme resource commitments. On the key drivers of the NSP II cost, analysis of cost output across the five service areas of the strategy reveals the provision of ART services as the largest cost driver. ART services were allocated about 72% of the NSP II Total Cost, thus underscoring government's commitment to achieving the 90-90-90 policy goals. While it is desirable to have a plan that is feasible and fundable, modifying the ART coverage targets for that purpose would amount to a shift in government's policy. Government and its partners must at this point explore other opportunities to mobilize resources for fund the resource gap.

Some useful suggestions aimed at leveraging additional resources for the full implementation of the Strategy are subsequently presented as recommended next steps. A good place to start in addressing the funding gap would be to improve domestic funding of the national response. From table 10, the Government currently accounts for 2.4% of the resource required to fund the Strategy. However, should the Federal Government decide to commit additional ₦3.2 Billion annually and the 36states and FCT each set-aside ₦1.3Billion annually as their contributions to HIV treatment, the current gap would be reduced by 80%. In addition to increasing budgetary allocation to HIV programming at both National, States and LGAs levels, Government can mobilize more resource by integrating HIV services into the package of care of the social insurance scheme. Likewise, funds can be sourced from the private sector. The government should consider a mechanism that incentivizes private sector contributions to HIV programming.

Improving efficiencies of HIV services especially costs associated with ART services presents yet another potential source for mobilizing funds for the NSP II implementation. By promoting local production of Anti-Retroviral Drugs (generic), it is anticipated that the investment required for treatment would be significantly lower on account the cost of locally sourced ARVs. Evidence has shown that local production has the potential of reducing the cost by almost 50%, thus reducing the overall cost of the plan by as much as ₦200Billion.

Another approach aimed at ensuring the adequacy of the resources to drive the NSP II lies in the effective coordination of development assistance. The government can increase the predictability of required funds by mobilizing donors to pre-commit their resources in alignment with the strategy. By this approach, Government would guarantee accountability of this assistance; thereby minimizing the recurrent duplication of effort amongst partners whilst ensuring geographical coverage of the national response.

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Annex I: Summary of HIV State Strategic Plan 2017-21 Total Cost Across 36 States and FCT (in ₦ Billion)

Name of State & Zones	Prevention	HIV Testing Services (HTS)	EMTCT	Treatment	Care & Support	Prog Coord/M&E	Total
Benue State NC	₦ 1.1	₦ 0.9	₦ 1.3	₦ 60.1	₦ 0.2	₦ 0.5	₦ 64.2
Federal Capital Territory NC	₦ 3.9	₦ 4.3	₦ 2.6	₦ 24.9	₦ 2.7	₦ 0.3	₦ 38.8
Kogi State NC	₦ 1.8	₦ 1.7	₦ 2.1	₦ 15.9	₦ 1.7	₦ 0.2	₦ 23.4
Kwara State NC	₦ 1.5	₦ 1.3	₦ 1.0	₦ 5.6	₦ 0.6	₦ 0.2	₦ 10.2
Nasarawa State NC	₦ 1.4	₦ 1.3	₦ 1.1	₦ 22.3	₦ 0.6	₦ 0.2	₦ 26.9
Niger State NC	₦ 1.0	₦ 1.4	₦ 1.0	₦ 12.6	₦ 0.7	₦ 0.3	₦ 16.9
Plateau State NC	₦ 0.8	₦ 1.7	₦ 1.7	₦ 17.0	₦ 0.7	₦ 0.2	₦ 22.1
Bauchi State NE	₦ 0.8	₦ 2.3	₦ 0.5	₦ 9.9	₦ 0.6	₦ 0.3	₦ 14.4
Gombe State NE	₦ 0.9	₦ 1.1	₦ 0.7	₦ 11.7	₦ 0.2	₦ 0.3	₦ 14.9
Adamawa State NE	₦ 1.4	₦ 0.7	₦ 1.2	₦ 23.1	₦ 0.6	₦ 0.2	₦ 27.2
Borno State NE	₦ 1.8	₦ 1.6	₦ 1.1	₦ 12.1	₦ 0.9	₦ 0.3	₦ 17.9
Taraba State NE	₦ 0.2	₦ 0.6	₦ 0.1	₦ 29.1	₦ 0.8	₦ 0.2	₦ 31.0
Yobe State NE	₦ 1.0	₦ 0.7	₦ 0.6	₦ 8.0	₦ 0.1	₦ 0.2	₦ 10.5
Jigawa State NW	₦ 0.5	₦ 1.2	₦ 0.6	₦ 10.6	₦ 0.1	₦ 0.2	₦ 13.2
Kaduna State NW	₦ 2.9	₦ 1.1	₦ 4.6	₦ 34.0	₦ 1.3	₦ 0.4	₦ 44.3
Kano State NW	₦ 2.0	₦ 3.3	₦ 1.9	₦ 20.2	₦ 1.2	₦ 0.2	₦ 28.8
Katsina State NW	₦ 0.6	₦ 2.0	₦ 0.6	₦ 8.6	₦ 1.5	₦ 0.2	₦ 13.6
Kebbi State NW	₦ 1.6	₦ 2.1	₦ 1.0	₦ 8.1	₦ 0.9	₦ 0.2	₦ 13.9
Sokoto State NW	₦ 1.2	₦ 1.2	₦ 0.4	₦ 19.2	₦ 0.1	₦ 0.2	₦ 22.3

