

# NATIONAL HIV/AIDS PREVENTION PLAN

2014 -2015

## Foreword

The national HIV response has achieved considerable success in coordinating prevention activities over the years. A retrospective review of the previous National HIV/AIDS Prevention Plans shows a change in the strategic focus and approach to prevention. The National Prevention Plan 2007-2009 (NPP 2007-2009) addressed the challenge of low effectiveness resulting from the use of a range of single intervention approach by service providers. Single intervention approach did not actualize the expected levels of behavioural change required to avert new HIV infections. Therefore, NPP 2007-2009 provided a reference point and direction in prevention intervention planning processes as well as justification for resource mobilization requirements by the government and implementing partners.

The goal of the National Prevention Plan 2010-2012 was to reduce the incidence of HIV by scaling up implementation of effective HIV and AIDS prevention interventions within the context of the National HIV and AIDS Policy and Strategic Framework. It introduced the combination prevention approach, locally called the “Minimum Prevention Package Intervention” (MPPI) which emphasized dosage and intensity of interventions. It also defined a range of prevention intervention packages. It emphasized the need to address the drivers of the epidemic which vary for different sub-populations as the focus of interventions that will catalyze and sustain the desired behaviour change. NPP 2010-2012 promoted the concept of ownership and sustainability by emphasizing active stakeholders' involvement and participation.

The NPP 2014-2015 took into consideration the outcome of the evaluation of the NPP 2010-2012. It provides a guide for evidenced-based programming and implementation of the MPPI. It also provides standardized approaches to HIV prevention from the evolving evidence on drivers of the HIV epidemic in Nigeria, lessons learnt on planning, implementation and scale up of HIV prevention programmes as key in strategic HIV prevention programming.

The National Prevention Plan has come a long way in providing direction for all actors in the national HIV response. I am confident that the use of this document by all stakeholders working in the area of HIV and AIDS prevention will contribute significantly to achieving the national prevention targets. It will contribute towards the realization of the President’s Comprehensive Response Plan, the Millennium Development Goals of halting and reversing the HIV epidemic by 2015 and keeping over 95% of Nigerians, who are presently uninfected, free of HIV/AIDS. As this NPP ends in 2015 along with some national strategic documents, I look forward to counting better successes than were recorded with previous National Prevention Plans for HIV/AIDS in Nigeria.



**Professor John Idoko**

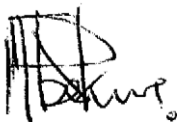
**Director General, NACA**

## **Preface**

This National Prevention Plan 2014-2015 is a plan aimed at providing direction for the implementation of the Behaviour Change and Prevention of New HIV infections track of the 2010-2015 National HIV/AIDS Strategic Plan. It builds on the successes and outcomes of previous national prevention plans (especially NPP 2010-2012), as outlined in the 2012 Mid-term Review of the National HIV and AIDS Strategic plan.

This is the third in a series of national prevention plans developed by the National Prevention Technical Working Group (NPTWG). The plan is focused on evidence-based programming and standardization of approaches to HIV prevention in the country. It draws on the evolving evidence, the success of national and state level programmes, operational research findings and the outcome of monitoring and evaluation of ongoing prevention programmes in the country. It builds on efforts of the NPP 2010-2012 that encouraged the generation of the required evidence and data for HIV prevention programming. The NPP 2010-2012 also built on the efforts of the NPP 2007-2009 which focused on organizing approaches and systems for delivering HIV prevention programmes in Nigeria.

In view of the efforts of the last few years, this plan focuses on addressing four thematic areas of HIV prevention: HIV Counseling and testing (HCT), prevention of mother to child transmission of HIV (PMTCT), biomedical HIV prevention and prevention of sexual transmission of HIV. The NPP supports HIV/Sexual and Reproductive Health (HIV/SRH) integration including promoting access to contraceptive/family planning services for People living with HIV, as part of the effort to address Prongs 1 and 2 of the national PMTCT programme. This plan is an improvement over the previous plan as further evidence such as epidemic appraisal and Mode of Transmission studies have informed programming for Most At Risk Populations (MARPs). HIV prevention programming for the general population and the vulnerable populations remain important. This plan also takes cognizance of emerging trends in prevention which include treatment as prevention (TasP), pre-exposure prophylaxis (PrEP), vaccines and microbicides and voluntary male medical circumcision (VMMC). Positive Health Dignity and Prevention (PHDP) will be addressed as part of care and support thematic area by the Care and Support Technical Working Group. It is envisaged that the implementation of this plan will contribute to Nigeria achieving its target for universal access and coverage by 2015, in line with the President's Comprehensive Response Plan for HIV/AIDS.



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**Chairperson, National Prevention Technical Working Group**

## **Acknowledgements**

The development of the National Prevention Plan 2014-2015 (otherwise known as NPP 2014-2015 or NPP3) involved a thorough process that engaged various stakeholders and experts. The process was rigorous, drawing on outcomes of the independent review of the NPP 2010-2012 (NPP2), outcomes of the review of the MPPI, mid-term review of the National Strategic Plan reports and other related studies and research. Several players were involved in thinking through the focus and design of this national prevention plan.

The National Agency for the Control of AIDS (NACA) acknowledges the leadership provided by the Director General of NACA Prof. John Idoko. We also acknowledge the support and cooperation given by members of the National Prevention Technical Working Group (NPTWG), the staff of the Programme Coordination Department, NACA and the University of Manitoba (UoM) team – local and international – who made the process of thinking through the way forward for HIV prevention programming in Nigeria and of putting together this plan an easy and seamless one. The input and support of Directors at NACA especially Dr. Akudo Ikpeazu are also appreciated.

We acknowledge the unstinting efforts of the following: Project Managers/Chief Executive Officers/Executive Secretaries/Chairpersons of SACAs, MDAs, CSO networks and the private sector. We are also grateful to Development Partners including USG, UK DFID, UNAIDS, UNFPA, UNICEF. The process would not have been possible without the financial and technical support of our partners. In particular we thank the World Bank, India Learning Network (ILN), USAID, FHI 360, IHVN, DFID-Supported ENR programme and the Society for Family Health (SFH) for their role in the process. We acknowledge our partners' continued support. We thank Dr Morenike Ukpong who contributed in pulling together this document.

Finally, the efforts of the NGOs, FBOs, CBOs, health care workers, community leaders and all others who have been on the field making it happen and providing all the support for the successful implementation of HIV prevention efforts in Nigeria are duly acknowledged. All your efforts are coming together to enable us write a national HIV prevention success story.

## List of Contents

	Page
Foreword	1
Preface	2
Acknowledgements	3
List of Tables	5
List of Figures and Boxes	5
Acronyms	6
Executive summary	8
1.0 BACKGROUND	11
1.1 Socio-demographic profile	11
1.2 The global HIV epidemic	13
1.3 Epidemiology of HIV in Nigeria	13
1.4 Overview of HIV/AIDS prevention in Nigeria	23
1.5 Lessons learnt, challenges, opportunities, and achievements (broader context & National Prevention Plan (2010-2012))	24
1.6 Expenditure on HIV and AIDS in Nigeria	25
2.0 THE DEVELOPMENT OF THE NATIONAL PREVENTION PLAN (2014-2015)	27
2.1 Goal of the National Prevention Plan 2014-2015	27
2.2 Objectives of the National Prevention Plan 2014-2015	27
2.3 Development process for the NPP	27
2.4 Rationale for the national prevention plan (NPP 2014-2015)	28
2.5 Guiding principles of the National Prevention Plan (NPP)	29
2.6 Target audience of the NPP	29
2.7 Target population for the NPP 2014-2015	30
2.8 National HIV Prevention Strategy	31
2.9 The cluster model of the implementation	34
2.10 State priorities identified during the NPP zonal consultations	35
3.0 PROGRAMMATIC CONTEXT FOR NATIONAL HIV PREVENTION EFFORTS	37
3.1 Thematic area: HIV counselling and testing	37
3.2 Thematic area: Prevention of mother to child transmission	40
3.3 Thematic area: Biomedical HIV prevention	42
3.4 Thematic area: Prevention of sexual transmission of HIV infection	46
3.5 Other key themes and emerging areas	49
3.6 Coordination	56
4.0 MONITORING AND EVALUATION	61
4.1 NPP Indicators and target	61
4.2 Data Sources for NPP indicators	68
4.3 Data Flow	71
4.4 Data dissemination and information use	73
4.5 NPP indicators definition and data sources	74
Appendix 1: Overview of State health service data for planning PMTCT services	82

## List of Tables

	Page
1 Trends in estimated new HIV infections (2001-2013)	17
2 Distribution of new HIV infections by mode of exposure in the adult population in 6 States	19
3 Factors that affect the risk of HIV transmission in Nigeria	20
4 Overview of the Minimum Prevention Package of Intervention for the target populations	33
5 NPP review Zonal Consultations: Summary of state priorities	35
6 Roles and responsibilities of stakeholders engaged with the National HIV prevention response	56
7 National Prevention Plan Index Matrix	62
8 List of the M & E Data collection and Reporting Tools by Thematic area	69
9 NPP Monitoring and Evaluation Index Reference table	74

## List of Figures

1 HIV Prevalence Trend in Nigeria (1991-2010)	13
2 HIV prevalence by age group and sex, FMoH, Nigeria, 2013	14
3 HIV prevalence by sex and zones, FMoH, Nigeria, 2013	14
4 Map of HIV prevalence by States	15
5 HIV prevalence by States	16
6 HIV prevalence among Most-at-Risk Populations in Nigeria in 2007 and 2010	17
7 Distribution of new infections by mode of exposure	18
8 Total HIV/AIDS Expenditure from all sources (2009-2012)	26
9 HIV Counselling and Testing (National targets and achievements from 2010 to 2013)	37
10 Male circumcision across zones in Nigeria	46
11 NPP data flow and reporting	72

## List of Boxes

1 Summary of risk factors and drivers of HIV	23
2 Achievements of the National Prevention Plan (NPP 2010-2012)	25
3 Key programme implications for MARPs programming	47

## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARVs	Anti-Retroviral Drugs
BBFSW	Brothel Based Female Sex Workers
CSOs	Civil Society Organisations
EID	Early Infant Diagnosis
FCT	Federal Capital Territory
FLHE	Family Life Health Education
FMoH	Federal Ministry of Health
FMWASD	Federal Ministry of Women Affairs and Social Development
FP	Family Planning
FSW	Female Sex Workers
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPDP 2	HIV/AIDs Programme Development Project 2
IBSS	Integrated Biological and Behavioural Sentinel Survey
IDUs	Injecting Drug Users
IGA	Income Generating Activities
LACA	Local Government Area Action Committee on AIDS
LGAs	Local Government Areas
MARPs	Most-at-Risk-Populations
MDAs	Ministries, Departments, and Agencies
MDGs	Millennium Development Goals
MOT	Mode of Transmission
MPPI	Minimum Prevention Package Intervention
MSM	Men who have Sex with Men
NARHS	National AIDS and Reproductive Health Survey
NASCP	National AIDS Control Programme
NBBFSW	Non Brothel Based Female Sex Workers
NBTS	National Blood Transfusion Service
NDHS	National Demographic Health Survey
NGOs	Non-Governmental Organisations
NIBUCAA	Nigeria Business Coalition against AIDS
NNRIMS	Nigeria National Response Information Management System

NPP	National Prevention Plan
NPTWG	National Prevention Technical Working Group
NSP	National Strategic Plan
NYSC	National Youth Service Corps
OVC	Orphans and Vulnerable Children
PABA	Person Affected By AIDS
PCRP	Presidential Comprehensive Response Plan
PEP	Post Exposure Prophylaxis
PET	Peer Educators Trainers
PHC	Primary Health Centers
PHDP	Positive Health and Dignity Programme
PITT	Prevention Intervention Tracking Tool
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-exposure Prophylaxis
SACA	State Action Committee on AIDS
sdNVP	Niverapine
SFH	Society for Family Health
SHC	Secondary Health Centres
SME	Small and Medium scale Enterprise
SMoH	State Ministry of Health
SMT	State Management Team
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TasP	Treatment as Prevention
TB	Tuberculosis
TBA	Traditional Birth Attendants
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organisation



## **EXECUTIVE SUMMARY**

Nigeria had an estimated population of about 174, 507,539 people in 2013. About two-thirds of this population reside in the rural areas. There are about 400 ethnic groups in Nigeria and the predominant religions are: Christianity, Islam and traditional religion. These socio-cultural differences have implications for HIV prevention service delivery and uptake.

The HIV prevalence in the general population is estimated at 3.4% (FMoH, 2013). The HIV prevalence among pregnant women (antenatal sentinel survey) was 4.1% in 2010 (FMoH, 2010). It is estimated that about 3.2 million people are living with HIV and about 220,393 new HIV infections occurred in 2013. These high numbers of new infections show that we must continue to prioritize prevention as a key strategy in halting and reversing the HIV epidemic in Nigeria.

This National Prevention Plan 2014-2015, is the third in the series of developing national prevention plan. This plan provides strategic direction and guidance for HIV programming in Nigeria. It has been informed by the expanded evidence-base (including NARHS 2013, epidemic appraisals, findings of the mid-term review of the National Strategic Plan for HIV/AIDS and other studies undertaken at the regional and state levels).

There is evidence that there are geographical differences in HIV prevalence. Some sub-populations are considered as high risk for HIV (key target populations). Among these are female sex workers, injecting drug users and men having sex with men (these are classified as MARPs) Other high risk groups are Transport Workers (TWs), Uniformed Service Personnel (USP). Other population sub-groups considered vulnerable with respect to HIV infection include young people especially females, females that are widowed, separated or divorced, people with disability and people living in poverty.

In Nigeria, the major route of transmission of HIV is through sexual transmission (accounting for about 80% of HIV infections). About 42% of infections occur among people that are 'low risk' heterosexuals. Directly, MARPs alone contribute about 23% of new HIV infections and with their partners' contribute 40% of new infections. Risk factors and drivers of the HIV epidemic in Nigeria include early sexual debut, low condom use, transaction sex and multiple sexual partners, low perception of risk, transfusion of poorly screened blood, poor injection safety, etc.

The national response for HIV and AIDS is largely donor-funded, with Nigeria's contribution comprising of 25% of HIV funds. Although funding for HIV has increased from 415 million (in 2009) to 577 million dollars (in 2012), the proportion spent on prevention remains low (12.5% in 2012) and out-of-pocket expenditure for HIV services are considerably high.

The goal of this Plan (NPP 2014-2015) is to scale up evidence-based programming using targeted interventions and standardized intervention packages at scale. The objectives are to: promote and scale up HCT (client and provider initiated HCT) especially targeting high risk groups and use of a mix of delivery approach including community-based service models; promote and scale up interventions for PMTCT, early infant diagnosis; promote dual protection benefits of condoms

(male and female condoms, and lubricants); prevent biomedical transmission through blood safety, injection safety, safe healthcare waste management, adherence to universal precautions, safe male circumcision, post-exposure prophylaxis, early diagnosis and treatment of STIs; and promote the integration of HIV prevention programmes with other health services (TB/HIV, SRH/HIV, MNCH, etc.) This NPP emphasizes the implementation of the Minimum Prevention Package of Interventions, the generation and use of evidence of effective interventions and service models in HIV programming.

The underlying guiding principles of the NPP are to enhance access of PLHIV, key populations and vulnerable groups to comprehensive programmes that address behavioural, biomedical and structural vulnerabilities. The NPP also address gender factors that increase female vulnerability to HIV, promote integration of services and evidence-based HIV programming. The priority interventions for target populations will emphasize coverage, depth and quality of service provision as well as consider geographical variations in prevalence. Identified state priorities should be addressed, including the engagement of the private health sector, private businesses and implementation of HIV workplace programmes.

HCT can serve as an entry point into HIV treatment and care services. This Plan prioritizes the scale up on PICT and client initiated testing and the use of a mix of effective service delivery approaches including community-based HCT approaches. HCT targeting high risk groups at scale while emphasizing consent, confidentiality and connection to treatment and care.

The NPP prioritizes the scale up of PMTCT and implementation of the 4 prong approach to PMTCT, with emphasis on prongs 3 and 4. It aims to strengthen coordination of PMTCT services at state and local government levels, promote operational research and knowledge based approach to programming including use of management of information systems and use of data-analysis to inform service provision. This plan recommends the involvement of private sector engagement in the provision of PMTCT services and scale up of early infant diagnosis.

Measures to reduce biomedical transmission of HIV include safe blood supplies, injection safety for both medical and non-medical injections and universal precautions in healthcare settings. Increase access to post-exposure prophylaxis for HIV prevention. Strengthen inter-sectoral collaboration with key stakeholders on healthcare waste management. This plan emphasizes the use of the findings of the epidemic appraisal for MARPs to provide targeted interventions at scale. Seamless integration and linkage with other health programmes and services is a major theme that should become a reality at scale. Overall, the programmes and services should be gender sensitive and responsive, with gender related barriers reduced to a minimum.

Finally, this NPP recognizes the need to re-energize and expand HIV workplace programmes in both the public and private sectors and apply the minimum prevention package of interventions. New prevention technologies such as treatment as prevention, pre-exposure prophylaxis (PrEP) will be explored within the Nigerian context. Natural and human-induced disasters are increasing in number and intensity and resulting in displacement of people and increased vulnerability. These have implications for HIV in humanitarian settings and crisis situations; consequently each state

should have adequate plans and pre-positioning of essential commodities (such as condoms, rapid test kits, family planning resources, ARVs) and key into their State Emergency Management team and plans.

## 1.0 BACKGROUND

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### 1.1 Socio-demographic profile

Nigeria is one of the most populous countries in sub-Saharan Africa and has a land area of 923,768 square kilometers. Based on the 2006 national population census, Nigeria's population was 140,431,790.<sup>1</sup> Nigeria has a projected 2013 population of 174, 507, 539 with an annual growth rate of 2.54%.<sup>2</sup> A gender disaggregated distribution of the population reflects a 51% male and 49% female composition. Children under five years account for 20% of the population and young people under 15 years account for 42% of the population. Young people between 15-24 years account for 19.3% of the population (male - 17, 201, 067; female - 16, 451, 357). About two-thirds of the population live in rural areas, which often lack many modern social amenities.

The population distribution in Nigeria is uneven. While large expanse of sparsely populated land occurs in some parts of the country, many of the major urban centers have high population density. A high level of rural-urban migration occurs in the country and this has implications on the demand for social infrastructure, general development planning and quality of life of the citizenry.

There about 400 ethnic groups in Nigeria. The dominant religions are Christianity and Islam. These socio-cultural differences have implications for HIV prevention service delivery and uptake.

Nigeria is a federation made up of a Federal Capital Territory (Abuja) and 36 States which are divided into 774 Local Government Areas (LGAs). The states are grouped into six geo-political zones; North Central, North East, North West, South East, South-South and South West zones. The LGAs are further sub-divided into 9,565 wards. The ward is the smallest political structure that consists of a geographical area with a population range of 10,000 to 30,000 people. There are on average, ten (10) wards per LGA. The ward is the operational area for delivering a minimum health care package and the ward is expected to mobilize political commitment for health service delivery and social development. Structurally, each ward has a Ward Development Committee (WDC) with the functions of identifying the health and social needs of the Ward and planning solutions. An understanding of these structures and information are useful for effective planning, ownership and sustainability of HIV prevention programmes at the community and the local government levels.

The under-5 mortality rate decreased from 201 deaths per 1,000 live births in 2003 NDHS to 128 deaths per 1,000 live births in the 2013 NDHS. The estimated infant mortality rate in the 2003 NDHS was 100 deaths per 1,000 live births, which decreased to 75 deaths per 1,000 live births in the 2008 NDHS and further to 69 deaths per 1,000 live births in the 2013 NDHS. These data suggest that Nigeria still has a long way to go to achieve the MDG target of reducing the under-5 mortality to 64 deaths per 1,000 live births and the infant mortality to 30 deaths per 1,000 live

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<sup>1</sup> FRN Official Gazette, 2009

<sup>2</sup> National Population Commission, 2013

births by 2015 (Government of Federal Republic of Nigeria, 2010). Breastfeeding is nearly universal in Nigeria, with 96% of children aged 6-8 months being breastfed. The proportion of children who are still being breastfed decreases steadily with age and 35% of children aged 20-23 months are still breastfed. However, the recommendation to exclusively breastfeed children for the first six months of life is met for only 17% of children.

Most users of contraceptives rely on a modern method (10%) and 5% use traditional methods. Among the modern methods, injectable (3%), male condoms (2%), and the pill (2 %) are the most common methods in use. The practice of all other modern methods is far less (< 1%). Married women in urban areas are considerably more likely to use any method of contraception (27%) than women in rural areas (9 %).

## **1.2 The Global HIV Epidemic**

Globally, an estimated 35.3 (32.2-38.8) million people were living with HIV in 2012, an increase from previous years as more people are receiving the life-saving antiretroviral therapy. There were 2.3 (1.9-2.7) million new HIV infections globally, showing a 33% decline in the number of new infections from 3.4 (3.1-3.7) million in 2001. At the same time the number of AIDS deaths is also declining with 1.6 (1.4-1.9) million AIDS deaths in 2012, down from 2.3 (2.1-2.6) million in 2005.<sup>3</sup> The epidemic continues to disproportionately affect sub-Saharan Africa, home to 70% of all new HIV infections in 2012.

Recent surveys in several countries in sub-Saharan Africa have detected decreases in condom use and/or an increase in the number of sexual partners. Efforts to reduce transmission related to sex work and men who have sex with men remain insufficient, as evidenced by recent trends in HIV prevalence among these groups.

The UNAIDS 2013 report on global AIDS epidemic highlighted that although a global meta-analysis of studies determined that 'behavioural interventions reduce sexual risk behaviour and avert sexually transmitted infections and HIV', many countries lack a comprehensive strategy for rolling out these programmatic approaches. It is clear that only when a comprehensive set of HIV prevention initiatives is rolled out on a national scale, with sufficient access to, and frequent use of, quality services, will countries realize the optimal prevention returns. It is important to note that as new biomedical tools become available and are rolled out, effective social-behavioural and structural programmes will not only remain essential in their own right but will also be needed to maximize the efficacy of biomedical approaches. The global revolution in information and communications technology offers new opportunities to expand and reinvigorate social-behavioural and structural programming.

HIV prevention coverage for people who inject drugs remains low, with only two of 32 reporting countries providing the recommended minimum of at least 200 sterile syringes per year for each

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<sup>3</sup> UNAIDS 2013. Global Report: UNAIDS Report on global AIDS epidemic 2013

person who injects drugs. In addition to exceptionally low coverage, an effective AIDS response among people who inject drugs is undermined by punitive policy frameworks and law enforcement practices, which discourage individuals from seeking the health and social services they need.

