Ten Targets of The United Nations General Assembly 2011 Political Declaration on HIV and AIDS

National Agency for the Control of AIDS in Nigeria
in collaboration with UNAIDS, Nigeria

1.0 Background and Context

1.1 Brief overview of the HIV epidemic and national response:

Nigeria has the second highest burden of HIV in the world, though the epidemic has continued to stablise since 2011 (UNAIDS, 2012). With a national prevalence of 3.1% (Spectrum, 2012) the estimated number of people living with HIV in 2012 was 3.4 million people while 270,000 new infections occurred in that year (Spectrum modeling, 2012). Seventy percent of the HIV infections were concentrated in 12 of the 36 states and the Federal Capital Territory: Benue, Akwa-Ibom, Bayelsa, Anambra, FCT, Plateau, Nasarawa, Abia, Cross-River, Rivers, Kano, and Kaduna. Also the estimated number of AIDS-related deaths in the same year was 250,000 (Spectrum modeling, 2012). The country considers its epidemic a mixed epidemic with both the general and most at risk populations contributing significantly to HIV incidence in the country.

The HIV epidemic in the country shows geographical and population variation. HIV prevalence figures range from 0% in Kwami in Gombe State, Rano in Kano State, Owhelogbo in Delta State and Ganawuri in Plateau State, to 21.3% in Wannune in Benue State. Also, some sub-populations have HIV prevalence rates well above the national HIV prevalence. This is exemplified by brothel based female sex workers (BBFSW), with a current estimated prevalence rate of 27.4%, non-brothel based female sex workers (NBBFSW), with an estimated prevalence rate of 21.7% and men having sex with men (MSM), with an estimated prevalence of 17.2% (IBBSS, 2010).

Populations with high-risk behaviours for HIV infection (FSW, IDU and MSM) are responsible for 40% of new infections, although they constitute only 3.4% of the populations. The bulk of the infection is, however, still due to heterosexual transmission (MOT 2009, 2010).

Women are disproportionately affected by HIV with 58% of the PLHIV population being women. Young women between 20 and 24 years have a higher prevalence than men of the same age group. Also, women are infected earlier in life when compared to men (NARHS 2007). Even amongst key target populations, women have a higher prevalence rate than men. The prevalence of HIV amongst female IDUs is almost seven times higher than that of male IDUs [21.0% vs 3.1%] and higher amongst female police officers [4.5% vs 2.0%] when compared to their male colleagues (IBBSS, 2010).

HIV and AIDS been a major cause of death of parents, with Nigeria having the highest burden of children orphaned by HIV in the world (National Situation Assessment and Analysis, 2008). The social and economic vulnerability of children is exacerbated by HIV/AIDS because children migrate between households when parents fall chronically ill from AIDS. Of the 17.5 million vulnerable children in Nigeria, an estimated 7.3 million have lost one or both parents due to various causes. Of these, 2.23 million were orphaned by HIV/AIDS, while about 260,000 children are living with HIV/AIDS. About 20.3% OVC are not regular school attendants, and 18% have been victims of sexual abuse (FMWASD, 2008). In the first half of 2012, about one half of a million, OVCs were served (PCRP, 2013).

Key Facts about HIV in Nigeria		
	2008	**2012**
National median HIV prevalence (spectrum analysis)	3.5%	3.1%
Estimated Number of PLHIV	2,980,000	3,400,000
Annual AIDS Death	192,000	250,000
Number requiring Antiretroviral Therapy	857,455	Total: 1,660,000 Adults: 1,400,000 Children: 260,000
New HIV Infections	336,379	Total: 270,000 Adults: 210,000 Children: 60,000
Total Number of AIDS Orphans	2,175,760	2,200,000

New Infections: Recent estimates indicate that the annual number of new infections in the country has been on a steady decline, decreasing by 7.1% between 2008 and 2010 and by 5.6% between 2010 and 2012. The decline in new infections resulted from the decline of new infections recorded in adults (12.5% between 2008 and 2012). On the other hand, there was a 3% decrease in the number of new infections in children between 2008 and 2010 and a sharper decline of 9.1% was recorded between 2010 and 2012. New infections in females continue to surpass that in males, contributing to about 52.4% of sero-conversions that occurred in 2012 (Spectrum modeling, 2012).