Zamfara State NW	₦ 0.2	₦ 1.2	₦ 4.0	₦ 6.7	₦ 2.9	₦ 0.3	₦ 15.2
Abia State SE	₦ 3.3	₦ 2.4	₦ 9.6	₦ 17.6	₦ 1.5	₦ 0.3	₦ 34.7
Anambra State SE	₦ 2.1	₦ 2.4	₦ 2.5	₦ 18.1	₦ 1.6	₦ 0.2	₦ 26.9
Ebonyi State SE	₦ 0.5	₦ 1.4	₦ 0.6	₦ 7.7	₦ 0.5	₦ 0.2	₦ 10.9
Enugu State SE	₦ 0.9	₦ 1.0	₦ 1.3	₦ 10.6	₦ 0.1	₦ 0.2	₦ 14.1
Imo State SE	₦ 1.1	₦ 1.4	₦ 1.2	₦ 18.5	₦ 0.3	₦ 0.2	₦ 22.7
Akwa Ibom State SS	₦ 1.0	₦ 1.6	₦ 0.5	₦ 4.5	₦ 0.7	₦ 0.1	₦ 8.4
Bayelsa State SS	₦ 0.7	₦ 1.4	₦ 1.3	₦ 10.6	₦ 0.5	₦ 0.3	₦ 14.8
Cross River State SS	₦ 1.7	₦ 1.2	₦ 1.4	₦ 15.4	₦ 1.1	₦ 0.2	₦ 21.0
Delta State SS	₦ 1.3	₦ 1.5	₦ 1.7	₦ 8.8	₦ 0.2	₦ 0.2	₦ 13.8
Edo State SS	₦ 0.0	₦ 3.6	₦ 0.1	₦ 22.7	₦ 0.0	₦ 0.2	₦ 26.6
Rivers State SS	₦ 4.3	₦ 1.9	₦ 2.6	₦ 23.1	₦ 0.9	₦ 0.3	₦ 33.0
Ekiti State SW	₦ 4.6	₦ 6.8	₦ 4.3	₦ 7.0	₦ 4.6	₦ 0.2	₦ 27.5
Lagos State SW	₦ 7.0	₦ 2.1	₦ 4.4	₦ 38.3	₦ 0.8	₦ 0.4	₦ 53.0
Ogun State SW	₦ 1.2	₦ 3.3	₦ 0.4	₦ 13.6	₦ 0.3	₦ 0.3	₦ 19.0
Ondo State SW	₦ 4.2	₦ 4.6	₦ 2.3	₦ 14.6	₦ 1.6	₦ 0.2	₦ 27.5
Osun State SW	₦ 3.4	₦ 1.4	₦ 2.0	₦ 10.9	₦ 0.0	₦ 0.3	₦ 18.0
Oyo State SW	₦ 0.3	₦ 1.1	₦ 0.2	₦ 30.8	₦ 0.1	₦ 0.3	₦ 32.7
National Aggregate	**₦ 64.2B**	**₦ 70.8B**	**₦ 64.4B**	**₦ 632.4B**	**₦ 33.3B**	**₦ 9.3B**	**₦ 874.4B**

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