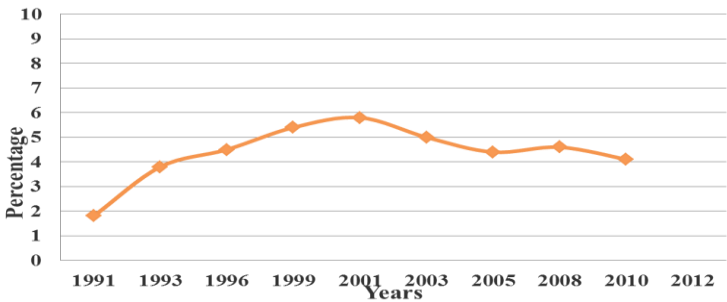
Antiretroviral coverage among pregnant women living with HIV reached 62% in 2012, and the number of children newly infected with HIV in 2012 was 35% lower than in 2009. In 2012, 9.7 million people in low- and middle-income countries received antiretroviral therapy, about 61% of all who were eligible under the 2010 World Health Organisation (WHO) HIV treatment guidelines. But under the 2013 WHO guidelines, the HIV treatment coverage in these countries represented only 34% of the 28.6 million people eligible in 2013.

Continued gains were made in mobilizing financial resources for the AIDS response in 2012, although AIDS expenditures remain short of the global target of US\$ 22-24 billion in annual financial resources. Although international HIV assistance remained flat in real terms in 2012, many low- and middle-income countries have increased financial outlays for HIV; domestic spending accounted for 53% of all HIV-related spending in 2012. Condom programming is an integral component of effective HIV prevention. Funding challenges undermine efforts to ensure ready access to both male and female condoms. Funding issues have complicated national forecasting, procurement, supply and distribution. In 2012, the donor community decreased their supplies of both male and female condoms compared to 2011.

**1.3 Epidemiology of HIV in Nigeria**

The epidemiology of HIV in Nigeria is mainly informed by two national surveys, the Antenatal Clinic (ANC) survey conducted among pregnant women and the National HIV/AIDS and Reproductive Health Survey (NARHS) which is a general population based survey. A review of the ANC survey data (Figure 1) has shown that HIV prevalence has declined and stabilized in Nigeria. The ANC 2010 survey reported a national HIV prevalence of 4.1% and the States’ prevalence ranged from 1% in Kebbi State to 12.7% in Benue State.\*

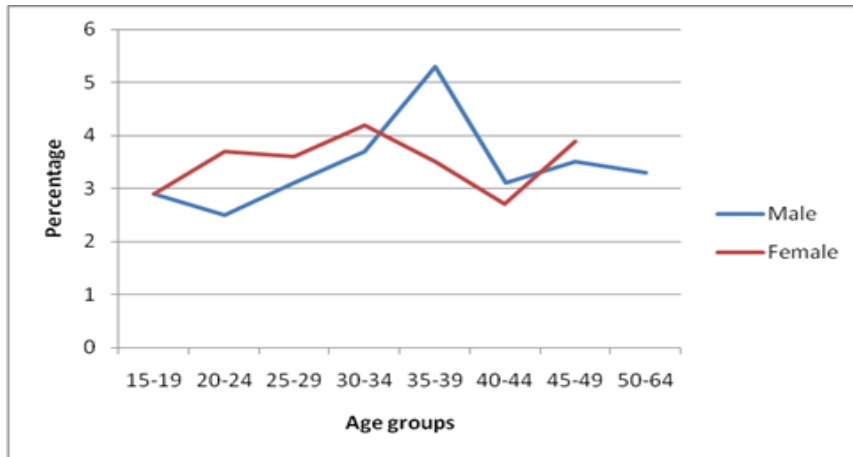
**Figure 1: HIV Prevalence Trend in Nigeria (1991 – 2010)**



Data source: ANC, 2010

NARHS 2013 reported a national HIV prevalence rate of 3.4%, lower than 3.6% reported in 2007. It is estimated that about 3,229,757 people live with HIV in Nigeria and about 220,393 new HIV infections occurred in 2013 and 210,031 died from AIDS related cases. HIV prevalence was highest among the 35-39 years age group (4.4%) and lowest among the 15-19 years age group (2.9%) while the widowed had the highest prevalence (6.2 %). Figure 2 shows the HIV prevalence by age-group and sex. The HIV prevalence was generally higher among respondents with primary and secondary education (4.0%) and lowest among respondents that had Qur'anic education only (2.4%).

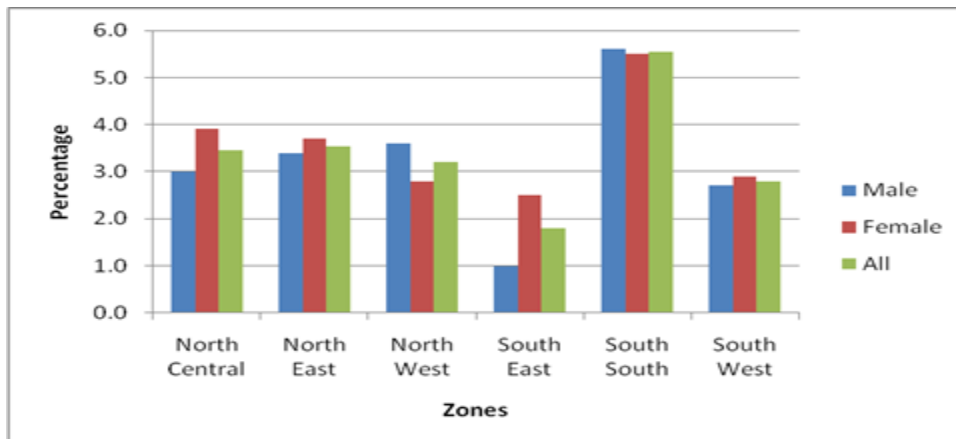
**Figure 2: HIV Prevalence by age group and sex, FMoH, Nigeria, 2013**



Source: NARHS 2013

NARHS 2013 also reported that HIV prevalence was slightly higher in the rural areas (3.6%) compared with the urban (3.2%). Figure 3 presents the HIV Prevalence by sex and zone. There were zonal and state differences in the HIV prevalence (Figures 3-5).

**Figure 3: HIV Prevalence by Sex and Zones; FMoH, Nigeria, 2013**

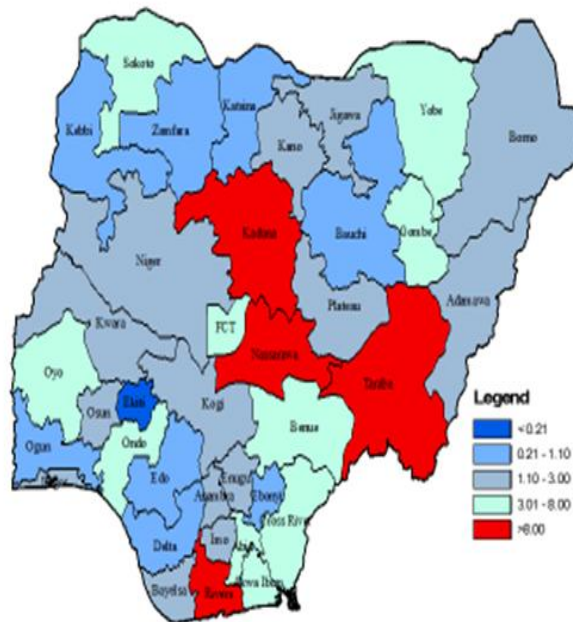


Source: NARHS 2013

Geographically, the HIV prevalence was highest in the South South zone (5.5%) and lowest in the South East (1.8%). The high prevalence of 5.5% in the South-south zone showed an increase from 3.5% in 2007. There were gender differences too. In the South East the HIV prevalence is 2.5% for females compared to 1.0% amongst males. The HIV prevalence was considerably higher in females in NC (3.9%) compared with 3.0% among males. In the NW zone the prevalence among males is 3.6% and 2.8% among females.

**Figure 4: Map showing HIV prevalence of all states in Nigeria**

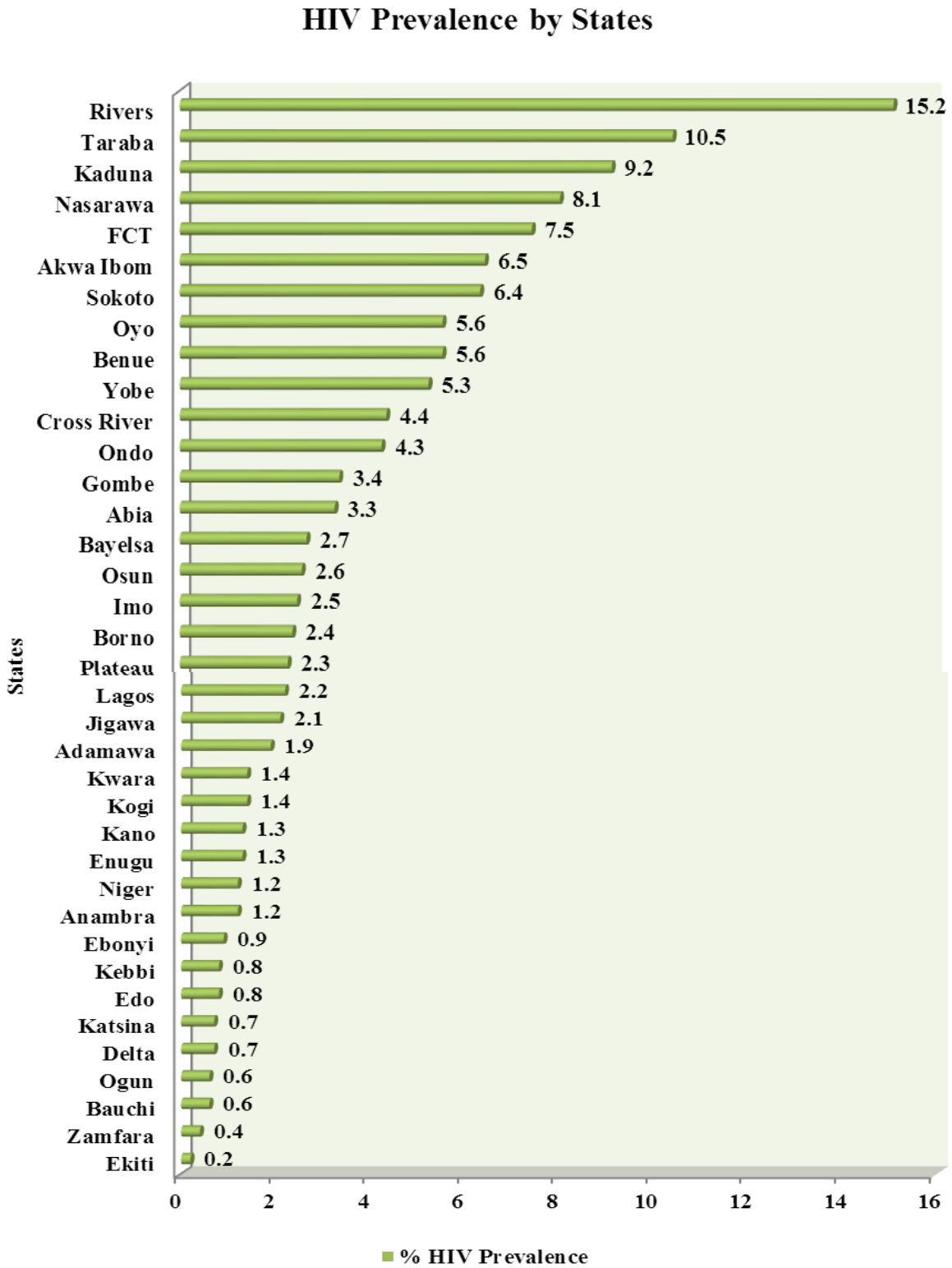
### HIV Prevalence across States, NARHS 2012



Source: National AIDS Reproductive Health Survey 2013



Figure 5: HIV prevalence across the States

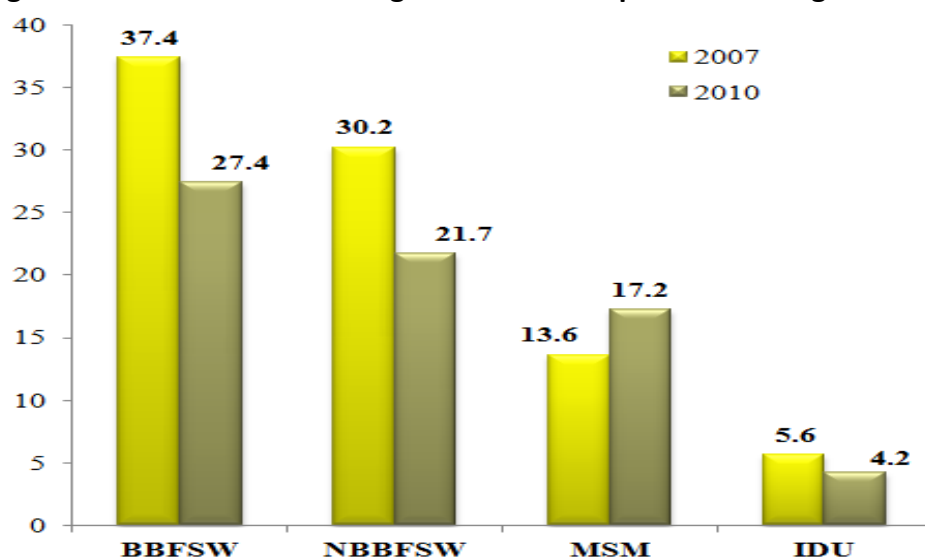


Source: National AIDS Reproductive Health Survey 2013

### 1.3.1 HIV prevalence among MARPs

Based on IBBSS 2010 and 2007 data, the HIV prevalence among MARPs is high. The brothel-based female sex workers (BBFSW) had an estimated prevalence of 27.4% and the non-brothel based Female sex workers (NBBFSW) had a prevalence of 21.7%. Men who have sex with men (MSM), had a prevalence of 17.2%. Figure 6 shows that while the HIV prevalence among FSW declined from 37.4% (2007) to 27.4% (2010), the prevalence increased among MSM: from 13.5% (2007) to 17.4% (2010).

**Figure 6: HIV Prevalence among Most at Risk Populations in Nigeria in 2007 and 2010**



Source: IBBSS 2007, 2010

### 1.3.2 HIV incidence (New infections)

Recent estimates indicate that the annual number of new infections in the country has steadily declined from 288,870 in 2009 to 220,393 in 2013 (Table 1). However, the total number of new HIV infections in females continued to surpass that of the males.

**Table 1: Trends in estimated new HIV infections 2009 to 2013**

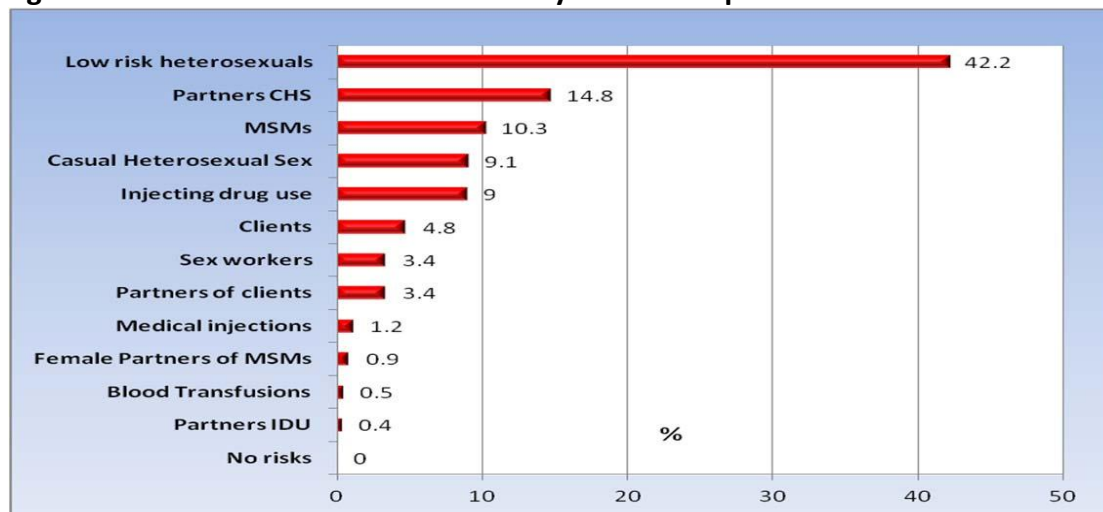
Year	Female	Male	Total
2009	157,976	130,893	288,869
2010	154,973	128,616	283,589
2011	149,864	124,504	274,368
2012	130,497	109,209	239,706
2013	120,003	100,390	220,393

Source: Global AIDS response country progress report Nigeria (NACA 2014)

### 1.3.3 Modes of Transmission

The main mode of HIV transmission among adults in Nigeria is heterosexual intercourse.

**Figure 7: Distribution of new infections by mode of exposure**



Source: Global AIDS Report Progress Report for Nigeria (GARPR) 2014

About two-fifths (42%) of the infections occur amongst persons that are ‘low-risk’ heterosexuals, a sub-population that includes co-habiting or married sexual partners (Figure 7). Condom use in this group tends to be particularly low.

However, the high risk groups still contribute a significant proportion of the new HIV infections. Directly, Female Sex Workers, IDUs and MSMs alone, who constitute about 1% of the adult population, contribute about 23% of new HIV infections. These most-at-risk- population (MARPs) groups and their partners contribute as much as 40% of new infections, a population that makes up only about 3.4% of the adult population. Half of the infections contributed by MARPs and their partners are attributed to female sex workers, their clients and clients’ partners alone, showing a profound need for programmatic response focus on this sub-population group. MSMs and IDUs and their partners contribute about 10% and 9% respectively of the annual new infections. Targeting these groups will contribute to reversing the spread of the epidemic in Nigeria.

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

Table 2 summarizes the distribution of new HIV infections by mode of exposure in adult population in 6 states. The key findings are shown below and these have implications for HIV prevention programming.

**Table 2: Distribution of new HIV infections by mode of exposure in the adult population in 6 states in Nigeria**

Groups	Akwa Ibom %	Benue%	Cross Rivers%	Kaduna State %	Lagos %	Ogun %
Blood transfusion	0.73	0.41	0.67	0.11	0.03	0.46
Medical injections	0.22	0.16	0.21	0.05	0.14	0.08
<b>Low risk heterosexual</b>	<b>51.62</b>	<b>34.32</b>	<b>51.62</b>	<b>47.28</b>	<b>55.34</b>	<b>45.12</b>
Partners CHS	6.28	12.95	8.93	3.73	6.78	14.85
Casual heterosexual sex	30.44	15.75	23.32	6.96	13.48	9.76
Female partners of MSM	0.04	0.06	0.06	0.56	1.11	0.92
MSM	3.64	4.68	1.98	11.86	13.37	3.83
Partners of clients	0.00	0.00	0.98	1.16	0.96	0.78
Clients	1.49	7.17	1.47	1.14	2.27	0.93
Sex workers	3.83	14.95	15.45	3.54	3.29	5.22
Partners IDU	0.00	1.49	0.31	2.89	0.24	1.82
Injecting drug use (IDU)	1.72	8.06	4.55	20.72	2.99	16.17

**Source:** State Reports on the Mode of Transmission study in 6 States

- In Akwa Ibom State, most of the infections occur among low risk heterosexual (52%) and MARPs (11%).
- In Benue State, sex work is considered a major mode of transmission, directly or indirectly accounting for 22% of the new HIV infection in the state.
- In Cross River State, 42% of new HIV infections occur from 'low risk' heterosexual route and 23% among casual heterosexual encounters.
- In Kaduna State, most of the infections occur among low risk sex (47%)
- In Lagos State, about 55% of new HIV infections occur among the sub-population that are classified low risk heterosexual.
- In Ogun State, about 45% of new infections occur among 'low risk sex'. MARPs contribute 25%, of these IDU account for 16%.

### **1.3.4 Key risk factors and drivers of the epidemic**

The term 'drivers' of the epidemic classically refers to structural and social factors – poverty, gender inequality and human rights violations - that increase people's vulnerability to HIV infection. Risk factors include personal behaviour and lifestyles, environmental exposures and innate characteristics which are so widespread as to account for the increase and maintenance of an HIV epidemic at the population level (UNAIDS, 2007). Some of these factors include risky sexual behaviour, poor perception of HIV risk, poverty, ineffective STI programming, poor integration of HIV/AIDS and sexual & reproductive health services and gender inequality.

The HIV prevalence and pattern across the country differ. A possible explanation and contributory factor is the variation in socio-cultural practices. Societal norms and cultural practices influence

the risk of HIV transmission. Table 3 outlines some common practices and/or behaviours that have implications for HIV transmission. Consequently, HIV prevention programmes should consider the critical relationships between the epidemiology of HIV prevention, risk behaviours and practices that predispose to HIV, the cultural, institutional and structural factors that aid and reduce people's ability to access and use HIV services. These drivers are further discussed below.

**Table 3: Factors that affect the risk of HIV transmission in Nigeria**

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

**Source:** NACA 2010. National HIV/AIDS policy review: report of desk review and stakeholders' interaction in Abuja, Nigeria

### **1.3.5 Risky sexual behaviours**

There are a range of risky sexual behaviours which influence HIV transmission that occur in Nigeria. These include:

#### ***Early sexual exposure among young people***

The 2013 NARHS reported that 83% of female respondents and 78% of the male respondents reported that they have 'ever had sex'. Among young people aged 15-19 years, 37% of the females and 20% of the males had engaged in sex, showing slight decline from 2007 NARHS of 43% among females and 22% among males. Females in the NE and NW reported the lowest median age at first sex (15 years) and among males it was lowest for South-South (16 years).

#### ***Unprotected sex among young people***

Some studies have shown low level of condom use among young people (15-24) that are sexually active. About 55% of young people reported using male condom during last sex with non-marital partner. The proportion was higher in males (63%), compared to females (45%) and higher in urban than rural areas (NARHS, 2013). The proportion of young people reporting such use of condom was highest in the SW (62%) and lowest in the NE (51%).

#### ***Condom use***

NARHS (2013) reported that awareness of male condoms was considerably higher (73%) than that of female condoms (4%). Overall, only 54% of sexually active respondents reported using male condoms within the last 12 months preceding the survey. About 55% who had sex with a non-marital partner reported using condoms with their last non-marital partner. SW reported the highest proportion of condom usage (62%) with non-marital partners, while NW was low (49%). The use of condom with non-marital partners increased with level of education and with age and peaked at 25-29years, after which condom use declined with increasing age. Condom use at last sex within boyfriend/girlfriend relationship was higher among males (61%) compared to females (46%)

Among men, those who are unmarried and have never had sex are least likely to be aware that using condoms and limiting sexual intercourse to one uninfected partner reduce the risk of HIV transmission (62%). On the other hand, men who have never been married but who had sex are most likely to be aware of these prevention methods (81%) (NDHS, 2013).

#### ***Transactional sex***

NARHS (2013) showed that 5% of females and 7% of males reported that they have ever accepted or given gifts of some kind in exchange for sex. The proportion of respondents that received /gave gifts in exchange for sex was higher among the younger age group (15-29 years), and in urban areas, this was also highest in the South-South for females (13%) and in the southeast for males (10%).

#### ***Multiple sexual partners***

The preliminary report of the NDHS (2013) reported that multiple sexual partners is more common among men, as 13% of men age 15-49 reported having had more than one sexual

partner in the last 12 months. The higher reporting of sexual partners by men may partially be attributed to the prevalence of polygamous unions and the greater social acceptance of men having more than one partner. Multiple sexual partners among men increase with age: under 25 years old (4%), 25-29 age-group (13%), age 30-39 (17%) and among men age 40-49 (23%). Having multiple sexual partners among men is highest in rural areas (14%) and among men with no education (18%).

NARHS (2013) reported that of the respondents who have had sex within the past 12 months, only 6% of females' and 27% of males reported having multiple sex partners. There were differences across the zones, age groups and education levels. Among females, the least level of multiple sex partners was reported in the NW (2%) compared with NC (10%). Among males, multiple sex partnering was high in the SE (21%), SS (25%) and NC (35%). A high proportion of never-married females (18%) and separated/widowed (19%) compared with married females (4%) reported having multiple sex partners. These findings were similar among men, but substantially higher. Multiple sex partners among never married males was 39%, separated/widowed 39% compared with married men 23%. Having multiple sexual partners was high among women with higher education (10%) compared with 3.4% among females that had never attended school. Among males, having multiple sexual partners was similar among men with no education and those with higher education (27%) and those with primary education (24%).

Overall, among men who had ever had sexual intercourse, the mean number of partners in a lifetime is 4.1. Men reporting a higher than average mean number of lifetime partners are older men (4.6), urban men (4.7), men with more than secondary education (5.2), and men in the South South (6.9) (NDHS, 2013).

### ***Multiple partners and condom use***

Overall, 20% of men age 15-49 who reported having multiple sexual partners also reported using condoms during their last sexual intercourse. Condom use is much more frequent in urban areas than in rural areas (36% compared with 11%) and increases with education, from 25% among men with no education to 45% among men with more than secondary education (NDHS, 2013).

Education is positively associated with women using condoms during such an encounter. Urban women are more likely than rural women to have had two or more partners in the past 12 months and also more likely to have used condoms during the last sexual intercourse (44% and 15% respectively).

### ***Multiple non-marital partners***

Sexual intercourse with non-marital sexual partners is often considered to be of higher risk than sex with marital partners and this risk increases with multiple non-marital partners. About 2% of females and 9% of males had multiple non-marital partners. Females with secondary school education (3%) and higher education (4%) reported having multiple non-marital sex partners (NARHS, 2013). Males that are divorcees/separated/widowed were more likely to have multiple non-marital sexual partners. Having multiple sex partners put people at higher risk of STIs including HIV.

### ***Low perception of risk***

HIV risk perception among the general population in Nigeria is low. NARHS 2013 reported that respondents who perceived themselves at high risk for the HIV infection had an overall prevalence of 5% compared to those with low risk perception (4%).

Box 1 presents a summary of risk factors and drivers of the HIV epidemic in Nigeria

#### **Box 1: Summary HIV Risk Factors & Drivers**

- Low comprehensive knowledge of HIV (including knowledge about HIV transmission)
- Low knowledge of HIV status
- Low correct and consistent condom use
- Multiple concurrent sexual partners
- Early sexual initiation
- Stigma and discrimination
- Presence of untreated STIs
- TB/HIV co-infection
- Unsafe blood and blood products
- Sharing of sharps and needles

### **1.4 Overview of HIV/AIDS prevention in Nigeria**

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

Key documents that have guided the national HIV prevention response include: National HIV/AIDS Policy (2005 and 2010) National Strategic Framework (2005, 2009 & 2010-2015) National HIV/AIDS Strategic Plan (2010-2015) National HIV/AIDS workplace policy; National HIV/AIDS Prevention Plan (2007-2009 & 2010-2012) and the National HIV/AIDS Behavioural Change Communication Strategy (2009- 2014) etc. Drawing from these, several sub-national and sectoral HIV related policies and plans have been developed and are currently being implemented across sectors and at all levels.

Prior to 2007, HIV/AIDS prevention efforts were largely driven by donor interests, not evidence informed and were poorly coordinated. Many of these efforts took little cognizance of the drivers of the epidemic, cultural or societal norms and structural issues that influence and affect behaviour. Hence, these efforts did not generate the levels of behaviour change that was expected to avert new HIV infections. The 'UNAIDS practical guidelines for intensifying HIV



prevention towards Universal Access' stresses that scaling up national HIV prevention efforts must emphasize full access to proven and effective strategies (UNAIDS, 2007). The evidence-base was expanded through national surveys (including NARHS, 2007; IBBSS 2007) and Nigeria developed her first National HIV /AIDS Prevention Plan (NPP, 2007-2009). NPP 2007-2009 provided a reference point and direction in prevention intervention planning processes and efforts including 'ABC' approach. It also provided justification for resource mobilization by the government and implementing partners.

The National Prevention Plan 2010-2012 introduced the combination prevention approach, locally called the "Minimum Prevention Package Intervention" (MPPI) which emphasized dosage and intensity of interventions. It also defined a range of prevention intervention packages. It emphasized the need to address the drivers of the epidemic which vary for different sub-population as the focus of interventions that will catalyze and sustain the desired behaviour change. NPP 2010-2012 promoted the concept of ownership and sustainability by emphasizing active stakeholders' involvement and participation.

The NPP 2014-2015 took into consideration the outcome of the evaluation of the NPP 2010-2012. It promotes evidence-based programming and implementation of the MPPI. It provides standardized approaches to HIV prevention from the evolving evidence on drivers of the HIV epidemic in Nigeria. A key emphasis is prioritizing and tailoring the response to the epidemic, as well as scaling up interventions to prioritized groups and activities to address the drivers of the epidemic.

Given that Nigeria has a large burden of HIV and also accounts for about a third of the global burden of children born with HIV, the national HIV policy (2009) has highlighted prevention as a critical strategy for halting new HIV infections in Nigeria: "Prevention remains the most important strategy as well as the most feasible approach for reversing the HIV epidemic since there are no vaccines, nor medical cure for HIV. Similarly, the National Strategic Plan (NSP) declares prevention as an overarching priority.

The prevention efforts are targeted at two broad streams: the general population and the Most at Risk Populations. The Nigeria's version of the combination prevention is applied to any group as the Minimum Prevention Package of Interventions (MPPI) that seek to address the socio-behavioural, biomedical and structural components of prevention interventions. This approach also emphasizes the application of intensity and dose of interventions to achieve the desired behavioural response, to reduce new HIV infections. The HIV prevention interventions cover key thematic areas including HIV testing, Prevention of Mother to Child transmission, Treatment care and support, Sexual prevention, Biomedical prevention, etc.

## **1.5 Lessons learned, Challenges, Opportunities and Achievements (Broader national context & NPP 2010-2012)**

### **Lessons Learnt**

- Poor dissemination and weak capacity built on the NPP 2010-2012 was a challenge to effective scale up and implementation of quality prevention interventions in Nigeria.

## Challenges

- Inadequate financial resourcing by government and development partners contributed largely to under achievement of the goals and objectives of the NPP.
- Poor understanding and inadequate human resources for HIV prevention also impacted negatively on the achievement of the NPP 2010-2012.

## Opportunities

- The last plan provides a framework for the development of the revised plan.
- The poor implementation of the past plan gives scope for an improved implementation of this revised plan (NPP 2014 – 2015)
- It provides opportunities/platform for prioritizing research within each thematic areas.

## Achievements

Box 2 outlines some of the achievements realized during the implementation of the NPP (2010 -2012)

### Box 2: Achievements of the NPP 2010 - 2012

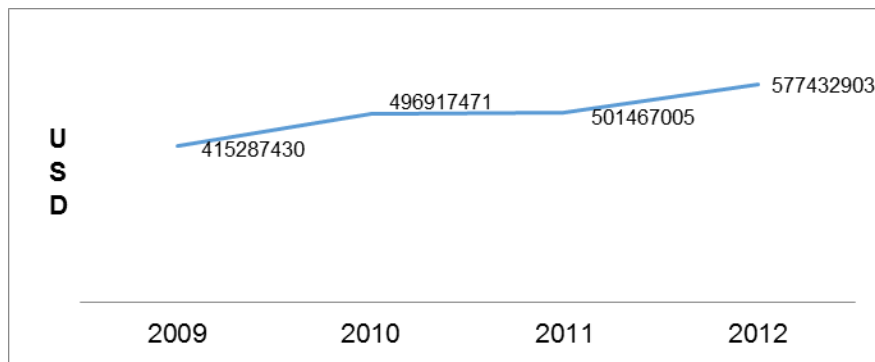
- The implementation of the combination prevention and packaged intervention approaches have increased within the national response.
- Continued coordination and standardization of prevention efforts with specific focus on the development of intervention packages.
- Introduced focus to targeted interventions (e.g. HCT for MARPs).
- Facilitated increase in resources mobilized for prevention activities (Global Fund, World Bank HAF-Fund, PEPFAR and GoN/PCRP).
- Produced more evidence based programming (MARPs programming EPI-Appraisal)
- Development of guidelines and frameworks e.g. PMTCT demand strategy, Female Sex Workers (FSWs) implementation guidelines and tools, SBCC users guide.
- Facilitated the development of SBCC short courses in research and academic institutions.
- Greater commitment of government at the highest level (the Presidency) to focus on specific key underperforming HIV thematic areas with an aim to achieve universal access targets and millennium development goals.
- The plan served as a reference guide for the development of some other African countries' national prevention plans.

## 1.6 Expenditure on HIV and AIDS in Nigeria

In Nigeria, the HIV funding is largely undertaken by international donors, with government

contribution accounting for only 25% of HIV funds. In 2010, it was proposed that the Government of Nigeria will increase its contribution to 50% of the total fund for HIV/AIDS interventions by 2015. Although, funding for HIV has increased steadily from 415 million dollars (in 2009) to 577million in 2012, the proportion spent on prevention remains low (Figure 8).

**Figure 8: Total HIV/AIDS Expenditure from all sources (2009-2012)**



Source: National AIDS Spending Assessment (NASA) 2012

On HIV expenditure by programmatic areas, treatment and care, programme management and human resources accounts for more than 85% of HIV expenditure. The proportion of HIV funds spent on prevention was 8.71% in 2009 and 12.45% in 2010. In 2010, the HIV expenditure by programmatic area is as follows: prevention (12.45%), care and treatment (37.44%), OVC activities (1.43%), programme management (24.52%), human resources (19.3%), social protection and services (0.04%), enabling environment (4.4%) and research activities (0.42%).<sup>4</sup> It is estimated that out-of-pocket expenditure for HIV services account for about 40% of the total expenditure.

In recognition of the national funding gap and the fact that the nation was not on track to achieve the universal access targets, the President requested a plan that both State and Federal governments buy into and fund. In an effort to promote long-term sustainability of national responses a growing number of countries are exploring innovative financing methods, including dedicated tax levies and AIDS trust funds. Nigeria should consider these innovative financing options for long-term sustainability of our national HIV response.

Consequently, the President’s Comprehensive HIV/AIDS Plan (PCRPP) was developed and unveiled in July 2013. Consequently, some funds are being released by the Federal Government and several States to fund the HIV and AIDS programme in Nigeria. However, the International Donor funds are beginning to decline. There is a need to maximize all the resources available for HIV response in Nigeria, while striving for more engagement of the private sectors, ownership and funding of HIV response especially at the State and Local Government Levels.

<sup>4</sup> NACA 2011: Nigeria National AIDS Spending Assessment (NASA) 2009-2010; Level and flow of resources and expenditures of the national HIV and AIDS Response.

## **2.0 THE DEVELOPMENT OF THE NATIONAL PREVENTION PLAN (2014- 2015)**

### **2.1 Goal of the 2014-2015 NPP**

The goal of the NPP is to scale up evidence-based programming using targeted interventions and standardized intervention packages at scale.

### **2.2 The objectives of the NPP 2014-2015 are as follows:**

- (i) Promote and scale up HIV counseling and testing, including both client-initiated and provider-initiated HIV counseling and testing;
- (ii) Promote and scale up interventions for the prevention of mother-to-child transmission of HIV including Early Infant Diagnosis;
- (iii) Promote appropriate HIV/AIDS-related behaviour change among the general population and subgroups considered at high risk for HIV infection in Nigeria (Key Populations);
- (iv) Increase knowledge about dual protection benefits and promote appropriate use of male and female condoms as well as lubricants among the general population and Key Populations;
- (v) Prevent biomedical transmission of HIV through blood safety, injection safety, safe healthcare waste management, adherence to universal precautions and post-exposure prophylaxis interventions;
- (vi) Promote early treatment and the control of sexually transmitted infections to reduce the risk of HIV transmission;
- (vii) Promote linkages to Positive Health, Dignity and Prevention Interventions for PLHIV;
- (viii) Recommend robust prevention strategies that capture current global thinking on combination prevention and ensure that all segments of the population are reached and that all the prevention thematic areas are addressed through the application of effective technologies and thinking;
- (ix) Promote integration of HIV prevention programming with other health services.

### **2.3 Development process for the NPP**

An evidence-driven national prevention plan provides the directional thrust for HIV prevention programming in the country. In 2009, the second series of the National HIV/AIDS Prevention Plan was developed and its three-year implementation period ended in 2012. Following the expiration of this plan in 2012, NACA recognized the need to review the implementation of the NPP 2009 - 2012, appraise its effectiveness and impact and use the findings to develop an updated national prevention plan that will guide the delivery of comprehensive HIV prevention programming in Nigeria. The new NPP is expected to respond to the emerging paradigms, evidence, challenges and concerns in HIV prevention programming and serve as a blueprint for the design,

development and implementation of prevention programmes in the country within the context of a comprehensive HIV and AIDS response.

The concept note for the development of the new NPP was drafted and shared with the National Prevention Technical Working Group (NPTWG). A core team from the NPTWG was formed to provide oversight and management of the NPP review process and also serve as the clearing house for data and documentation. The development process was preceded by a rapid appraisal of the implementation of the MPPI (an approach that was the crux of the expired plan) and development of minimum prevention package of interventions for general population and for MARPs.

A participatory desk review was also conducted at a five-day retreat with key partners from the public sector, donor partners, networks of PLHIV, civil society organisations, media institutions and implementing partners. Other countries' national prevention plans were also reviewed including Uganda, Kenya, Ethiopia, Malawi and Sierra Leone. The review considered available evidence on HIV epidemic in Nigeria and reviewed the current prevention responses across thematic prevention areas, states, regions and populations to determine the response capacities and gaps that exist at different levels. The development of the plan took into consideration the priorities of the PCRP. As part of this process, the review questions and the template for the zonal consultations were agreed.

In recognition of the need for an innovative approach to programme planning that fosters ownership and sustainability, a logical consultative process was used to obtain broad stakeholder participation and evidence-based planning. A team comprising officers of NACA and members of the national prevention technical working group (NPTWG) facilitated the consultations and provided the technical guidance for the development of the document.

Consultative meetings were held in all six geopolitical zones of the country. The objectives of the consultations were to understand the challenges to prevention programmes in the States, identify the capacities and gaps that exist in the States, and discuss ways of addressing these in the new plan. Some capacity building on MPPI, priority setting and target setting was built into the process.

The NPTWG met to develop a framework for the NPP and a draft of the Plan. A consultant was engaged to further develop the draft that subsequently underwent peer review. The NPTWG had a meeting to address the peer reviewers' comments and make the necessary improvements to the Plan. The consultative process was concluded by a national validation workshop.

#### **2.4 Rationale for the National Prevention Plan (NPP 2014- 2015)**

*“Prevention remains the most important strategy as well as the most feasible approach for reversing the HIV epidemic since there are no vaccines and no medical cure. The majority of Nigerians are HIV-negative; keeping them uninfected is critical to the future of the epidemic and this underscores the importance of prevention as a cornerstone of the national HIV and AIDS*

response” (National Policy on HIV/AIDS, 2009).<sup>5</sup> The last national HIV and AIDS prevention plan expired in 2012. An updated and revised plan is required to respond to emerging trends in the HIV epidemic in Nigeria and new paradigms and technologies in HIV prevention programming.

In addition, the evidence-base for HIV response in Nigeria has expanded through the epidemic appraisal for MARPs (covering size estimation, venue profiling, rural appraisals), 2012 Mid-term Review of the National Strategic Plan, Joint Annual Review 2012, National AIDS Reproductive Health Survey 2012, National AIDS Spending Assessment 2012, NDHS 2013, etc. The evidence provided by these recent studies are critical in designing future prevention interventions in the country. Finally, the new plan will provide strategic direction and guidance to HIV prevention programming in Nigeria for the next few years. The NPP will consider various regional and international declarations on HIV to which Nigeria is a signatory.

## **2.5 Guiding Principles of the National Prevention Plan (NPP)**

The following are the guiding principles of the NPP:

- *Provide leadership and strategic technical direction for the national prevention response:* The NPP will be the overarching document that provides strategic technical direction for HIV prevention programme planning, implementation and evaluation in efforts to actualize the goals and objective of the national prevention response.
- *Enhance access of PLHIV, key populations and vulnerable groups to comprehensive HIV prevention programmes that address behavioural, biomedical and structural vulnerabilities.* Reduce the vulnerability of key populations (FSW, MSM, IDU), vulnerable groups (women, children, transport workers, uniformed service men, people with disability) and PLHIV by providing an enabling environment for quality HIV prevention service delivery.
- *Address gender factors that increase female vulnerability to HIV:* Commitment to address social, economic and cultural factors responsible for disproportionate vulnerability of women and girls to HIV infection.
- *Delivery of integrated services:* Also Facilitates integration of services with and linkages to RH, MNCH, ART, OVC, TB/HIV etc.
- *Evidence-based HIV/AIDS programming:* Commitment to evidence-based approach including programme and implementation science approaches, operational researches, ethnographic studies, surveillance, surveys etc.

## **2.6 Target audience of the National HIV and AIDS Prevention Plan (NPP 2014 -2015)**

This NPP (2014 – 2015) is designed in line with the principles of “The Three Ones” (one national coordination authority, one national AIDS framework, and one monitoring and evaluation

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<sup>5</sup> Federal Government of Nigeria 2009. National Policy on HIV/AIDS. October, 2009

framework), to promote a comprehensive and multi-sectoral approach. This document is to be used by all stakeholders addressing the HIV and AIDS epidemic in Nigeria, particularly all individuals and public and private sector organisations engaged in HIV prevention including:

- Public sector Ministries, Departments, and Agencies (MDAs);
- Uniformed services such as the armed forces, police force, and prison services;
- Academic and Research Institutions;
- Civil Society Organisations (CSOs), Community-Based Organisations, Non-governmental organisations, Faith-Based Organisations;
- Profit-private establishments;
- International development partners, such as multilateral agencies, bilateral agencies, and international non-governmental organisations;
- People living with HIV (PLHIV), people affected by AIDS (PABA) and their organisations and networks;
- General populace.

## **2.7 Target populations for the NPP 2014-2015**

The target populations for the NPP 2014-2015 are divided into two major groups: the general and the most-at-risk populations. This is based on the national HIV prevalence in these populations and the emerging dynamics of exposure to and transmission of HIV in these populations.

### **A. General Population**

**Anyone outside of the most at risk population is considered as part of the general population.**

The bulk of new infections occur among persons who are not engaging in high risk sex and that includes those who are co-habiting or married. This population contributes 42.0% of the new infections in Nigeria.<sup>6</sup> The general population includes:

- Men and women of reproductive age
- Pregnant women

However, among the general population, there are also groups of people who are considered more vulnerable to HIV infection in certain situations or context. These include:

- adolescents, particularly adolescent girls
- orphans
- destitutes
- people in closed settings (such as prisons or detention centers)
- people affected by humanitarian crisis
- people with disabilities
- migrant /mobile/displaced populations

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<sup>6</sup> National Agency for the Control of AIDS, UNAIDS, World Bank. Modes of HIV transmission in Nigeria: analysis of distribution of new HIV infections in Nigeria and recommendations for prevention.2010.

- widows, divorcees, single mothers
- children
- persons with special needs
- health workers

## B. Most at Risk Populations (MARPs)

Most at risk population can be defined as populations that are at higher risk of being infected and affected by HIV, who play a role in how HIV is spread and whose involvement is vital for an effective and sustainable response to HIV. Though the most at risk population forms an estimated 1.0% of the adult population, they account for 23% of new infections, however, MARPs groups and their partners contribute as much as 40% of new infections (GARPR, 2014). These populations are most often also vulnerable due to social and institutional rejection and discrimination. Within the national response, MARPs include the injecting drug users (IDUs), female sex workers (FSW) and men who have sex with men (MSM).

- *Female Sex Workers (FSW)*: A FSW is a sexually active female who undertakes sexual activity with a man in return for financial or material benefit. They operate in brothel, non-brothel, home or hostel. The transactions may occur in streets, bars, home, brothels and other conducive environments.
- *Men who have sex with men (MSM) and Male Sex Workers (MSW)*: MSM is used to denote all men who have anal sex with men as a matter of preference or practice, regardless of their sexual identity or sexual orientation, and irrespective of whether they also have sex with women or not. Men who sell sex for money or material benefits are also recognized in this context (MSWs).
- *Injection Drug Users (IDU)*: An Injecting drug user is defined as a person who injects drugs, for non-therapeutic purposes, irrespective of the type of drug injected.

## 2.8 National HIV Prevention Strategy

**2.8.1. Minimum Prevention Package Intervention Implementation Approach:** The minimum prevention package intervention (MPPI) is a strategy for implementing the combination prevention framework in Nigeria. It uses information about the drivers of the epidemic as it relates to various target populations with emphasis on dosage and intensity. It recognises the processes of behaviour change and structural influencers of behaviour (Table 4). The MPPI is defined as *“the strategic, simultaneous use of different classes of prevention activities (biomedical, behavioural, structural) that operate on multiple levels (individual, community and societal /structural), to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritizing, partnership, and engagement of affected communities”*<sup>7</sup> Key features of Minimum Prevention Package Intervention are as follows:

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<sup>7</sup> UNAIDS Prevention Reference Group Definition.



1. It is carefully tailored to address the national and local needs based on available information on the modes of HIV transmission, the populations or groups at risk of HIV exposure and transmission and the context that shape their risk and vulnerability.
2. It is a strategic mix of structural, biomedical and behavioural interventions that are required to meet the needs of population groups, focusing both on their immediate risks and underlying causes of vulnerability. Through structural interventions, they create a more enabling environment for prevention action.
3. It is planned to operate synergistically and consistently over time, on the multiple levels that reinforce or challenge risk behaviours.
4. It prioritizes strategy investment with the full engagement of affected communities; mobilizes resources in the community, the private sector, government and internationally to achieve needed participation, coverage and continuity.
5. It requires, benefits from and invests in enhanced partnership and coordination in the design, resourcing and management of programmes. It also gives special attention to investment in decentralized and community responses.
6. It is flexible enough to enable modifications based on outcomes of assessment of programme performance and impact. This would involve improvement of strategies and use of new tools and approaches to enable strategies to evolve in response to epidemiological, technological, or social changes.

The efforts of the National Technical Working group in putting together the Minimum Prevention Package Intervention (MPPI) had measureable impact over the years. The result of the rapid appraisal of the MPPI showed that although the MPPI costs more to implement, 'it *makes more economic sense*' since it inputs quality to HIV education efforts in the country. It is considered a '*paradigm shift (in HIV programming) in the right direction*'. Combination of interventions are now widely implemented with implementers having a clear understanding of the need for re-enforcement and quality of HIV prevention programming rather than implementing one-off event or activity.<sup>8</sup>

**2.8.2. Priority Interventions for Target Populations:** Priority program interventions for the target populations will emphasize coverage, depth and quality of services provided; it should also take into consideration geographical variations in prevalence. Interventions should be gender sensitive and gender responsive. Prioritization of intervention combination for target populations will be based on lessons learnt from field experiences. This implies that the NPP shall be regularly monitored to assess contextual factors that determine risk behaviour and act as barriers to HIV prevention service uptake and utilization. Table 4 provides an overview of the MPPI.

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<sup>8</sup> NACA: MPPI rapid appraisal report, 2013.

**Table 4: Overview of the Minimum Prevention Package Intervention for the Target Populations**

Programme Component	General Population	Key Populations
<b>Behavioural</b>	<ol style="list-style-type: none"> <li>1. Outreach</li> <li>2. Peer Education</li> <li>3. Condom and lubricant programming</li> </ol>	<ol style="list-style-type: none"> <li>4. Outreach</li> <li>5. Peer Education</li> <li>6. Condom and lubricant programming</li> </ol>
<b>Biomedical</b>	<ol style="list-style-type: none"> <li>1. HCT</li> <li>2. PMTCT</li> <li>3. Condom and lubricant programming</li> <li>4. STI control and Treatment</li> </ol>	<ol style="list-style-type: none"> <li>5. HCT</li> <li>6. PMTCT</li> <li>7. Condom and lubricant programming</li> <li>8. STI control and Treatment</li> <li>9. Harm reduction intervention for IDUs</li> </ol>
<b>Structural (to address gender issues, Stigma and discrimination, policy issues, individual empowerment)</b>	<ol style="list-style-type: none"> <li>1. Community mobilization and Dialogue (empowerment and capacity building)</li> <li>2. Advocacy</li> <li>3. Individual Empowerment/Income Generating Activities</li> </ol>	<ol style="list-style-type: none"> <li>4. Community mobilization and Dialogue (empowerment and capacity building)</li> <li>5. Advocacy</li> <li>6. Individual Empowerment/Income Generating Activities</li> </ol>

**2.8.3: Sexually Transmitted Infections (STIs):** The strategic focus is to expand the provision of good quality STI care into primary health care, sexual and reproductive health services and HIV services. Comprehensive STI services should include:

- correct diagnosis by syndrome approach or laboratory test;
- Provision of effective treatment at first encounter;
- Reduction in further risk-taking behaviour through age-appropriate education and counselling;
- Promotion and provision of condoms, with clear guidance on correct and consistent use;
- Notification and treatment of STIs in sexual partners, when applicable;
- Screening and treatment for syphilis in pregnant women;
- Provision of hepatitis and human papillomavirus (HPV) vaccines to prevent genital and liver cancers;
- HIV testing and counseling in all settings providing care for STIs.

For primary care settings, WHO recommends syndromic management of STIs in patients presenting with consistently recognized signs and symptoms. Treatment for each syndrome should be directed against the main organisms responsible for the syndrome within that geographical setting. Ensure that interventions for STI prevention and care are integrated.

Services for STI prevention, case management and partner treatment also contribute to HIV prevention by promoting correct and consistent condom use, supporting health education and behaviour change. STI prevention and care also reduces the risk of HIV infection.

## **2.9 The Cluster Model of Implementation**

The implementation of the national response should use the Cluster Model as the agreed mode of operational service delivery. The goal of a cluster model is to ensure effective management and improved efficiency of service delivery within the cluster. It is to ensure that in every locality there is a “cluster” of comprehensive health and psycho-social services that cover behavioural, biomedical (ART, PMTCT, HCT, Malaria, TB treatment including Direct Observation Treatment DOTs and SRH) and structural interventions (home-based care, PLHIV support groups, advocacy support, media, legal, law enforcement and OVC support programs) and also the presence of service providers such as CSOs and CBOs within the cluster.

The model is expected to ensure the expansion of the continuum of care from prevention and testing, to treatment care and support services across health care delivery levels for people living with HIV/AIDS (PLHIV). The model also strengthens referral linkages between facility and community based services. It will also promote greater community involvement and the sustainability of programmes.

### **Cluster Composition**

A cluster of hotspots and intervention sites within each location in the LGA is linked to a secondary and a number of PHCs offering HIV testing, STI management, PMTCT and ART. A cluster also includes CBOs, community structures like support centers and groups, security operatives/stations and other service providers. A cluster is expected to be saturated with prevention interventions by CSO/CBOs

### **Coordination of cluster**

CSOs working with populations in hotspots and/intervention sites within a defined cluster are expected to ensure that cluster meetings hold monthly and reports submitted to the LACAs for transmission to the SACAs or directly to the SACAs where the LACAs are not functional. Should more than one CSO operate in the cluster, a cluster coordinator and secretary is selected from amongst the available CSOs.

### **Issues to discuss in a cluster meeting**

Any issues affecting the implementation of intervention in a cluster can be discussed during a cluster coordination meeting. Such issues could include, but not limited to the following:

- Review progress on implementation at cluster level;

- Service uptake on ART, PMTCT, HCT, support services, security etc;
- Review Community mobilization efforts (including IEC materials at sites);
- Referral linkages and follow up of clients;
- Stock levels of drugs and other related products with respect to providing timely feedback LACA/SACA;
- Capacity building and on-site mentoring;
- Monitoring and Evaluation issues e.g. timely reporting, quality of data;
- Review of quality assurance issues;
- Providing timely reports to LACA/SACA on problems identified;
- Steps should be taken to solve problems.

## 2.10 State priorities identified during the NPP Zonal Consultations

This section outlines some priorities that State teams identified during the zonal consultation. Consultative processes during the preparation of this plan at zonal regions led to the identification of some priorities peculiar to specific geographic zones of the country. These priorities are important for programming and are outlined below (Table 5):

**Table 5: NPP Review Zonal Consultations: Summary of State Priorities**

Zone	State	Priorities	Priority level
North Central	Benue	Women of reproductive age; MSM in four LGAs, FSWs in 5 LGAs and clients of FSWs	High
	FCT	Women of reproductive age in 6 area councils; MSM in 3 area councils, IDUS, FSWs and clients of FSW in 4 area councils	High
		Young people in 6 area councils and Police	Medium
		Armed forces and transport workers	Low
	Kogi	Women of reproductive age, high risk out of school youths, PLHIV and high-risk long distance drivers in 7 LGA. MSM, IDU, FSW and clients of FSW in 4 LGAs	High
	Kwara	In and out of school youth in 16 LGAs, FSWs in 6 LGAs	
		Traditional birth attendants, religious leaders/community gatekeepers, Clients of FSW (transport workers, migrant workers, teenagers) in 16 LGAs	Medium
		MSM in 6 LGAs	Low
	Nasarawa	Men and women of reproductive age in 13LGAs, MSM, IDU and FSW in 6 major towns	High
Clients of FSW in 6 major towns		Medium	
South East	Abia	FSW in 3 LGAs	
	Anambra	FSW in 5 LGAs, IDU in 5 LGAs and MSM in 5 LGAs; road transport workers and youth/young adults with multiple sex partners and who engage in transactional sex in 5 LGAs; women of reproductive age and men within sexual activity age bracket in 6 LGAs; pregnant women attending ANC and traditional birth homes in 10 LGAs	

Zone	State	Priorities	Priority level
	Ebonyi	FSW in 8 LGAs, uniformed forces in 11 types of establishments, IDU and MSM (survey pending- locations yet to be determined); long distance drivers in 11 identified locations, quarry workers, out of school youths, undergraduate students, motorcycle and taxi drivers, displaced persons in 5 identified locations	
	Enugu	FSW in 8 LGAs, IDUs in 6 LGAs, MSM in 3 LGAs, youth/young adults with multiple sex partners and who engage in transactional sex in 9 LGAs, youth in tertiary institutions located in 7 LGAs, in-school youth primary and secondary in 6 educational zones, road transport workers in 7 LGAs, women living with HIV in 9 LGAs, children orphaned by AIDS in 9 LGAs; pregnant women in 10 LGAs; women of reproductive age in 6 LGAs and men of reproductive age 9 LGAs	
	Imo	FSW, long distance drivers, uniformed service men, in school and out of school youths and women of reproductive age in 3 LGAs,	
South-South	Akwa Ibom	General population engaged in Low risk heterosexual sex, and casual heterosexuals sex in urban and rural areas; FSW and their clients in urban and rural areas	High
		MSM in urban and rural areas	Medium
	Cross River	FSW in 11 LGAs, MSM in 3 LGA and pregnant women in 7LGAs	High
		IDUs in 4 LGAs, transport workers in 17 LGAs, PLHIV in 6 LGAs, in school and out of school youths in 13 LGAs	Medium
	Delta	Women of reproductive age and pregnant women state-wide; FSW in 3 LGAs (+more pending results from mapping), vulnerable children in 7 LGAs	High
		MSM and IDU	Low
	Edo	FSWs and their clients in 14 LGAs, PLHIV/PABA in 11 LGAs	
		Women of reproductive age in 18 LGAs	
Rivers	FSW in 8 LGAs, MSM in 3 LGAs and pregnant women in all 23 LGAs through primary and secondary health facilities,	High	
	Out of school youths in rural an urban communities	Medium	
South West	Lagos	FSW, MSM and IDU statewide	*Very high
		Females in reproductive age group, male and female out of school youths, clients and boyfriends of FSW statewide	High
		In school youth statewide	Medium
	Ogun	Low risk heterosexuals in 20 LGAs, FSW in 6 LGAs, IDU in 4 LGAs and MSM in 1 LGA	High
	Ondo	FSW in 3 LGA, low risk heterosexuals, in school and out of school youth in all 18 LGAs	High
		MSM in 2 LGAs and IDU	Low
	Oyo	FSW in 2 LGA, IDU in 2 LGA, MSM in 1 LGA, out of school youth, long distance driver, farmers/migrant laborers, pregnant women	High
		In school youth, adult males and females (30-59)	Medium

Source: Zonal Consultations workshop on the development of the NPP 2014-2015

### 3.0 PROGRAMMATIC CONTEXT FOR NATIONAL HIV PREVENTION EFFORTS

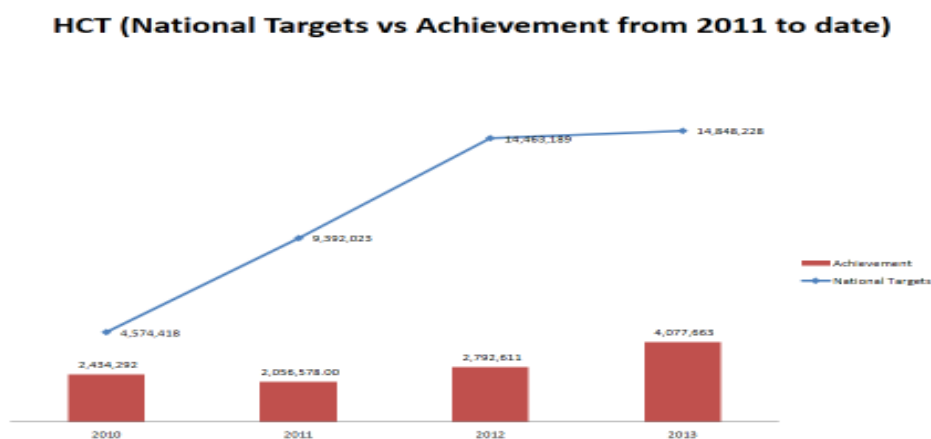
This section presents the priority programme areas and other emerging themes to address including new technologies, HIV in emergencies and humanitarian settings.

#### 3.1 Thematic area: HIV Counseling and Testing

The overall HIV testing and counselling goal for a national HIV programme is to identify as many people living with HIV as early as possible and link them to prevention, care and treatment services in an appropriate and timely manner. HIV Counselling and Testing (HCT) is considered an entry point for HIV prevention, treatment, care and support. Yet majority of Nigerians are not aware of their HIV status. NARHS (2013) reported that respondents that have ever tested for HIV was low (26.3%) with variations between regions, target populations, sex and age groups. The percentage of those that have ever tested was highest in the South East, 40% (35% male, 44% female) and least in the North West 13% (12% in male, 14% female). Amongst adolescent and young people (AYP) aged 15-19 years old, the percentage that have ever tested for HIV was 12.7% (12.4% male and 13% female)(NARHS, 2013). Only about 36% of those that have ever tested, took the HIV test less than 12 months prior to the survey. Another survey, IBBSS (2010) reported that amongst MARPs, HCT uptake in the last 12 months preceding IBBSS (2010) was highest amongst brothel based FSW (54.3%) and least amongst IDUs (27.7%).

NARHS (2013) reported that willingness to test was high (78%). Of those that ever tested, 30% voluntarily requested for a test, 37% were offered an HIV test and they accepted to be tested, 24% took the test because they were mandated to do so. From the 2013 NARHS report, only 62% of males and 61% of females know where to get an HIV test. In 2012, the number of health facilities that provide HIV counseling and testing services was 2,624. This is low in relation to over 22,000 health facilities across the nation. A higher proportion of current HCT services are located in secondary and tertiary healthcare facilities and in urban areas. This has implications in terms of accessibility of HIV testing to the rural population (that makeup two-thirds of the population).

**Figure 9: HIV Counselling and Testing (National targets and achievements from 2010 to date)**



Source: Nigeria GARPR 2014.

The zonal consultation to assess the implementation of the NPP 2010-2012 identified several issues/gaps around HCT programming in Nigeria including: inadequate test kits, stock-out of HIV test kits, non-adherence to national testing algorithm, poor integration of HCT into other services, poor linkages/referral to treatment and care services and inadequate private sector involvement in HCT. In addition, other issues raised at the zonal consultations are outlined below:

- Absence of objective/target for paediatric HCT, absence of workplace HCT strategy;
- No mention of operations research for best practices for reaching people with HCT (facility testing Vs community-based testing, Provider Initiated counselling and testing, self-testing);
- Accelerate the scale up of integrated HIV services, promote media campaigns and de-emphasize stand alone test centers;
- Link Self-testing to HIV Treatment services for confirmation and appropriate management;
- Plan should provide options for different segments of the population and make decisions on who can have what option;
- Provide HCT in settings where evidence suggest high uptake e.g. workplace, educational and prison settings;
- Test availability remains an issue, mention steps for ensuring availability should be explicit;
- Private sector involvement;
- Details for scale up, expansions required. Coverage and distribution of services.

In the light of the evidence above, the NPP 2014-2015 recognizes the need to rapidly scale up uptake of HCT via increased public awareness and demand creation campaigns, scale up PICT and address the bottlenecks associated with HIV test kit access. There is need also to scale-up HCT provision to prioritized groups in line with known drivers of the HIV epidemic and use effective models of delivering HIV testing, for maximum coverage, reach and impact.

Diverse models of HIV testing and counselling services are available to increase access to HIV diagnosis, including testing services in health care facilities, freestanding sites and a wide range of community-based approaches. In order to increase the uptake of HIV testing, a strategic mix of service delivery models should be used to achieve equitable access to HIV testing and counselling in the community and the choice of service delivery models should be based on the local context, the nature of the epidemic, effectiveness and available resources. The mix of approaches should facilitate diagnosing as many people living with HIV as early as possible to enable timely linkage to ART.

HIV testing and counselling for most-at-risk and vulnerable groups should emphasize consent and confidentiality as well as ensuring that HIV testing and counselling is part of a comprehensive prevention, care and treatment programme. All forms of HIV testing and counselling should be voluntary and adhere to the five C's: consent, confidentiality, counselling, correct test results and connections to care, treatment and prevention services.

As Nigeria has a generalized epidemic and in line with WHO guidelines, NPP recommends the promotion of the following:

- Provider-initiated testing and counselling (PICT) for everyone (adults, adolescents and children) attending all health facilities, including medical and surgical services; sexually transmitted infection, hepatitis and TB clinics; public and private facilities; inpatient and outpatient settings; mobile or outreach medical services; services for pregnant women (antenatal care, family planning and maternal and child health settings); services for key populations; services for infants and children and reproductive health services.
- Community-based HIV testing and counselling with linkage to prevention, care and treatment services, in addition to PICT.
- Community-based HIV testing and counselling for key populations, with linkage to prevention, care and treatment services.

Community-based HIV testing and counselling includes using mobile, door-to-door, campaign, workplace and school-based HIV testing and counselling approaches. The few studies comparing the cost per person tested using facility- and community-based testing found that the cost per person tested was similar in both approaches.

### **Objectives**

This NPP promotes the scale-up of HIV testing of the general population and MARPs with a view to achieve higher coverage for MARPs, pregnant women and AYP.

Objective 1. At least 80.0% of the population access HCT services by 2015.

Objective 2. At least 80.0% of MARPs access HCT services by 2015.

Objective 3. At least 95.0% of all pregnant women have access to HCT by 2015.

### **Strategic focus**

- Scale up HCT programme as a component of MPPI. Programmers should prioritize geographic locations and target populations based on available evidence on vulnerability within local context and current HCT coverage.
- Promote the age disaggregation of HCT data to ensure information on children, adolescents, young adults and adults accessing HCT are captured.
- Increase access of HCT to adolescents, young boys and girls, FSWs, MSM and IDUs, pregnant women, through a mix of community-based approaches.
- Put in place strategies to target populations like AYP and MARPs that stigma and discrimination and unfriendly services (perceived or real) can hinder uptake.
- Use the cost-effective service delivery model for HCT to reach the priority populations.
- Promote HCT approaches including the client initiated and provider initiated counselling and testing and provide testing at every service delivery point including family planning, maternal



care, STI clinics, and adolescents/youth's sexual and reproductive health services, drug rehabilitation clinics, general and outpatient clinics, in-patient care, mobile HCT services, etc.

### **3.3 Thematic area: Prevention of Mother to Child Transmission of HIV (PMTCT)**

Mother to Child transmission of HIV (MTCT) is the transmission of HIV from HIV-positive mother to her child during pregnancy, labour, delivery or breastfeeding. It accounts for over 90% of HIV infection in children less than 15 years. In the absence of interventions, the risk of MTCT is 30-45%. With intervention, the risk of MTCT can be reduced to less than 2%. Universally, the Prevention of Mother to Child transmission of HIV (PMTCT) is undertaken through a four pronged approach:

Prong 1: Primary prevention of HIV infection in women of reproductive age group and their partners.

Prong 2: Prevention of unintended pregnancies among HIV positive women.

Prong 3: Prevention of HIV transmission from HIV infected mothers to their infants.

Prong 4: Care and support for HIV infected mothers, their infants and family members.

In Nigeria, Mother To Child Transmission of HIV remains a huge public health issue accounting for 10% of new infections. It is estimated that about an average of 60,000 children are born annually with HIV in Nigeria and the number of AIDS-related death among children are high. Despite this huge burden, a high number of women and their babies do not access PMTCT services. For example, in 2012, the percentage of women who tested for HIV and received their result was about 17%, while the percentage of HIV pregnant women who received ARV to reduce the risk of mother to child transmission was approximately 20.2% (MTR 2013). Only 6.2% of infants born to HIV infected women received ARV for prophylaxis for PMTCT and the HIV exposed infants who received a virological test for HIV within two months of birth was extremely low (4.1%) (MTR, 2013).

The poor PMTCT coverage and uptake in Nigeria is a reflection of factors affecting the supply and demand of PMTCT services. There were 2,216 sites as at Dec 2012, a far cry from the 16,378 sites required for adequate service coverage (PCR, 2013). This represents 13.5% of the PMTCT sites required for elimination of mother to child transmission of HIV. Anecdotal evidence suggests that there is geographical inequality in the distribution of PMTCT sites. In addition, there are few sites within the private sector. With intensive effort, the PMTCT sites have increased to 5,622 in 2013. It is important to ensure that these sites are functional and provide quality HIV services.

Further expansion of PMTCT sites and EID services, should be informed by analysis of geographical distribution (state and zonal) of current PMTCT services in relation to proportion of women of reproductive age in the state and zone and HIV prevalence. In Nigeria, other factors affecting the provision of PMTCT services include challenges with human resources for health (including issues of recruitment and retention of healthcare workers, mal-distribution of HCWs, shortage of commodities (including test kits and drugs), weak referral and follow up mechanisms.

It is estimated that the annual number of pregnancies is 8 million with a crude birth rate of 41.5/1000 and annual births of over 6 million. The utilization of ANC and maternity services is low and this has negatively impacted on the PMTCT scale-up efforts. National estimate shows that only 61% of pregnant women attend ANC at least once and about 63% of births occur outside the health facility (NDHS, 2013). Across geopolitical zones, the proportion of mothers reporting that they received antenatal care from a skilled provider is markedly lower in the North West (41%), North East (49%). Women in the South East (91%) and South West (90%) are most likely to have received antenatal care from a skilled provider. Factors such as community norms, religious beliefs, HIV-related stigma, attitude of health-care workers, weak community mobilization and gender-based factors including the influence of male partners on health-seeking practice contribute to the poor uptake of PMTCT services.

PMTCT is a proven intervention that has worked in reducing MTCT. This National Prevention Plan prioritizes PMTCT scale-up. This is in consonance with Nigeria's identification with global declaration to achieve an AIDS free generation. As a party to the global consensus of elimination of mother to child transmission of HIV (EMTCT) by 2015, there are concerted efforts and renewed political commitment to scale up PMTCT services and eliminate MTCT in Nigeria. A phased approach has been adopted with focus on the 12+1 priority states that contribute about 70% of the national HIV burden. The President's Comprehensive Response Plan for HIV/AIDs in Nigeria (PCRP) designed to address the priority thematic areas and service delivery challenges, prescribed the need to rapidly accelerate provision of quality PMTCT and increase uptake of PMTCT services, taking into consideration the elimination goal.

While Nigeria embraces the four-pronged approach to PMTCT, emphasis has largely been placed on prongs 3 and 4. In order, to achieve the EMTCT, it is vital to make adequate provisions and programming for prongs 1 and 2. **The goal of prevention of MTCT is to eliminate mother to child transmission and scale service coverage to 95% of the national need by 2015.** The national goal is to eliminate MTCT, in line with the PCRP (NACA, 2013) and this plan will pursue the achievement of this goal in the next two years. The elimination targets were agreed in 2012 and they are as follows:

- At least 50% reduction in HIV incidence among 15-49 yr old women by 2015.
- At least 90% reduction in unmet need for Family Planning among women with HIV by 2015.
- At least 90% of all pregnant women have access to quality HIV counselling and testing by 2015.
- At least 90% of all HIV positive pregnant women and breastfeeding infant-mother pairs receive ARV prophylaxis by 2015.
- At least 90% of all HIV exposed infants have access to early infant diagnosis services by 2015.
- At least 90% of pregnant women requiring ART for their own health receive lifelong ART.

The Mid-term review (MTR, 2013) of the national response showed that Nigeria is not on track to achieve these targets. The implementation of the strategic focus outlined below will contribute towards achieving the nationally set targets.

## **Strategic focus**

- Strengthen coordination of PMTCT services at State and Local government levels.
- Integration of SRH/HIV programmes including promoting and providing family planning services during ANC, postpartum period, immunization program, etc.
- Promote the implementation of the four prongs approach with emphasis on the peculiarities of the population that the programme is addressing.
- Promote operational research and knowledge based approach to PMTCT programme including management information systems (MIS). The operational research is needed to understand the barriers to PMTCT uptake. For example, expansion of PMTCT sites and EID services should be informed by data-analysis of geographical distribution (state and zonal) of current PMTCT services in relation to proportion of women of reproductive age in the state and zone and HIV prevalence, including HRH, commodities etc.
- Capacity building and task shifting including recruitment and retention of trained HCW.
- Improve the quality and increase uptake of PMTCT services. The services should adhere to the national consolidated HIV guidelines.
- Increase private sector engagement in the provision of PMTCT services.
- Decentralization services into primary care.
- Scale up implementation of early infant diagnosis (EID).
- Evaluation and impact assessment of PMTCT and EID services.
- Intensive state focused approach to scale up (see appendix that outlines useful local data for planning and scale up of PMTCT services).

### **3.4 Thematic Area: Biomedical HIV Prevention:**

#### **Objective**

- 100% of blood and blood products are screened for HIV and other transfusion transmissible infections by 2015.
- At least 80% of health facilities institute safe healthcare waste management measures.
- At least 80% of health facilities provide Post-exposure prophylaxis (PEP) to healthcare workers, rape survivors and those exposed to HIV infection by 2015.

Biomedical transmission prevention programme is primarily aimed at addressing HIV transmission that could happen through blood transfusion, re-use of syringes, exposure to contaminated healthcare waste, accidental exposure to HIV through occupational exposures (needle stick injuries, handling blood products without gloves, surgical accidents), rape or unprotected sex, unsafe male medical circumcision, female genital cutting. Biomedical transmission prevention programmes can be delivered through blood safety, injection safety, safe healthcare waste management, safe male medical circumcision, adherence to universal precautions and post-exposure prophylaxis interventions as well as new prevention technologies.

### **3.4.1 Blood safety**

Several interventions and measures can reduce the risk of blood borne transmission. These include safe blood supplies, injection safety for both medical and non-medical injections, universal precautions in health care settings, as well as minimizing exposure to infected blood through procedures associated with traditional and complementary practices. HIV transmission through transfusion of blood and blood products can be virtually eliminated through the establishment of blood banks, recruitment of low risk donors (voluntary and non-remunerated), and screening of all donated blood.

The key issues affecting blood safety include the following:

- Low availability of skills in voluntary non-remunerated blood donor (VNRD) recruitment.
- Poor use of HIV diagnostic testing algorithms and screening of donated blood.
- Poor blood banking expertise.
- Inadequate attention to appropriate use of blood and haemo-vigilance.
- Poor blood supply and distribution logistics including commodities.
- Incomplete and improper screening of blood for Transfusion Transmissible Infections (TTIs).
- Proliferation of family replacement and paid blood donors.
- Weak capacity at facilities for blood safety (personnel & institutional).

#### **Strategic focus**

- Strengthen well-organised, centrally coordinated blood safety activities across country and partners (e.g. SMOH, Health Facilities and other partners).
- Strengthen efforts to actualize 100% voluntary non remunerated blood donor system.
- Enforce testing of all donated blood for transfusion-transmissible infections using EIA as minimum standard.
- Emphasize the appropriate clinical use of blood and avoid unnecessary blood transfusion.
- Implement standards specified by National Blood Transfusion Service NBTS/national policy on screening including emergency screening targets of less than 20% of blood transfused.
- Promote a quality assurance system covering all stages of the transfusion process.
- Emphasize training consistent with the national plans and policies regarding blood safety
- Ensure quality indicators are utilized to secure a safe blood supply.
- Promote capacity building of health facilities and service personnel with regards to phlebotomy, donor recruitment, laboratory screening blood banking and haemo-vigilance.
- Establish proper data and blood supply/distribution logistics management coordinated with National Blood Transfusion Service (NBTS).
- Strengthen collaboration with partners involved in related programmes such as HCT, malaria prevention, Maternal Health, Laboratory services, etc.
- Encourage adequate blood supply across the entire country, not limited to the centralized urban areas.

- Appropriate designation, recognition and public enlightenment on ‘Blood Safety Service Units’.
- Increase access to post-exposure prophylaxis (PEP) for HIV prevention.

### **3.4.2 Injection Safety and Health Care Waste Management**

The global burden of disease from unsafe medical injections has been estimated for the year 2008 by the World Health Organisation from a probabilistic model. In total, unsafe medical injections led to 340,000 HIV infections, 15 million Hepatitis B virus (HBV) infections, 1 million Hepatitis C virus (HCV) infections, 3 million bacterial infections and 850,000 injection site abscesses in 2008. These infections accounted for 14% of HIV infections, 25% of HBV infections, 8% of HCV infections and 7% of infections with bacteraemia worldwide and accounted for 28 million disability adjusted life years, years of life lost to death and disability from AIDS, acute hepatitis, liver cancer, end-stage liver disease and fatal sepsis.

Reductions in unsafe therapeutic injection frequency have prevented 430,000 HIV infections, 5 million HBV infections and 1 million HCV infections in the developing world each year. Auto disable syringes, introduced for all immunization injections in 1999, prevented 5,000 HIV infections, 200,000 HBV infections, 50,000 HCV infections, 86,000 bacterial infections and 34,000 injection site abscesses in 2008. Vaccination for hepatitis B prevented 1.5 million hepatitis B infections from unsafe medical injections in 2008.

In Nigeria, there are key issues affecting injection safety in our national response and these include the following:

- Poor dissemination of Post exposure prophylaxis (PEP) guidelines.
- Lack of functional infection prevention and control committees at all levels.
- Inadequate facilities for treatment and disposal of injection materials and other healthcare waste.
- Over-prescription and inappropriate use of injections.
- Limited availability of guidelines on injection safety practices including the care of needle stick injuries at all healthcare levels.
- Poor capacity of health workers to implement the guidelines on injection safety practices including the care of needle stick injuries.
- Inadequate supply of injection materials leading to re-use of injection supplies without sterilization.
- Weak inter-sectoral collaboration between key stakeholders on health care waste management.
- Inadequate personal protective equipment for health workers and waste handlers.

## Strategic Focus

- Establish and implement standardized Post Exposure Prophylaxis (PEP) protocols in all facilities
- Establish and strengthen infection prevention and control committees in health care facilities and at all levels.
- Establish a system that ensures proper management of injections and other health care waste by persons and facilities generating them in the health sector and the community.
- Construction and installation of injection and other health care waste treatment and disposal facilities.
- Institutionalizing healthcare waste management systems into government structures.
- Incorporating private sector participation into the healthcare waste management system as a strategy for sustainability.
- Use behaviour change approaches to discourage over-prescription and inappropriate use of injections. Disseminate guidelines and promote implementation of injection safety practices including the care of needle stick injuries at all health care levels.
- Train health care workers in injection safety issues and appropriate waste disposal practices.
- Appropriate procurement, distribution and monitoring of injection equipment and related supplies such as safety boxes, auto-disable syringes and needle cutters.
- Mainstream healthcare waste management into HIV programmes to strengthen health care waste management at all service delivery points.
- Improve collaboration between stakeholders on healthcare waste management.
- Promote adoption and practice of universal precautions at all levels.
- Integrate injection safety and healthcare waste management into a holistic system with private sector participation at the state level.

### 3.4.3 Safe Male Medical Circumcision

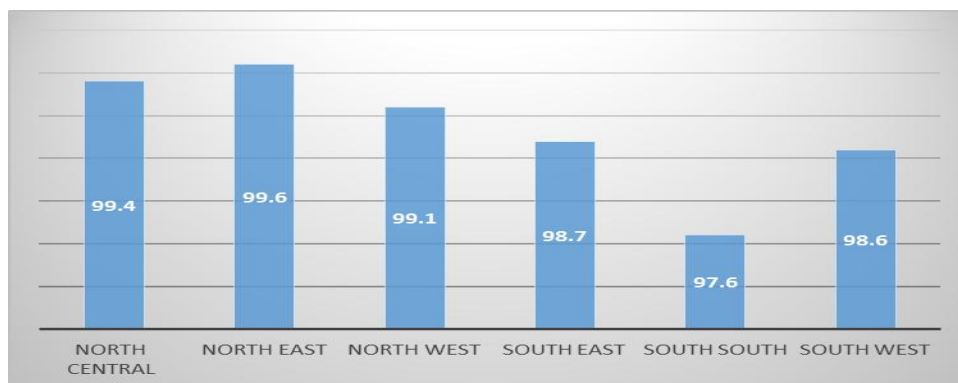
Male Circumcision is a common practice in many parts of Nigeria for traditional, health and other reasons. It often serves as a rite of passage to adulthood. It is done from 8 days old to adult age. Voluntary Medical Male Circumcision has been shown to reduce the risk of HIV transmission by as much as 60%.<sup>9,10</sup> The practice is almost universal and shows little variation across age groups, ethnicity, zones and educational levels. NDHS (2013) shows that 99% of men aged 15-49 are circumcised. Figure 10 show the levels of circumcision across the geopolitical zones.

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<sup>9</sup> Gray, R. *et. al.* (2007). Male circumcision for HIV prevention in men in Rakai, Uganda: A randomized trial. *Lancet*, 369: 657–666.

<sup>10</sup> Bailey, R.C. *et. al.* (2007). Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomized controlled trial. *Lancet*, 369: 643–656.

**Figure 10: Male circumcision across zone in Nigeria**



Source: NDHS 2013

The concern in the Nigeria situation where male circumcision is being encouraged as an HIV/AIDS biomedical prevention strategy is about ensuring that the practice is safe and sterile as well as providing access to data. The emphasis is on carrying out Safe Medical Male Circumcision in a hospital, or by trained health personnel, but if outside of the hospital environment, observing the necessary universal precautions.

#### **Strategic focus**

- Build capacity of health workers on safe medical male circumcision.
- Community mobilization and sensitization on safe medical male circumcision.

### **3.5 Thematic area: Prevention of Sexual Transmission of HIV Infection**

Sexual transmission accounts for over 80% of HIV transmission (MOT, 2009). NARHS (2013), a general population based survey reported some signals of declining situation with HIV prevention efforts as only 24% of young men and women aged 15-24 correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. Also NARHS (2013) reported that 15.5% of young men and women aged 15-24 had sexual intercourse before the age of 15, an increase from 11.9% reported in NARHS 2007. The percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months preceding the survey in 2012 was 16.3% compared to 11.4% in 2007.

This study also noted an increase in risky sexual behaviours, as evidenced by non-condom use. NARHS (2013) reported that the use of male condom in last sex by young people with a non-marital partner was 55%. Proportions was higher in males (63%) than females (45%) and higher in urban than rural areas. The south west zone had the highest use of male condom among young people (62%) while the NE had the lowest (51%). Health seeking behaviour of respondents in the NARHS (2013) survey was equally poor as only 22% of respondents use health facilities, while 15% patronize patent medicine store; 11% patronize traditional healers; private health facilities 10% and pharmacies 8%.

The above evidence suggests the persistence of high-risk sexual behaviours in the general population and this was also similar in both urban and rural areas (Epidemic Appraisals, 2013) with persistence of risky behaviours such as transactional sex, unprotected extramarital sex, multiple sexual partnerships among unmarried men and women, low condom use (NARHS, 2013).

Despite the high prevalence among most-at-risk populations (FSW, MSM and IDU), there is low risk perception, low accurate knowledge of HIV prevention, low condom use with regular partners and boyfriends (IBBSS, 2010). The Epidemic Appraisal (2013) reported that there is significant overlap between venues where sex worker networking occurs and venues where casual sex networking takes place. This presents a unique opportunity to target “general population” that engage in a high-risk behaviour (bridge population). Anecdotal evidence suggests that there are adolescents <18 yrs who are SW, MSM or IDU. These young populations are often not captured by MARPs programmes.

Epidemic appraisal was conducted in eight (8) States to obtain information about MARPs (Sex workers, MSM, IDUs). The epidemic appraisal included the following:

- **MARPs mapping (size estimation, distribution and typology of MARPs):** to determine the scale of effort required for coverage and set realistic target indicators, geographic areas to be prioritized, venues to target for greatest reach.
- **Venue profiling:** to provide information on types of sexual networking, the number and types of venues used by local population for meeting new sexual partners.
- **Rural appraisal:** to assess levels of risk at the rural level, presence of high risk networks (e.g. FSWs), pattern of high risk sexual behaviour and which behaviours to focus on.

Key findings of the epidemic appraisal in the 8 states are summarized below and the implications for MARPs programming are highlighted in Box 3:

- A large number of the FSWs are non-brothel based. This is an important finding, since a large proportion of previous HIV prevention programmes in Nigeria have focused on brothel-based FSWs. The appraisal showed that focusing solely on BBFSWs will yield a coverage of only 16% of all urban FSWs in these eight states. Expand programmes to the FSWs, including those working in in bars and nightclubs (28%) and hotels/lodge (32%).
- Large differences existed in the size and density of FSW populations between the LGAs. Scaling up of interventions should focus initially on LGAs with both the highest populations and density of FSWs, to achieve the greatest impact on the epidemic.

### **Box 3: Key Programme implications for MARPs**

#### **Urban MARPs**

- FSWs are of highest priority.
- Scale up interventions for non-brothel based FSWs.
- States should focus on key LGAs with high concentrations of FSWs.
- Reach MSMs at key hot spot venues.



**Urban venue profiling**

- Venues provide an efficient target for focused HIV prevention programmes.
- Bars, nightclubs and hotels/lodges are most important venues to target.
- Priority should be given to venues which facilitate both casual and sex work networking.
- Maximize impact by focusing on local geographic zones with a high density of venues that facilitate sexual networking.
- Enhance condom programming targeting high risk venues.

**Rural appraisal**

- HIV burden is high in rural areas, and requires a strategic response.
- FSWs are widespread in rural areas, so HIV prevention programmes should include a strategy for rural FSWs.
- HIV prevention programmes for the general population in the villages is required, particularly in Benue and Cross Rivers State.
- Programmes should focus on both reducing the number of partners and increasing condom use.

**Objectives**

1. At least 80.0% of sexually active persons in Nigeria with STIs have access to services by 2015.
2. At least 80.0% of all persons have comprehensive knowledge on HIV and AIDS by 2015.
3. At least 80.0% of young people 15 to 24 years adopting appropriate HIV/AIDS related behaviour by 2015.
4. At least 80.0% of sexually active males and females use condoms consistently and correctly with non-regular partners by 2015.
5. At least 80.0% of MARPs adopt appropriate HIV and AIDS related behavior.
6. At least 80.0% of MDAs in Nigeria have in place HIV workplace intervention by 2015.
7. At least 80.0% of corporate organisations in Nigeria have in place HIV workplace intervention by 2015.
8. At least 80.0% of health facilities have integrated SRH/HIV programmes by 2015.

**Strategic Focus**

- Increase the capacity building of CSO to programme for general population and other vulnerable populations.
- Increase the capacity building for CSOs to programme for MARPs.
- Scale up male and female condom programming and lubricant access.
- Promote community awareness and involvement to support scale-up, ownership and sustainability of programmes.

- Improve STI treatment services and referrals.
- Integration of SRH/HIV service provision for general population and MARPs.
- Use of context-specific evidence to set priority populations, locations and issues to be addressed.
- Establish and sustain HIV workplace programmes.
- Strengthen Social Behavioural Change Communication (SBCC) to facilitate positive behaviour change at individual, community and structural levels.
- Identify and address context-specific structural issues to create an enabling environment for behaviour change especially for young people, women and MARPs

### **3.6 Other key Themes and Emerging Areas**

#### **3.6.1 Integration and linkage of health services**

HIV services should be delivered across a continuum of care. This requires integrated and linked service provision at all levels of the health system, from primary to secondary to tertiary (specialist) care, embracing all elements of the health system, including home-based and community based outreach care. Linkage between Primary Health Care Centers and comprehensive health care hospitals is imperative to provide quality HIV prevention services.

‘Integration’ refers to delivering multiple services or interventions to the same patient by an individual health care worker or by a team of health care workers and possibly, workers from other fields and community based service providers. Strong linkages (with referral and coordination between service providers) and integrated services are needed in particular areas of HIV prevention, such as family planning, care for mothers and newborn infants (MNCH), mental health care, sexual reproductive health, TB/HIV and care for people living with HIV. All of these may involve a range of services and service providers including home-based and community-based ones.

Integrating HIV-related services into all maternal and newborn care and sexual and reproductive health care service delivery is a priority focus of this HIV Prevention Plan. In addition, integrating HIV-related and TB-related services into one package of services remain a priority of this plan.

Currently, the practice in most hospitals where pregnant women with HIV are identified in the antenatal clinic and then referred for HIV-related services that are in another area of the facility, or in another facility altogether often results in a significant ‘loss to follow-up’; many of these women do not appear at the HIV clinic, even if it is in the same facility. Thus emphasizing the focus of this plan on, full integration of HIV intervention delivery within services for antenatal care, childbirth, newborn and postpartum care. This integration should include HIV testing and counseling, assessment of whether antiretroviral for treatment or prophylaxis are needed, initiation and monitoring of antiretrovirals in women and exposed infants, follow-up HIV testing for infants, clinical review and cotrimoxazole prophylaxis when infants return for immunization.

Sexual and reproductive ill-health and HIV infection share the same driving forces, causes or contributors: poverty, limited access to information, gender inequality, cultural norms, and social marginalization of the most vulnerable and at-risk populations. Thus the need for effective linkages between responses to HIV and responses to sexual and reproductive health concerns, as well as the need for integration of related services. These integrated services should include: promoting condom use for preventing unintended pregnancy, sexually transmitted infections (STIs) and HIV; reproductive choice counseling and counseling for family planning and contraception; education on sexual health for people living with HIV; and youth-friendly health services covering sexual and reproductive health.

The high incidence of TB among people living with HIV and the frequent occurrence of HIV infection among people with TB provide the rationale for linkages between responses to TB and HIV, and integration of TB-related and HIV-related services. The linkages and integration have already resulted in substantial increases in the proportion of TB patients tested for HIV and then referred to HIV-care services (or provided with some HIV services on-site). In addition, HIV programmers are increasingly committed to TB control, intensified TB case finding among HIV-infected patients, and to offering Isoniazid prophylaxis after excluding active TB.

### **Recommendations**

- Promote linked or integrated services for HIV and other health care services, including TB, sexual and reproductive health, maternal and newborn health care services.
- Promote linked or integrated services with other sectors, such as education and social welfare, and to those provided within homes and communities by families, international and national NGOs, community-based organisations, faith-based organisations, etc.
- Reduce parallel structures and systems and promote integration of HIV in broad health and development efforts
- Recognize integration as a core priority and promote integration in national strategic plans, including linking HIV and management of chronic non-communicable diseases.

### **3.6.2 Gender**

One of the guiding principles of the National Policy for HIV/AIDS is mainstreaming of gender into all policy-related and programming activities and related structures to ensure that all interventions and programmes are gender-sensitive and gender-responsive, appropriately meeting the separate as well as related needs of females and males. In spite of this fact, gender inequalities and harmful gender norms continue to contribute to HIV-related vulnerability. Nearly all countries (92%) that conducted mid-term reviews of their national AIDS response acknowledged the central importance of addressing gender inequalities. Mid-term reviews indicate that less than half of countries allocate funds for women's organisations, broadly

integrate HIV and sexual and reproductive health services, or have scaled-up initiative to engage men and boys in national responses.

Nigeria conducted the gender assessment of national HIV/AIDS response in 2013 by carrying out secondary analysis of NARHS 2007 & 2012. This was to enable a review of the HIV epidemic, context and response from a gender perspective. Findings from the assessment indicated a feminization of the epidemic. The prevalence is higher for females than male across all age groups except 35-39years and 40-44 years age groups. Among key population, prevalence is highest among FSW followed by MSM. It is disproportionately higher among female IDUs than their male counterpart. Contextual factors contributing to the epidemic comprised of poverty, child marriage, gender-based violence, masculinity and femininity norms, disabilities, harmful traditional rites as well as human right, legal and political factors.

### **Strategic focus**

Key recommendations to ensure scale up of strategies for gender equality are:

- Build the capacity of programme managers, policy-makers and health care providers to understand and address the links between gender inequalities and HIV. Particular attention should be given to identification and remediation services for gender based violence.
- Ensure that HIV policies and programmes explicitly integrate gender and allocate financial and human resources to promote gender-responsive strategies.
- Ensure implementation of the MPPI with particular attention to analyzing and addressing gender as a structural issue in prevention services. This will also include promoting equality between women and men in sexual decision-making and building women's skills to negotiate safer sex including use of female and male condoms.
- Ensure HIV data are disaggregated by sex and age and other appropriate parameters for programme monitoring and evaluation. This will help to identify who is at risk, whether they are being reached equitably, and whether programmes are working for those most in need
- Address women's fear of potential experience of negative consequences of HIV testing and counseling by incorporating safety planning (reduction of violence) as part of disclosure and risk-reduction counseling.
- Reduce gender-related barriers to accessing services, including non-affordability; the need for women to obtain permission from husbands or other family members to go to a health facility; stigma and discrimination against those most-at-risk for or living with HIV including marginalized groups; and providing an appropriate mix of male and female health care providers.
- Support women care givers who provide the bulk of care for those living with and affected by HIV including orphans and vulnerable children. Strategies should also incorporate challenges faced by older women in assessing HIV prevention, treatment care and support services.

- Advocate for gender equality in policies and laws related inheritance rights, widowhood, girl child education and employment

### 3.6.3 Workplace programmes

The workplace offers unique opportunities to reach millions of people in locations where they spend most of their time. The majority of People Living with HIV (PLHIV) working in the private- and public sectors are in their productive age bracket. In many countries the workplace has been a critical cornerstone of national HIV response and has in place protection mechanisms for people against abuse and coercion, discrimination against people living with HIV. For many, HIV workplace programme has been the entry point for HIV related services. Through the workplace, access to HIV prevention services, anti-stigma and anti-discrimination policies and lifesaving treatment can be increased.

Under Global Fund Round 5, a workplace project was undertaken to increase the capacity of the private sector to implement workplace HIV/AIDS programmes. NACA through its sub-recipients (Society for Family Health, Nigeria Business Coalition against AIDS (NIBUCAA) and the Federal Ministry of Labour and productivity implemented workplace HIV/AIDS programmes in private organisations, 170 Small Medium Enterprise (SMEs) in 12 states in Nigeria. An evaluation of this SME workplace project showed that the foundational components of a HIV workplace programme were in place in several private SMEs. Overall, 73/129 (56.6%) SMEs had a HIV/AIDS policy, 51 (46%) had a written policy and had communicated it to their employees. The proportion of companies with a written policy rose by 200% (from the 10% national baseline in 2008). Other HIV workplace programmes in Nigeria (e.g. AED/SMARTWork Nigeria and Swedish Workplace HIV/AIDS programme) have adopted a similar approach of including the development of a HIV policy and peer education in their workplace programme).<sup>11,12</sup> The evaluation reported a statistically significant higher uptake rate of HIV testing (among those that had peer education intervention/encounter compared with employees with no peer education intervention).<sup>13</sup> Other key elements for a successful HIV and AIDS workplace programme and policy implementation are hinged on the bipartite responsibility of management and employees. The formation of workplace committees is also essential for the synergistic process.

Overall, the HIV workplace programme in Nigeria has not been implemented on a large scale as previous efforts were grossly inadequate in terms of: geographic coverage, sub-population groups served and service packages provided. Most of the workplace programmes were implemented as vertical programmes providing mostly HIV testing services (HCT) and informational services to the work populace.

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<sup>11</sup> Dada I. *et. al.* 2010. Implementing a country-wide workplace HIV/AIDS programme through labour unions in Nigeria (AED/SMARTWork Nigeria).

<sup>12</sup> SWHAP 2010. Swedish Workplace HIV/AIDS Programme 2009 annual report and launch of SWHAP in Nigeria, Oct 2010), accessed via [www.swhap.org](http://www.swhap.org).

<sup>13</sup> NACA 2011. Evaluation of small/medium private companies with HIV/AIDS interventions under global fund round 5 programmes in Nigeria

This Plan promotes and encourages implementation of workplace programmes at scale using established platforms like NIBUCCA, Vanguard Labor unions and workers' unions. Strategic focus for the workplace programmes will include:

- Increased access to quality prevention services (utilizing the MPPI approach) in the work place with scale up effort in engaging the private sector.
- Promote development of Workplace policy on HIV/AIDS for all SMEs, public and private sector organisations.
- Promote linkage of all HIV positive workers identified to treatment, care and support continuum of services.
- Promote provision of services for partners of workers and other family members to ensure comprehensive approach and acceptance of services.
- Promote increased adoption of safer sex practices and behaviour among workplace populace.
- Promote reduction in stigma and discrimination in the workplace.
- Promote the best practice of having dedicated budget and focal officers for HIV workplace programme in the workplace.

#### **3.6.4 New Prevention Technologies**

There is the need to embrace New Prevention technologies in HIV AIDS prevention in Nigeria following the issues on efficacy and effectiveness of existing prevention tools such as the male condom. Some of these new prevention technologies include; use of microbicides (foam, gel or cream applied vaginally or rectally), Treatment as Prevention (using either one drug or a combination drug taken daily), Pre-exposure prophylaxis, Female condoms, diaphragms etc.

- Promote introduction, access and use of microbicides as prevention tools by males and females
- Build capacity of health workers in the introduction and research on new prevention technologies.
- Promote access and use of female condoms.

##### **3.6.4.1 Treatment as Prevention (TasP)**

Treatment as prevention (TasP) is the use of medications for the treatment of HIV to reduce the risk that an HIV-positive person will pass the virus to their sexual partner. The strategy uses the familiar tools of combination antiretroviral drugs known as antiretroviral therapy (ART) that HIV-positive people take to preserve life and health. ART preserves the immune system, keeps people with HIV healthy and prolongs their productive lives. The HPTN 052 trial has found that ART reduces the risk that an HIV-positive person will pass the virus to their sex partner. TasP is a strategy that works even when people living with HIV feel healthy and have high CD4 cell count. A high viral load can mean a higher risk of passing the virus on to someone else – no matter the CD4 cell count. ART brings down viral load and reduces the risk of passing on HIV. TasP is a strategy that works when viral load levels are low (or undetectable).

#### **3.6.4.2 Pre-exposure prophylaxis (PrEP)**

**PrEP** is a strategy that involves use of antiretroviral medications (ARVs) to reduce the risk of HIV infection via sexual exposure. All of the current effectiveness and follow-on trials are testing tenofovir-based regimens—using either TDF/FTC (an antiretroviral containing tenofovir (TDF) and emtricitabine (FTC) that is sold under the brand name Truvada) or TDF (an antiretroviral pill marketed under the brand name Viread). Based on the data that have been collected to date the US Food and Drug Administration (FDA) announced its approval of daily oral TDF/FTC for PrEP in 2012. This is the first ARV to be approved for HIV prevention in HIV-negative adults. In July 2012, the WHO released guidance on PrEP for serodiscordant couples, MSM and transgender women in the context of demonstration projects. A proposal study for a demonstration project on PrEP has been developed.

#### **3.6.4.3 HIV Vaccine**

An AIDS vaccine is an experimental strategy that aims to teach the body's immune system how to fight HIV to reduce the risk of infection or to reduce viral load in those who get the vaccine and go on to become infected. There are no AIDS vaccines available today. Efforts are on-going to develop and produce an AIDS vaccine.

#### **3.6.4.4 HIV in Humanitarian settings**

Human-induced and natural disasters uproot millions of people each year and constitute important aggravating factors fuelling the HIV/AIDS epidemic. Sexually transmitted infections (STIs) and HIV spread faster in communities where there is social disruption and instability, combined with poverty - conditions that are extreme during conflicts and in the aftermath of natural disasters. Addressing the needs of communities and individuals who have lost their security, their homes, and their access to support requires a broad set of humanitarian interventions – food, shelter, sanitation, health, social support and protection measures. Within the context of broader humanitarian relief interventions, it is increasingly recognized that HIV/AIDS prevention and other essential sexual and reproductive health services must be seen as an integral part of the response and supported with resources and technical assistance.

In Nigeria, the incidence of disasters and emergencies has increased in frequency and intensity in the last decade. Recent disasters in Nigeria include floods, bush-burning incidents, erosion in the Southeast areas, boat/canoe accidents in the riverine areas, community-clash, bomb-blasts and acts of terrorism have resulted in loss of lives, displacement of populations and grossly affected the economic activities in the affected areas. The floods of 2012 affected 34 states, affected 7 million and displaced over 2.3 million people. These incidents have implications for internally displaced persons who become vulnerable and are confronted with several risks including sexual violence, sexual exploitation.

Widespread population displacement, whether caused by human-induced or natural disaster, can severely undermine access to reproductive health information and services at the same time as it increases vulnerabilities to HIV. The specific interventions adopted for provision of STI and HIV

prevention, treatment and care must vary according to the circumstances of the emergency and depend on access to the populations at risk. The focus on HIV prevention emphasizing condom promotion and special programmes for young people and pregnant women is particularly relevant in humanitarian situations and should be seen as a life-saving intervention. The disintegration of community and family life in conflict and people displacement situations leads to the break-up of stable relationships and the disruption of social norms governing sexual behaviour. Displacement mixes populations of varying HIV prevalence levels; forced migration from rural to heavily populated (often higher prevalence) areas can significantly increase risk as rural populations are often less aware of HIV/AIDS and of means of prevention. Ensuing poverty and desperation can increase risk behaviours, while also diminishing access to information and modes of prevention.

The Inter-Agency Standing Committee (IASC) Guidelines is a document detailing the framework on which multiple agencies can draw up a plan for inter-phasing their activities during an emergency. It provides for components of initial response and expanded response as it applies to HIV interventions during emergencies. The minimum initial response outlines a set of HIV-related interventions to be carried out during the early stages of any emergency regardless of the specific local or epidemiological context of the epidemic while the expanded response focuses on additional core HIV interventions that should be planned and implemented as soon as possible, taking into account the local contexts and priorities, the epidemiological profiles and the capacity of different sectors to deliver the interventions. The guidelines provides information on the sectoral response to HIV in humanitarian settings for nine key sectors: HIV awareness raising and community support; Health; Protection, Food security, nutrition and livelihood support, education; shelter; Camp coordination and camp management, water, sanitation and hygiene; HIV in the workplace.

In Nigeria, HIV response in emergency is included within the National Contingency Plan. The HIV response is led at the national level by NACA and SACA at the State level. Given that natural and human-induced disasters occur, provisions should be made to promote HIV programming in emergencies and humanitarian settings and these include:

- Mainstream HIV and AIDS into the Basic Package for Education in Emergency (BEiE).
- Mobilize HIV/AIDS workers and teachers trained in FLHE, life skill and BEiE to disseminate information on HIV and AIDS.
- Establish gender friendly food distribution procedure and support and protect food security of PLHIVs, infected/ affected and at risk households or groups.
- Promote effective prevention and management of consequences of sexual violence.
- Pre-position HIV testing kits, IEC materials, Mama Kits, delivery kits, mosquito nets, ARVs, condoms, post exposure prophylaxis, family planning resources, etc.
- As part of preparedness activities, undertake and provide training on HIV response during emergency, coordination, planning and programming for HIV/AIDS. In addition, develop a local/state directory of actors in 'HIV emergency actors'.



### 3.7 Coordination

The coordinating structure of the national response is responsible for coordinating the implementation of the National Prevention Plan (NPP). This includes ensuring quality of service delivery, data management and use for decision making. A coordinated implementation of NPP is essential for achieving the goals and objectives of this revised plan. Table 6 gives a summary of the roles and responsibilities of all key stakeholders engaged in the implementation of the Plan.

The coordinating structure of the national response led by NACA shall provide leadership at the national level while SACAs and LACAs provide same at states and local government levels respectively. NACA, SACA and LACA shall work with line ministries, donors and international partners to design and implement the national and state HIV prevention plans in ways that promotes synergy of activities and sustainable institution capacity building.

At the national level, NACA interfaces in five domains namely: NACA-SACA, NACA-Civil Society organisations, NACA-private sector, NACA- public sector and NACA-development partners.

NACA and SACA may constitute task teams on needs basis to undertake specific assignments to facilitate effective implementation of the plan. The State Management Team constituted in each state, has SACA as its secretariat. The State Prevention Technical Working Group is one of the core TWGs reporting to SMT and SACA.

NACA and SACA shall facilitate the formation, funding and capacity building of CSOs and CSO networks into constituent coordinating entities to provide viable platforms for programme implementation. Coordination mechanisms and platform to facilitate CSO/public sector, CSO/Donors and CSO/Private sector interaction at national and state levels are important for supporting the implementation of the 2014- 2015 NPP.

**Table 6: Roles and Responsibilities of stakeholders engaged with the National HIV Prevention Response**

No	Stakeholders	Coordinating roles and responsibilities
1	NACA	<ul style="list-style-type: none"> <li>• Provide guidance for implementation of the National HIV Prevention Plan;</li> <li>• Facilitate the development and timely, periodic review of the NPP to ensure continuous responsiveness to the dynamics of the HIV and AIDS epidemic in Nigeria;</li> <li>• Coordinate the implementation of the NPP;</li> <li>• Constitute, support and facilitate the functioning of a multi-sectoral and multidisciplinary NPTWG;</li> <li>• Ensure the prioritization and sustainable resourcing of the NPP;</li> <li>• Establish and maintain up-to-date database on NPP programmes, institutions, personnel, data, and reports;</li> <li>• Facilitate collaboration between key stakeholders engaged with HIV Prevention programming;</li> <li>• Facilitate the engagement of all tiers of government and all sectors on issues of HIV/AIDS prevention;</li> <li>• Facilitate dissemination and access to information on outcomes of the national HIV prevention programmes nationally, regionally and internationally.</li> </ul>

No	Stakeholders	Coordinating roles and responsibilities
2	SACA	<p>SACAs perform similar functions of NACA at the state level:</p> <ul style="list-style-type: none"> <li>• Design and coordinate intense multi-sectoral approaches and plans for HIV/AIDS prevention and control;</li> <li>• Provide technical and financial support to the planning, implementation and management of HIV/AIDS interventions to line Ministries, CSOs, organised private sectors and LGAs;</li> <li>• Support biennial sentinel survey on the incidence and prevalence of HIV/AIDS and promote operational research on intervention strategies;</li> <li>• Promote and encourage multi-disciplinary collaboration and networking among all stakeholders including CSOs against HIV/AIDS;</li> <li>• Build capacity of personnel involved in the prevention and impact mitigation of HIV/AIDS at all levels;</li> <li>• Undertake resource mobilization and other activities;</li> <li>• Establish and maintain up-to-date database on NPP programmes, institutions, personnel, data, and reports. Ensure that provision is made to support workplace HIV programmes;</li> <li>• Facilitate and ensure the provision of comprehensive HIV prevention, treatment, care and support in the state;</li> <li>• Establish, encourage and promote training programmes for the human resource required for the operationalization of the prevention plan.</li> </ul>
3	LACA	<p>LACA performs similar functions of SACA at the local government level:</p> <ul style="list-style-type: none"> <li>• Establish and maintain up-to-date database on NPP programmes, institutions, personnel, data and reports;</li> <li>• Ensure that all HIV and AIDS interventions at the Local levels are coherent, concerted and complimentary to each other and devoid of duplication;</li> <li>• Facilitate and coordinate HIV activities of various sectors and actors at the LGA level;</li> <li>• Advocate mainstreaming of HIV and AIDS interventions into the activities of all LG departments and advocate for budgets from the Local Government;</li> <li>• Mobilize resources from other sources and coordinate equitable application of same for HIV and AIDS activities in the Local Government;</li> <li>• Monitor and evaluate all HIV and AIDS activities at the LG and community levels;</li> <li>• Facilitate the implementation of the policies and strategies in all sectors to leverage human, financial and organisational resources to support successful execution of Local Government HIV and AIDS response;</li> <li>• Develop and strengthen human capacity for effective management of the LG response;</li> <li>• Ensure that provision is made to support workplace HIV programmes.</li> </ul>
4	National Prevention Technical Working Group	<ul style="list-style-type: none"> <li>• Provide technical assistance and mentoring to the state Prevention TWG and relevant stakeholders involved in implementation of the NPP;</li> <li>• Provide technical leadership for the implementation, monitoring, review and evaluation;</li> <li>• Identifies, develops and undertakes periodic review of HIV prevention priority research issues, needs and agenda for the country, in collaboration with relevant stakeholders;</li> <li>• Facilitates the technical review of HIV prevention programme proposals to be sponsored or endorsed by NACA in the country in line with nationally-defined needs, priorities and agenda;</li> <li>• Facilitate the implementation of the NPP;</li> <li>• Identifies possible resource base (human, material and infrastructure, and financial)</li> </ul>

No	Stakeholders	Coordinating roles and responsibilities
		<p>necessary for the implementation of the NPP;</p> <ul style="list-style-type: none"> <li>• Evaluate and make necessary recommendations on the implementation of the NPP to NACA, and to other stakeholders as may be required;</li> <li>• Providing technical inputs and assistance in achieving the greatest positive impact in Prevention aspects of HIV/AIDS interventions at the National level in the most cost and time effective way;</li> <li>• Harmonizing and aligning programmes, plans and activities by the various stakeholders at the national level in Prevention aspects of HIV/AIDS interventions;</li> <li>• Strengthening the governance structure that is required for effective multi-sectoral responses in Prevention aspects of HIV/AIDS interventions;</li> <li>• Improving and sustaining performance in terms of targets and indicators of the various strategic/work plans at the national level in Prevention aspects of HIV/AIDS interventions;</li> <li>• Determining the effectiveness, efficiency, adequacy and continued relevance of the ongoing interventions in Prevention aspects of HIV/AIDS interventions at the National level;</li> <li>• Ensuring accountability and transparency in Prevention aspects of HIV/AIDS interventions at the National level.</li> </ul>
5	State Prevention Technical Working Group	<p>To perform similar functions of the NPTWG at the state level:</p> <ul style="list-style-type: none"> <li>• Support LACA in implementing prevention programmes and coordinating the response at the community levels;</li> <li>• Provide technical inputs and assistance in achieving the greatest positive impact in Prevention aspects of HIV/AIDS interventions at the State level in the most cost and time effective way;</li> <li>• Harmonize and align programmes, plans and activities by the various stakeholders at the state level in Prevention aspects of HIV/AIDS interventions;</li> <li>• Strengthen the governance structure that is required for effective multi-sectoral responses in Prevention aspects of HIV/AIDS interventions;</li> <li>• Improve and sustain performance in terms of targets and indicators of the various strategic/work plans at the state level in Prevention aspects of HIV/AIDS interventions;</li> <li>• Determine the effectiveness, efficiency, adequacy and continued relevance of the ongoing interventions in Prevention aspects of HIV/AIDS interventions at the State level;</li> <li>• Ensure accountability and transparency in Prevention aspects of HIV/AIDS interventions at the State level;</li> <li>• Provide technical inputs and assistance in ensuring effective coordination in Prevention aspects of HIV/AIDS interventions within the multi-sectoral response at the State level.</li> </ul>
6	MDAs	<ul style="list-style-type: none"> <li>• Coordinate sectoral response in respective ministries;</li> <li>• Ensure that provision is made to support workplace HIV programmes;</li> <li>• Ensure appropriate Advocate for allocation of 1% ministry budget for HIV programmes;</li> <li>• Ensure provision of adequate human, material and financial resources for the implementation of HIV prevention programmes that are related to their area of mandate;</li> <li>• Actively partner with stakeholders and provide linkage in the design and implementation, monitoring and evaluation of the MDA's HIV prevention related activities;</li> <li>• Implement the areas of the NPP as relevant to their mandates;</li> <li>• Ensure the implementation of Federal &amp; State Line Ministries HIV/AIDS Strategic Plans;</li> <li>• Participate in platforms for exchanging strategic information on HIV/AIDS issues;</li> </ul>

No	Stakeholders	Coordinating roles and responsibilities
		<ul style="list-style-type: none"> <li>• Use the technical support and guidance to the line Ministries;</li> <li>• Ensuring compliance with Federal /State guidelines, policy, processes, procedures and general direction on the HIV/AIDS programme and projects.</li> </ul>
7	CSOs	<ul style="list-style-type: none"> <li>• Play frontline role in advocating for adequate and timely funding for HIV Prevention programmes;</li> <li>• Work closely with established networks to ensure prompt implementation of the prevention plan at the community levels;</li> <li>• CSOs shall be responsible for prevention programme data collection and its transmission;</li> <li>• Participate in platforms for interaction between SACAs, the CSOs and Private Sector for exchanging strategic information on HIV/AIDS issues &amp; other various issues confronting them;</li> <li>• Ensure the implementation of their strategic and annual work plans;</li> <li>• Identifying and addressing capacity needs of the CSO and Private sector Organisations;</li> <li>• Providing technical support and guidance to the CSOs networks and Private Sector Organisations;</li> <li>• Review Civil Society HIV/AIDS response and CSO performance in coordinating, monitoring and mobilizing resources for the response.</li> </ul>
8	Implementing Partners	<ul style="list-style-type: none"> <li>• Provide technical support to the national response at national and sub-national levels;</li> <li>• Participate on all platforms for the implementation of the plan;</li> <li>• Contribute technically to the coordinating efforts of the national response;</li> <li>• Share the results and data of HIV prevention interventions with GoN and other relevant stakeholders.</li> </ul>
9	Organised Private Sector	<ul style="list-style-type: none"> <li>• Ensure coordination and implementation of workplace HIV programmes;</li> <li>• Actively partner with stakeholders to implement the NPP/SPP;</li> <li>• Support human capacity development for the implementation of the NPP/SPP;</li> <li>• Mobilize the private sector organisations through their leadership for active engagement in the State HIV/AIDS response;</li> <li>• Stimulate the interest of the private sector particularly the informal sector in HIV/AIDS activities;</li> <li>• Strategize on response entry points for the private sector entities;</li> <li>• Operationalizing of the concept of public-private partnership (PPP) in the context of the National and State HIV/AIDS response.</li> </ul>
10	Community leaders	<ul style="list-style-type: none"> <li>• Serve as gatekeepers to ensure conducive environment for the implementation of the NPP at the community level;</li> <li>• Ensure that the rights of the community and community members are protected;</li> <li>• Facilitate community mobilization for effective implementation of the plan.</li> </ul>
11	HIV prevention service recipient	<ul style="list-style-type: none"> <li>• Ensure they have access to accurate information on HIV transmission and prevention;</li> <li>• Report any untoward effects from HIV prevention services received.</li> </ul>
12	PLHIV	<ul style="list-style-type: none"> <li>• Responsible for the coordinating and implementing Greater Involvement of People Living with HIV/AIDS (GIPA)/ Meaningful Involvement of People Living with HIV/AIDS (MIPA) initiative;</li> <li>• Sensitize and mobilize peers, support groups within the communities to participate in</li> </ul>

No	Stakeholders	Coordinating roles and responsibilities
		HIV/AIDS prevention activities PHDP; <ul style="list-style-type: none"> <li>• Partner with service providers and other stakeholders to implement HIV prevention programmes.</li> </ul>
13	Media	Provide support through their various platforms to the national response for effective coordination and implementation of the plan

## **4.0 Monitoring and Evaluation**

In line with the principles of ‘The Three Ones’, Nigeria established a national monitoring and evaluation system for the national HIV response known as the Nigerian National Response Information Management System (NNRIMS). This system provides the framework for periodic monitoring of progress with the implementation of the national strategic plan. It shall also serve as the monitoring and evaluation framework for the national prevention plan.

At programme level, each organisation and programme implementer will generate activity related results. All organisations implementing HIV prevention programmes developed and guided by the NPP are expected to develop programme performance indicators with targets derived from the national targets outlined in this document.

Routine monitoring tools have been developed for each of the four thematic focal areas for the NPP. These tools should be used by implementers. The information generated will be complemented by results of national surveys, special studies and other specific information generation activities to help monitor the achievements of set targets in the NPP. The M&E section of the NPP describes the following: (i) NPP indicators and targets; (ii) Data sources for NPP indicators; (iii) Data flow & reporting; (iv) Data dissemination and use; (v) NPP indicator reference table with detailed definition of indicators

### **4.1 NPP Indicators and targets**

Performance indicators for the NPP have been developed for each of the four NPP thematic areas of focus and targets therein have been derived from existing national targets. The indicator matrix on Table 7 summarizes the NPP indicators; baselines and targets respectively:

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**Table 7: National Prevention Plan Indicator Matrix**

Indicators for thematic 1	2012 Target	2012 Achievement	2015 Target	NOP2	Recommended 2015 Target review
<b>Objective 1: At least 50.0% of the national population access HCT services by 2015</b>					
Percentage of children (0-14) who have accessed HCT services in the past 12 months and know their results	-	0.22% Male: 0.22% Female: 0.23%	41.0%		45.8% based on population stratification of the PCR target of 80,000,000
Percentage of adolescents (15-19) who have accessed HCT services in the past 12 months and know their results	-	12.7% Male: 12.5% Female: 13.0%	45.8%		57.0% based on population stratification of the PCR target of 80,000,000
Percentage of young adults (20-24) who accessed HCT services in the past 12 months and know their results	50.0%	24.5% Male: 20.4% Female: 27.5%	57.0%		57.0% based on population stratification of the PCR target of 80,000,000
Percentage of adults (25-49) who accessed HCT services in the past 12 months and know their results	50.0%	17.5% <sup>14</sup> Male: 14.3% <sup>15</sup> Female: 21.0%	57.0%		54.0% based on population stratification of the PCR target of 80,000,000
Number of children [0-14] counselled, tested and received results annually	-	Male: 80,268 Female: 83,536	-		To be determined through the annual HIV national workplan
Number of adolescents (15-19) counselled, tested and received results annually	-	Male: 159,104 Female: 174,891	-		To be determined through the annual HIV national workplan
Number of young adults (20-24) counselled, tested and received results annually	-	Male: 207,676 Female: 214,704	-		To be determined through the annual HIV national workplan
Number of adults [25-49] counselled, tested and received results annually	-	Male: 748,229 Female: 948,596	-		To be determined through the annual HIV national workplan

<sup>14</sup> Number of 25-49 year old males who accessed HCT services in the NARHS 2012 report is 8,457. The total number of males in the age group from the survey is 59,227. NARHS, 2012

<sup>15</sup> Number of 25-49 year old females who accessed HCT services in the NARHS 2012 report is 10,056. The total number of females in the age group from the survey is 47,975. NARHS, 2012

Percentage of 15-49 year old counseled and tested in the past 12 months and know their results	50.0%	26.3% Male: 23.5% Female: 29.9%	54.0%	40.0% based on population stratification of the PCRCP target of 80,000,000
Percentage of health facilities providing HCT	-	10.1%	90.0%	
<b>Objective 2: At least 80.0% of MARPs Access HCT by 2015</b>				
Percentage of MSM who received an HIV test in the past 12 months and know their results	62.0%	-	80.0%	
Percentage of FSW who received an HIV test in the past 12 months and know their results	62.0%	-	80.0%	
Percentage of IDU who received an HIV test in the past 12 months and know their results	-	-	80.0%	
<b>Objective 3: At least 80.0% of sexually active persons in Nigeria with STIs have access to services by 2015</b>				
Percentage of sexually active males and females with STI symptoms who accessed treatment services	M: 78.0% F: 70.0%	Male: 57.0% Female: 62.2%	Male: 90.0% Female: 90.0%	
<b>Objective 4: At least 80.0% of all pregnant women have access to HCT by 2015</b>				
Percentage of pregnant women counselled and tested for HIV and received test result	28.0%	17.0%	50.0%	90.0% in line with the PMTCT scale up plan
<b>Objective 5: At least 95.0% of all HIV positive women access ARV prophylaxis by 2015</b>				
Percentage of HIV positive pregnant women who received ARV prophylaxis to reduce the risk of mother to child transmission of HIV	50.0%	20.2%		Target increased to 95.0% in line with the PCRCP target
Percentage of HIV-infected pregnant women who assessed for ART eligibility through either clinical staging or CD4 testing during the period	23.0%	4.6%	41.0%	41.0% based on the NOP2 achievement
Percentage of health facilities providing PMTCT services	-	5.1%	55.7%	
<b>Objective 6: At least 80.0% of all HIV exposed infants have access to prophylaxis by 2015</b>				
Percentage of HIV exposed infants who received ARV prophylaxis	23.0%	6.2%	41.0%	95.0%



Percentage of infants born to HIV-infected women who were started on co-trimoxazole prophylaxis within two months of birth	18.0%	10.4%	41.0%	90.0%
Percentage of infants born to HIV infected women who test HIV positive 12 months after birth				
<b>Objective 7: At least 80.0% of all HIV exposed infants have access to early infant diagnosis services</b>				
Percentage of HIV exposed infants who received a virological test for HIV within 2 months of birth	23.0%	4.1%	41.0%	
<b>Objective 8: At least 80.0% of all persons in Nigeria have comprehensive knowledge on HIV and AIDS by 2015</b>				
Percentage of persons in Nigeria who correctly identified ways of preventing HIV & rejected major misconceptions the sexual transmission of HIV	52.0%	25.4% Male: 27.7% Female: 23.1%	80.0%	
Percentage of adolescents aged 15–19 who correctly identified ways of preventing HIV and rejecting major misconceptions the sexual transmission of HIV	52.0%	21.8% Male: 22.9% Female: 20.8%	TBD	60.0%
Percentage of young adults aged 20–24 who correctly identify ways of preventing HIV and rejecting major misconceptions the sexual transmission of HIV	52.0%	27.4% Male: 32.1% Female: 23.9%	TBD	60.0%
<b>Objective 9: At least 80.0% of young persons 15 – 24 years old adopt appropriate HIV and AIDS related behavior</b>				
Percentage of 15-19 year olds who have had sexual intercourse before the age of 15 years	M: 17.0% F: 33.0%	Male: 19.7% Female: 37.4%	M: 12.0% F: 23.0%	
Percentage of 15-19 year olds who reported the use of a condom during their last intercourse with non-marital sex partner	-	Male: 56.4% Female: 48.0%	-	70.0% 70.0%
Percentage of 20-24 year olds who reported the use of a condom during their last intercourse with non-marital sex partner	Male: 67.0% Female: 67.0%	Male: 64.8% Female: 58.1%	-	75.0% 75.0%
Percentage of 15-19 year olds who engage in transactional sex	-	Male: 9.2% Female: 8.9%	-	6.5% 6.0%
Percentage of 20-24 year olds who engage in transactional sex	-	Male: 7.9% Female: 7.5%	-	5.0% 5.0%
Percentage of 15-19 who have had sexual intercourse with more than one partner in the last 12 months	-	Male: 29.9% Female: 6.9%	-	20.0% 5.0%

Percentage of 20-24 who have had sexual intercourse with more than one partner in the last 12 months	-	Male: 33.6% Female: 8.0%	-	25.0% 6.0%
Percentage of 15 to 19 who are living with HIV	-	2.9% Male: 2.9% Female: 2.9%	-	2.0%
Percentage of 20 to 24 who are living with HIV	-	3.2% Male: 2.5% Female: 3.7%	-	2.5%
<b>Objective 10: At least 80.0% of sexually active adults use condom consistently and correctly with non-marital partners by 2015</b>				
Percentage of adults 25 and above who reported the use of a condom during their last intercourse with non-marital sex partner	-	<sup>16</sup> Male: 62.5% <sup>17</sup> Female: 38.7%	-	80.0% 50.0%
Percentage of adults 25 and above who reported the use of a condom during their last intercourse with girl/boyfriend	-	Male: 61.0% Female: 39.7%	-	80.0% 50.0%
Percentage of schools implementing the FLHE	27,576	<sup>18</sup> 41,786	34,470	
Number of teachers trained on FLHE			564,000	
Number of in-school adolescents exposed to FLHE	2,856,000 Male: 50.0% Female: 50.0%	1,823,421 Male: - Female: -	Male: 80.0% Female: 80.0%	
Number of peer educators trained to mentor in and out of school youths	53,851	61,191 Male: - Female: -	TBD	
<b>Objective 11: At least 80.0% of MARPs adopt appropriate HIV and AIDS related behavior</b>				
Number [%] of MSM reached with minimum HIV prevention package	-	-	60.0%	Data to be generated from IBBSS 2013
Number [%] of FSW reached with minimum intervention prevention package	-	-	60.0%	Data to be generated from IBBSS 2013
Number [%] of IDU reached with minimum HIV prevention package	-	-	60.0%	Data to be generated from IBBSS 2013
Percentage of MSM who reported the use of a condom during their last anal intercourse with a male partner	-	-	80.0%	Data to be generated from IBBSS 2013

<sup>16</sup> Based on the 2012 NARHS data, number of males using condom with non-marital sex partners is 1533 of 2451

<sup>17</sup> Based on the 2012 NARHS data, number of females using condom with non-marital sex partners is 683 of 1763

<sup>18</sup> 9,836 new schools implemented FLHE in 2011, and 8,970 new schools implemented FLHE in 2012. The target for 2012 is that 60% of schools in Nigeria implement the FLHE

Percentage of MSM who reported the use of a condom in the last six months when they had anal intercourse	62.8%	-	80.0%	Data to be generated from IBBSS 2013
Percentage of FSW who reported the use of a condom with their most recent client	99.0% 99.0%	-	99.0% 99.0%	
Percentage of IDU who reported the use of a condom during their last non marital sexual intercourse	-		Male: - Female: -	Important to generate data on male and female IDU in the IBBSS 2013
Percentage of IDU who reported use of sterile injecting equipment the last time they injected drugs	-	-	Male: - Female: -	Important to generate data on male and female IDU in the IBBSS 2013
Percentage of MSM with STI symptoms who accessed treatment services	-	-	-	Data to be generated from IBBSS 2013
Percentage of FSW with STI symptoms who accessed treatment services	-	-	-	Data to be generated from IBBSS 2013
Percentage of IDU with STI symptoms who accessed treatment services	-	Male: - Female: -	Male: - Female: -	Important to generate data on male and female IDU in the IBBSS 2013
Number of male condoms distributed				
Number of female condom distributed				
Number of lubricants distributed				
Ratio of condoms distributed/Condoms required				
Percentage of MSM who are living with HIV	13.6%	-	8.5%	Data to be generated from IBBSS 2013
Percentage of FSW who are living with HIV	19.2%	-	12.0%	Data to be generated from IBBSS 2013
Percentage of IDU who are living with HIV	3.2%	-	2.4%	Data to be generated from IBBSS 2013
<b>Objective 12: At least 80.0% of MDAs organisations in Nigeria have in place HIV workplace intervention by 2015</b>				
Percentage of line ministries and LACAs implementing HIV/AIDS workplan	-	20.6%	30.5%	
Number (%) of persons in workplace reached with MPPI	-	-	-	
<b>Objective 13: At least 80.0% of Corporate organisations in Nigeria have in place HIV workplace intervention by 2015</b>				
Number (%) of Corporate organisations with workplace policies	-	-	-	20.0%

<b>Objective 14: At least 80.0% of health facilities have integrated SRH/HIV programmes by 2015</b>				
Percentage of health facilities with integrated HCT and SRH services	-	2.9%	-	30.0%
Percentage of health facilities with integrated STI and SRH services	-	-	-	30.0%
<b>Objective 15: At least 100% of blood and blood products are screened for HIV and other Transfusion Transmissible Infections by 2015</b>				
Percentage of states that have legislated the use of 4 <sup>th</sup> generation ELISA techniques for the screening of blood, blood products and transplant organs	-	2.7%	-	32.4%
Percentage of units of blood collected and screened for TTIs using 4 <sup>th</sup> Generation ELISA techniques	-	-	-	
<b>Objective 16: At least 80.0% of health facilities institute health care safety measures</b>				
Number of health workers trained on infection control (injection safety and health care waste management)	-	-	-	-
Percentage of health facilities meeting minimum package of health care waste management	-	-	-	-
Percentage of states with health waste management policy	-	<sup>19</sup> 8.1%	-	50.0%
<b>Objective 17: At least 80% of health facilities provide Post-exposure prophylaxis (PEP) to healthcare workers, rape survivors and those exposed to HIV infection by 2015</b>				
Percentage of health facilities providing PEP to health workers, rape survivors and those exposed to HIV infection	50.0%	<sup>20</sup> 20.0%	-	50.0%
Percentage of reported HIV exposure who received PEP	50.0%	<sup>21</sup> 43.7%	-	80.0%

<sup>19</sup> AIDSTAR-One report notes Lagos, Benue and FCT had developed health waste management policy

<sup>20</sup> NACA: Presidential Comprehensive HIV and AIDS Response Plan. 2013:23. Data contentious since the number of facilities providing ART is just about 2.0%

<sup>21</sup> The 2012 pivotal Table from NASCP showed that 23,768 persons reported HIV exposure, while 10377 received PEP

## 4.2 Data Sources for NPP Indicators

Data for measuring the indicators in the NPP will be obtained from two main sources: routine data sources and non-routine data sources. Similarly standard national data collection and reporting tools have been developed by the relevant stakeholders led by NACA to facilitate data collection and reporting across the thematic areas of the NPP.

### 4.2.1 Routine Data Sources

Routine data sources provide data that are collected on a continuous basis during service provision at the service delivery level both at the health facility level and the community levels respectively. Although these data are collected continuously with individual patient or client encounters, processing, aggregation and reporting on the data usually takes place on a monthly or quarterly basis.

- Data collection from routine sources is useful because it provides information on a timely basis compared to non-routine sources. Since it is available more frequently, routine data can be used effectively to detect and correct problems in service delivery.
- However, it can be difficult to obtain accurate estimates of catchment areas or target populations through this method, and the quality of the data may be poor because of inaccurate record keeping or incomplete reporting.

Table 8 below contains a list of data collection and reporting tools by thematic areas of the NPP which provide routine data sources for indicators in the NPP.

**Table 8: List of the M & E Data Collection and Reporting Tools by Thematic Areas**

(Data collection and Reporting (DC &R) tools)

Thematic area	Level of Care	Data Collection Tools	Data Reporting Tools
Sexual Transmission Prevention [General Population]	Community, Schools, Workplace	National Prevention Forms and Registers: <ul style="list-style-type: none"> <li>• FSW Registration Form</li> <li>• MSM Registration Form</li> <li>• IDU Registration Form</li> <li>• General Population Registration Form</li> <li>• PE Attendance Sheet</li> <li>• PE Monthly Tracking form</li> <li>• Referral Form</li> <li>• Peer Educator Supervisor Monthly Summary Form</li> <li>• Referral Register</li> <li>• Quarterly PITT</li> <li>• Condom Outlet Summary</li> </ul>	, National Prevention Monthly Summary Form  MIS 002: Teachers' Quarterly summary Form
Sexual Transmission Prevention [FSW, MSM, IDU]	Hot spots		

Thematic area	Level of Care	Data Collection Tools	Data Reporting Tools
		<p>Form</p> <ul style="list-style-type: none"> <li>• Advocacy and Community Dialogue Form</li> <li>• IGA Attendance Form</li> <li>• Crisis Management Form</li> <li>• Advocacy and Community Dialogue Summary Form</li> <li>• Income Generating Activity Summary Form</li> <li>• Crisis Management Summary Form</li> </ul> <p>National FLHE Forms and Registers:</p> <ul style="list-style-type: none"> <li>• MIS 001: Family Life HIV/AIDS Education (FLHE) Teachers' register</li> <li>• MIS 002: Teachers' Quarterly summary Form</li> <li>• MIS 003: State Quarterly Summary Form</li> <li>• MIS 004: National Quarterly Summary Form</li> </ul>	
HIV Counselling and Testing	Community, Schools, Workplace, Hot spots	<p><b>National HCT Forms &amp; Registers:</b></p> <ul style="list-style-type: none"> <li>• Client Intake Form</li> <li>• HIV Testing and Counseling Register</li> <li>• Daily HIV Test Worksheet</li> <li>• Request and Result Form</li> <li>• Client Referral Form</li> <li>• Referral register</li> </ul> <p>HCT Client Register for Mobile Service</p>	<p>HCT monthly summary form</p> <p>National prevention monthly summary form</p>

Thematic area	Level of Care	Data Collection Tools	Data Reporting Tools
Prevention of mother to child transmission of HIV	Facilities	<b>National PMTCT Forms &amp; Registers:</b> <ul style="list-style-type: none"> <li>• General ANC register</li> <li>• PMTCT HCT Register</li> <li>• Partner register</li> <li>• Child Follow up Register</li> <li>• Maternal Follow up Register</li> <li>• Delivery Register</li> </ul> PMTCT ARV Register  Referral form Referral Register	PMTCT Monthly Summary Form
Biomedical prevention	HIV Facilities		

#### 4.2.2 Non Routine Data sources

Non-routine data sources provide data that are collected on a periodic basis, usually annually or biennially. Non routine data sources typically consist of data obtained from nationally representative surveys which are conducted periodically. Using non-routine data avoids the problem of incorrectly estimating the target population when calculating coverage indicators. However they have two main limitations: collecting them is often expensive, and this collection is often done on an irregular basis due to the expensive nature of the surveys. In order to make informed programme decisions, programme managers usually need to receive data at more frequent intervals than non-routine data can accommodate. Non routine data sources will either directly provide data or provide inputs for estimating data on agreed outcome and impact indicators. Altogether both routine and non-routine data sources provide the much needed data on progress of the indicators in the plan. Non routine data sources that will be expected to provide data for the NPP indicators include:

#### Sentinel Surveillance of ANC and STI Clinic Attendees

Sentinel surveillance data is based on antenatal clinics attendees who are women of child bearing age (15-49 years). The sentinel sites will be expanded to target more regions of the country and different population groups to help generate estimates of HIV prevalence that are nationally representative. The overall purpose of the HIV sentinel surveillance system is to monitor the trends in HIV prevalence in the country. Sentinel

surveillance involves testing women who attend ANC typically between April and September of that year. This information is collected every 2-3 years.

#### **Periodic Surveys (NARHS, NDHS and MICS)**

The National HIV/AIDS and Reproductive Health Survey (NARHS) and other periodic surveys (NDHS and MICS) are population-based surveys conducted every 5 years. The target groups in NARHS are women of reproductive age (15-49 years) and men aged 15-64 years. The survey obtains information on the knowledge, behaviour and practices related to the prevention and transmission of HIV and other STIs. Serological testing to estimate HIV prevalence has been incorporated into the NARHS since 2007.

These surveys provide national level measures of outcome indicators and focus on partner reduction, consistent use of condoms in regular and non-regular partnerships, delay of sexual activity among young persons, myths, stigma and discrimination and appropriate practices regarding STI/HIV/AIDS, knowledge and awareness of STI, and condom accessibility.

#### **Integrated Biological and Behavioural Surveillance Survey (IBSS)**

These surveys provide national level measures of outcome indicators and prevalence in high risk groups such as IDUs, MSMs and CSWs. They focus on use of condoms with regular and non-regular partners, myths and appropriate practices with regards to STI/HIV/AIDS, exposure to interventions, and other high risk behaviours such as substance abuse. It also includes collection of serological samples for HIV testing to determine the prevalence amongst MARPS. This survey is conducted every 2- 3 years.

### **4.3 Data flow**

In line with the '3 Ones' principle the monitoring and evaluation for the NPP will adopt or align with the agreed standard national data flow for the national HIV/AIDS M&E system in the country. This one national M&E system has been described in the national M&E operational plan (NOP). Under this data flow system programme implementers will collect routine data using the standard national data collection tools or MIS for each programme area. Data collected will be aggregated using standard monthly reporting forms on a monthly basis and reported electronic using the cloud based national District Health Information System (DHIS) platform. Data on service provision will be reported by the programme implementer or service provider not later than the end of the first week of the next month.

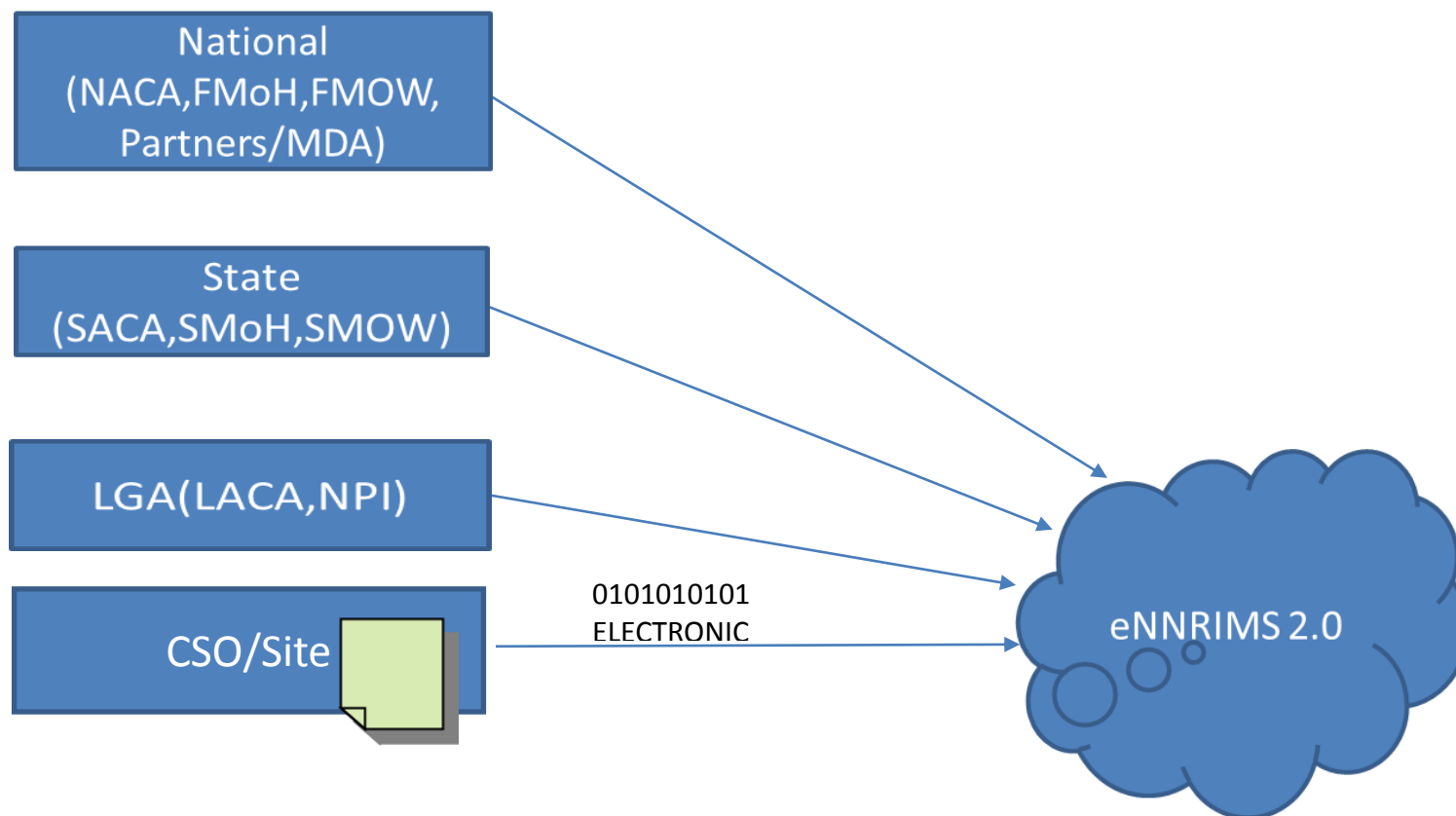
To facilitate reporting using DHIS the relevant stakeholders at the various levels will be granted access to the DHIS platform commensurate with their roles to either enter data, view the data, analyze and use the data. For instance a service provider will be granted access to both do data entry for his site or CSO and view and analyze the data. He or she will not have access to data generated by another service provider. At the LGA level the LGA focal person will be granted access to view data from CSOs or providers providing services in his LGA only but cannot do data entry. At the state level SACA and state level implementing partner will not be able to do data entry or change data but they will have access to view and analyze state wide data for only their state. At national level NACA will have access to data from all 37 states + FCT while donor partners and country office of the implementing partners will have access to view and analyze data from their supported sites and states only but they cannot do data entry or



change data that has been entered at the site or facility level. Thus data entry has been devolved to the service provision level only but the data entered is accessible at all levels of the HIV response. All donors, implementing partners will be expected to align themselves with this data flow pattern while NACA is expected to coordinate and ensure compliance by all stakeholders and partners.

Data collection will still be very much paper based unlike data reporting which will be done electronically using the DHIS. Data collection tools and registers will need to be retained at the site or facility level for audit and monitoring data quality. M&E stakeholders will however work to see how to customize data collection electronically using the DHIS. The data flow pathway is shown in Figure 11 below:

**Figure 11: NPP Data flow and reporting**



#### **4.4 Data dissemination and information use**

The National Agency for the Control of AIDS is responsible for the compilation, management and dissemination of all data collected through the national HIV/AIDS M&E system and sub-systems. NACA will serve as the clearing agency for all national multi-sectoral HIV/AIDS data and maintain functional reporting relationships with the National Bureau of Statistics, National Planning Commission and global HIV/AIDS organisations. At the state level SACAs are responsible for management and dissemination of data and information on the state HIV/AIDS response. NACA and SACA are expected to produce and disseminate widely various reports and information products as outlined in the National M&E Operational plan (NOP). Fora for dissemination of the reports, findings and results are also as described in the NOP 2011-2016.

## 4.5 NPP Indicators definition and data sources

**Table 9: NPP Monitoring and Evaluation Indicator Reference Table**

NPP Objectives	Indicators	Definition	Source
<p><b>Objective 1.</b> At least 50.0% of the national population access HCT services by 2015</p>	<p>Percentage of children (0-14) who have accessed HCT services in the past 12 months and know their results</p>	<p><b>Numerator:</b> Total number of children age 0-14 who received HCT service in the last 12 months and know their results  <b>Denominator:</b> Total population within the age group</p>	<p>Routine HCT data</p>
	<p>Percentage of adolescents (15-19) who have accessed HCT services in the past 12 months and know their results</p>	<p><b>Numerator:</b> Total number of children age 15-19 who received HCT service in the last 12 months and know their results  <b>Denominator:</b> Total number of 15-19 recruited for survey</p>	<p>NARHS</p>
	<p>Percentage of young adults (20-24) who accessed HCT services in the past 12 months and know their results</p>	<p><b>Numerator:</b> Total number of persons age 20-24 who received HCT service in the last 12 months and know their results  <b>Denominator:</b> Total number of 20-24 recruited for survey</p>	<p>NARHS</p>
	<p>Percentage of adults (25-49) who accessed HCT services in the past 12 months and know their results</p>	<p><b>Numerator:</b> Total number of persons age 25-49 who received HCT service in the last 12 months and know their results  <b>Denominator:</b> Total number of 25-49 recruited for survey</p>	<p>NARHS</p>
	<p>Percentage of adults (50 and above) who accessed HCT services in the past 12 months and know their results</p>	<p><b>Numerator:</b> Total number of persons age 50 and above who received HCT service in the last 12 months and know their results  <b>Denominator:</b> Total number of 50 and above recruited for survey</p>	<p>NARHS</p>
	<p>Number of children, adolescents and adults [male and female] counselled, tested and received results annually                      Percentage of individuals who received an HIV Counseling and testing in the last 12 months and who know their results</p>	<p><b>Numerator:</b> Total number of 50 and above recruited for survey</p>	<p>Routine monthly HCT data</p>
	<p>Percentage of health facilities providing HCT services</p>		<p>NARHS</p>

<p><b>Objective 2.</b> At least 80.0% of MARPs access HCT services by 2015</p>	<p>Percentage of MSM who received an HIV test in the past 12 months and know their results</p> <p>Percentage of FSM who received an HIV test in the past 12 months and know their results</p> <p>Percentage of IDU who received an HIV test in the past 12 months and know their results</p>	<p><b>Numerator:</b> Total number of MSM who received HCT service in the last 12 months and know their results <b>Denominator:</b> Total population recruited for survey</p> <p><b>Numerator:</b> Total number of FSW who received HCT service in the last 12 months and know their results <b>Denominator:</b> Total population recruited for survey</p> <p><b>Numerator:</b> Total number of IDU who received HCT service in the last 12 months and know their results <b>Denominator:</b> Total population recruited for survey</p>	<p>IBBSS</p>
<p><b>Objective 3.</b> At least 80.0% of sexually active persons in Nigeria with STIs have access to services by 2015</p>	<p>Percentage of sexually active males and females with STI symptoms who accessed treatment services</p>		<p>NARHS</p>
<p><b>Objective 4.</b> Objective 4: At least 95.0% of all pregnant women have access to HCT by 2015</p>	<p>. % of HIV infected pregnant women who received HIV counselling and testing and received their test results during pregnancy, labour, delivery and the post-partum</p>	<p><b>Numerator:</b> Number of pregnant women counseled and tested for HIV and received test result in the reporting period <b>Denominator:</b> Total Number of pregnant women in the reporting period</p>	<p>Routine facility data</p>

	Indicators	Definition	Source
<p><b>Objective 5:</b> At least 95.0% of all HIV positive women receive ARV prophylaxis for PMTCT by 2015</p>	Percentage of HIV infected pregnant women who received ARV during pregnancy, labour, delivery and the post-partum to reduce the risk of mother to child transmission according to national guidelines	<p><b>Numerator:</b> Number of HIV infected pregnant women who received ARV to reduce the risk of PMTCT during the reporting period</p> <p><b>Denominator:</b> Total Number of HIV infected pregnant women in the reporting period</p>	Routine facility data
	Percentage of HIV-infected pregnant women who assessed for ART eligibility through either clinical staging or CD4 testing during the period.	<p><b>Numerator:</b> Number of HIV-infected pregnant women who assessed for ART eligibility through either clinical staging or CD4 testing during the period.</p> <p><b>Denominator:</b> Total Number of pregnant women in the reporting period</p>	Routine facility data
	Percentage of health facilities providing PMTCT services		HIV programme report
NPP Objectives	Indicators	Definition	Source
<p><b>Objective 6:</b> At least 80.0% of all HIV exposed infants have access to prophylaxis by 2015</p>	Percentage of infants born to HIV infected women receiving ARV prophylaxis to reduce the risk of mother to child transmission	<p><b>Numerator:</b> Number of infants born to HIV infected women receiving ARV prophylaxis to reduce the risk of mother to child transmission</p> <p><b>Denominator:</b> Number of infants born to HIV infected women in the reporting period</p>	Routine facility data
	Percentage of infants born to HIV -infected women who were started on cotrimoxazole prophylaxis within two months of birth	<p><b>Numerator:</b> Number of infants born to HIV infected women who were started on cotrimoxazole prophylaxis within two months of birth</p> <p><b>Denominator:</b> Number of infants born to HIV infected women in the reporting period</p>	Routine facility data
	Percentage of infants born to HIV infected women who received an HIV test within 12 months of birth	<p><b>Numerator:</b> Number of infants born to HIV infected women who received an HIV test within 12 months of birth</p> <p><b>Denominator:</b> Number of infants born to HIV infected women in the last 12 months</p>	Routine facility data
		<p><b>Numerator:</b> Number of infants born to HIV</p>	Routine facility data

	Percentage of infants born to HIV infected women who test HIV positive 12 months after birth	infected women who test HIV positive 12 months after birth <b>Denominator:</b> Number of infants born to HIV infected women in the last 12 months	
<b>Objective 7:</b> At least 80.0% of all HIV exposed infants have access to early infant diagnosis services	Percentage of HIV exposed infants in the last 12 months who received a virological test for HIV within 2 months of birth	<b>Numerator:</b> Number of infants born to HIV infected women in the last 12 months who received a virological test for HIV within 2 months of birth <b>Denominator:</b> Number of infants born to HIV infected women in the last 12 months	Routine facility data
<b>NPP Objectives</b>	<b>Indicators</b>	<b>Definition</b>	<b>Source</b>
<b>Objective 8:</b> At least 80.0% % of all persons have comprehensive knowledge on HIV and AIDS by 2015	Percentage of persons in Nigeria who correctly identified ways of preventing and rejected major misconceptions the sexual transmission of HIV	<b>Numerator:</b> Number of persons who correctly identified ways of preventing and rejected major misconceptions the sexual transmission of HIV <b>Denominator:</b> Total number of survey respondents	NARHS
	Percentage of adolescents aged 15–19 who correctly identified ways of preventing and rejecting major misconceptions the sexual transmission of HIV	<b>Numerator:</b> Number of persons aged 15 to 19 years who correctly identified ways of preventing and rejected major misconceptions the sexual transmission of HIV <b>Denominator:</b> Total number of survey respondents 15 to 19 years	NARHS
	Percentage of young adults aged 20–24 who correctly identify ways of preventing and rejecting major misconceptions the sexual transmission of HIV	<b>Numerator:</b> Number of persons aged 20 to 24 years who correctly identified ways of preventing and rejected major misconceptions the sexual transmission of HIV <b>Denominator:</b> Total number of survey respondents aged 20 to 24	NARHS
	Percentage of young people 15–24 years who correctly identify ways of preventing and rejecting major misconceptions the sexual transmission of HIV % of people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		

<p><b>Objective 9:</b> At least 80.0% of young people 15 to 24 years adopting appropriate HIV/AIDS related behaviour by 2015</p>	Percentage of 15-19 year olds who have had sexual intercourse before the age of 15 years	NARHS
	Percentage of 15-19 year olds who reported the use of a condom during their last intercourse with non-marital sex partner	NARHS
	% of young women and men who have had sexual intercourse before the age of 15	NARHS
	Percentage of 20-24 year olds who reported the use of a condom during their last intercourse with non-marital sex partner	NARHS
	Percentage of Young Persons 15-24 Years who reported the use of a condom during their Last Sexual Act with a Non-marital Partner	NARHS
	Percentage of 15-19 year olds who engage in transactional sex	NARHS
	Percentage of 20-24 year olds who engage in transactional sex	NARHS
	<b>Percentage of Respondents Who Have Ever had Sex in Exchange for Gifts or Favours</b>	NARHS
	Percentage of 15-19 who have had sexual intercourse with more than one partner in the last 12 months	NARHS
	Percentage of 20-24 who have had sexual intercourse with more than one partner in the last 12 months	NARHS
<p><b>Percentage Distribution of Respondents Who Kept More than One Sex Partner (Marital or Non- Marital) in the Past 12 Months</b></p>	Percentage of 15 to 19 who are living with HIV	
	Percentage of 20 to 24 who are living with HIV	
<p><b>Objective 10:</b> At least 80.0% of sexually active males and females use condoms consistently and correctly with non-regular partners by 2015</p>	Percentage of adults 25 years and above who reported the use of a condom during their last intercourse with non-marital sex partner	NARHS
	<b>Percentage of Young Persons 15-24 Years who reported condom use during their Last Sexual Act with a Non-marital Partner</b>	NARHS
	% of women and men aged 15-49 who have had more	

	<p>than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse</p> <p>Percentage of adults 25 years and above who reported the use of a condom during their last intercourse with girl/boyfriend</p> <p><b>Percentage of Respondents Reporting Male Condom Use in Last Sexual Intercourse with Boyfriend or Girlfriend</b></p>		
<p><b>Objective 11:</b> At least 80.0% of MARPs adopt appropriate HIV and AIDS related behaviour</p>	<p>Number [%] of MSM reached with minimum HIV prevention package</p> <p>Number [%] of FSW reached with minimum intervention prevention package</p> <p>Number [%] of IDU reached with minimum HIV prevention package</p> <p>% of MARPs reached with individual and/or small group level MPP intervention</p> <p>Percentage of MSM who reported the use of a condom in the last six months when they had anal intercourse</p> <p>Percentage of MSM who reported the use of a condom during their last anal intercourse with a male partner</p> <p>% of males reporting the use of a condom the last time they had anal sex with a male partner in the last six month</p> <p>Percentage of FSW who reported the use of a condom with their last client</p> <p>Percentage of IDU who reported the use of a condom during their last non-marital sexual intercourse</p> <p>Percentage of IDU who reported use of sterile injecting equipment the last time they injected drugs</p> <p>Number of condoms distributed(male)</p> <p>Number of condom distributed (female)</p>		<p>National Prevention monthly summary form</p> <p>National Prevention monthly summary form</p> <p>National Prevention monthly summary form</p> <p>IBBSS</p> <p>IBBSS</p> <p>IBBSS</p> <p>IBBSS</p> <p>IBBSS</p> <p>PE Supervisors' summary forms</p> <p>PE Supervisors' summary forms</p> <p>PE Supervisors' summary forms</p> <p>PE Supervisors' summary forms</p>



	<p>Number of lubricants distributed</p> <p>Ratio of condoms distributed /Condoms required</p> <p>Percentage of FSWs living with HIV</p> <p>Percentage of MSMs living with HIV</p> <p>Percentage of IDUs living with HIV</p>		<p>IBBSS</p> <p>IBBSS</p> <p>IBBSS</p>
<p><b>Objective 12:</b> At least 80.0% of MDAs organisations in Nigeria have in place HIV workplace intervention by 2015</p>	<p>Percentage of line ministries and LACAs implementing HIV/AIDS workplan</p> <p>% of enterprises with an HIV/AIDS workplace policy and implementing programmes according to minimum prevention package</p>		<p>HIV Programme report</p> <p>HIV Programme report</p>
<p><b>Objective 13:</b> At least 80.0% of Corporate organisations in Nigeria have in place HIV workplace intervention by 2015</p>	<p>Percentage of Corporate organisations with workplace policies</p>	<p><b>Numerator:</b> Number of Corporate organisations with workplace policies</p> <p><b>Denominator:</b> Total number of corporate organisations surveyed</p>	<p>Special survey</p>
<p><b>Objective 14:</b> At least 80.0% of health facilities have integrated SRH/HIV programmes by 2015</p>	<p>Percentage of health facilities with integrated HCT and SRH services</p> <p>Percentage of health facilities with integrated STI and SRH services</p>		<p>HIV programme report</p> <p>HIV programme report</p>

NPP Objectives	Indicators	Definition	Source
<p><b>Objective 15:</b> At least 100% of blood and blood products are screened for HIV and other Transfusion Transmissible Infections by 2015</p>	<p>Percentage of units of Blood collected and screened for 4TTIs using 4<sup>th</sup> Generation ELISA techniques % of donated blood units screened for HIV according to national guidelines</p> <p>Percentage of States that have legislated the use of 4<sup>th</sup> generation ELISA Techniques for the screening of blood and blood products</p>	<p><b>Numerator:</b> Number of units of blood collected and screened for 4TTIs using 4<sup>th</sup> Generation ELISA Techniques <b>Denominator:</b> Total number of units of blood collected</p> <p><b>Numerator:</b> Number of state that have legislated the use of 4<sup>th</sup> Generation ELISA Techniques for the screening of blood and blood products <b>Denominator:</b> Total number of states</p>	<p>Routine data</p> <p>HIV programme report</p> <p>HIV programme report</p> <p>Health care facility survey</p>
<p><b>Objective 16:</b> At least 80.0% of health facilities institute health care safety measures</p>	<p>Number of health workers trained on infection control, including IS and HCWM</p> <p>Percentage of health facilities meeting minimum package of HCWM</p> <p>Percentage of states with health waste management policy</p>		<p>Special Survey</p> <p>Special Survey</p> <p>Special Survey</p>
<p><b>Objective 17:</b> At least 80% of health facilities provide Post-exposure prophylaxis (PEP) to healthcare workers, rape survivors and those exposed to HIV infection by 2015</p>	<p>Percentage of health facilities providing PEP to health workers, rape survivors and those exposed to HIV infection</p> <p>Percentage of reported HIV exposure who received PEP Percentage of exposed persons provided with post-exposure prophylaxis (PEP)</p>	<p><b>Numerator:</b> Number of health facilities providing PEP to healthcare workers, rape survivors and those exposed to HIV infection <b>Denominator:</b> Total number of health facilities</p> <p><b>Numerator:</b> Number of reported HIV exposure who received PEP <b>Denominator:</b> Total number of reported HIV exposure</p>	<p>HIV programme report</p> <p>Routine facility data</p>

**APPENDIX 1: Overview of useful State health service related data for planning PMTCT services**

**A. Local health service related data**

- Number of LGAs = LGAs
- Total Population=
- Under-1 Population=
- Under-5 Population=
- Population Women 15-49y=
- Pregnant Women Pop=
- % of hospital deliveries= (NARHS 2013)
- % of births attended by skilled personnel= (NARHS 2013)
- Total No of Health Facilities=
- Total Public Health Facilities =
- State owned general hospital-
- Primary health care facilities
- Tertiary health facilities-
- Federal health facilities-
- Military health facilities-

Total private health facilities =  
 Total NGO/FBO health facilities =

**B. Infrastructure in the health sector**

- nos of tertiary health facilities =
- nos of secondary health facilities- and the private hospitals-
- nos of primary health facilities- (PHC Board)
- nos of other health facilities-

Clinic- , dental clinic- , nursing homes- , maternity home -, lab - ,  
 Ophthalmology-

**Human resources in the state-total staff strength (by agency-& SMOH**

(Doctors = , Pharmacist= , Lab= , Nurses= , Health Educator= etc).

- PHC Board- Doctors = , Pharmacist= , Lab= , Nurses= , etc)
- SACA –Doctors= , Health Educator= , Pharmacist = , Nurse =

**\*\* Consider the inadequate and mal distribution of healthcare workers in the local health sector**

## C: State MNCH

### State MNCH PROFILE

	2010	2011	2012	2013
<b>➤ Annual deliveries-XX</b>				
▶ No of Health facilities providing MCH -	Ante-natal cases			
▶ No of Facilities providing Free MCH- (% of total above)	Total Deliveries			
▶ No of Sec Facilities providing Free MCH- (% of total above) only ANC and child welfare clinic is free	Total Babies			
▶ PHC Facilities providing Free MCH- (% of total PHCs) - 100%	XX	XX	XX	
▶ No of other facilities providing free MCH-	Total Maternal Death			
▶ No of Private Facilities providing MCH- (% of total Private HF) -	XX			
▶ Number of Health Facilities providing MCH + HTC for pregnant women -				
▶ How many MSS sites not providing PMTCT				
▶ No of MSS sites				

## D. STATE PMTCT

### State PMTCT Profile

- ▶ No of Health facilities providing PMTCT- insert no (% of total facilities & % of total MCH)
- ▶ No of Sec Health facilities providing PMTCT- insert no (% of total sec facilities)
- ▶ xx%
- ▶ PHC Facilities providing PMTCT- insert no (% of total PHCs & % PHC providing MCH)
- ▶ xx %
- ▶ No. of Private Health Facilities providing PMTCT - xxx (% of PHF providing MCH)
- ▶ Nos. of Health Facilities providing Pediatric ART
- ▶ xx
- ▶ Nos. of Health Facilities providing PCR for infant diagnosis site
- ▶ Insert no
- Nos. of HF providing ANC services that offer HTC and provide ARVs xxx
- Nos. of HF providing ANC services that offer HTC and provide ARVs for PMTCT reporting no stock out of test kits in last 3 months xxx
- Nos. of HF providing ANC services that offer HTC and provide ARVs for PMTCT report no stock out for ARV's in last 3 months xxx
- Nos. of HF providing ANC & CD4 testing on site - xxx
- Nos. of HF providing ANC & CD4 through sample logging and transportation to nearby lab
- Nos. of HF providing PCR for infant diagnosis from DBS xx

- XX% of pregnant women attending ANC tested for HIV , Insert number of ANC attendees
- XX% of HIV pregnant women attending ANC that receive infant - feeding counselling –
- % of HIV infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing-
- % of HIV infected pregnant women who received ARV for MTCT- (insert number)
- % of HIV exposed infants that received ARV prophylaxis for prevention of MTCT- (insert number)
- % of infants born to HIV infected mothers receiving virological test for HIV within 2 months of birth- insert number
- Number of PMTCT sites with continuous full supply of centrally procured HIV test kits and prophylactic ARVs (xxx stockouts)
- \*\*What % of sites reported stockouts? XX%

#### **E. Government contribution to PMTCT services**

- Commodities –Purchase of ARVs, Purchase of test kits, etc
- Funding –
- Human Resources for Health:
  - 1. Employment done to make up for the operational Maternal health centres in the state
  - 2. PHC Board recruitment of staff to bridge the staff gap at the PHCs across the state.
  - 3. Volunteer Scheme for PHC where a lot of science graduates are engaged to work across the PHC centres.
  - 4. staff exit replacement proces
- Leadership – Implementing policies and guidelines from the federal with respect to PMTCT.
- Capacity Development - Training and re-training of H/W
- Infrasructure:
- HMIS:E-Health operational in the state (although at the secondary/tertiary facility level) which is done in phases.

#### **F. Identify Major PMTCT Implementing Partners in the State**

- List of partners and type of support to state PMTCT programme e.g.
  - 1 **xx**:- Technical support, test kits, drugs, laboratory equipments and their consumables
  - 2 **xx** :- Technical support, test kits, drugs, laboratory equipments and their consumables
  - 3 **xx** :- Courier services for the movement of the DBS sample to the EID sites
  - 4 **xx**:- Technical support, test kits, drugs, laboratory equipments and their consumables
  - 5 **xx**- Technical support
  - 6 **xx** – Technical support for M&E

#### **G. List of State Coordination mechanisms and platforms, their links and focal persons**