HIV Counseling and Testing: The number of sites providing HCT has increased from 1064 in 2010 to 1357 as at December 2011 though the number still falls below the expected 23,640 sites required for adequate service provision (FMoH, 2012). The uptake of HCT is still low due to inadequate coverage especially in hard to reach rural areas and reluctance of men to take HCT (PRP, 2011). In 2012, 2,851,260 persons took a HIV test of which 2,792,611 (97.9%) received their test results. Of those who tested, 191,161 (6.7%) were less than 15 years old (FMOH, 2013). Strategic interventions put in place to address the challenges associated with low HCT coverage include: integrating HCT into routine health care services such as STI and TB clinics; antenatal care and other clinic settings at all levels of health care; expanded community outreaches and mobile HCT services and testing campaigns to rural communities and other hard to reach areas and populations.

Anti-Retroviral Therapy: While an estimated 1.66 million PLHIV require antiretroviral drugs, as at the end of 2012, only 459,456 adults and 31,565 children were receiving antiretroviral drugs provided through 516 sites. The country, however, needs 3,351 sites to be able to provide

adequate service coverage based on the old WHO guideline for ART commencement [CD4 count of 350/mm or less] (FMOH, 2013).

Prevention of Mother To Child Transmission: Mother to Child Transmission (MTCT) accounts for about 10% of new infections in Nigeria with the 2012 rate of transmission being 30% (Spectrum Modeling, 2012). In the same year 2012, only 40,465 HIV positive pregnant women received PMTCT services out of about 200,000 who needed them, representing a coverage of only 20.2%. The number of sites currently providing PMTCT services is 1,320 as against the required 14,480 sites for adequate service coverage (FMoH, 2013).

Financing for HIV and AIDS: As at 2010, international donor support accounts for 74.7% of HIV funding in Nigeria. The largest portion of HIV funding [37.4%] is expended on care and treatment, with research, social protection and social services receiving less than 1.0% of the funds. Spending on prevention accounted for only 12.5%. Domestic spending was 25.3%, of which less than 1% was made by the private sector during the same period (NASA, 2010).

1.2 Overall development since the adoption of the Political Declaration:

One of the most significant developments has been the push to increase domestic funding of the HIV response in Nigeria. The main development in this direction is the public announcement of the Presidential Comprehensive Response Plan (PCRP) which seeks to mobilise resources to achieve the Millennium Development Goals 4, 5 and 6, the elimination of Mother to Child Transmission of HIV and the attainment of 50% domestic financing of the HIV response in a renewed commitment of this administration. There have also been efforts by the national HIV response coordinating body to support the implementation of nine researches which should be able to provide some evidence for the review of policies and the design of the HIV response programme. The response to the HIV needs of MSM, IDU and FSW have also intensified with the mapping exercise to estimate the number of MARPs in the country as well as identify hotspots for effective response. Comprehensive response packages have since been designed for key target populations with programming guidelines developed for FSW.

2.0 Mid-Term Review Process and Methodology

2.1 Mid-term review processes:

The report writing process commenced with the formation of a Steering Committee by the National Agency for the Control of AIDS in Nigeria (NACA). This Steering Committee was tasked with supporting the national Midterm Review of the National Response ensuring adherence to the timeline for conduct of the Midterm Review. Technical Assistance was provided by the Nigeria UNAIDS Country Team.

Stakeholders from the government and civil society organizations contributed to this report by attending a validation meeting. A consultant was engaged for this process and progress toward the completion of the report was monitored by the Steering Committee. Data collection commenced on the 8th of July 2013 with a desk review of background documents on the HIV epidemic and response in Nigeria. The objective of the desk review was to conduct a detailed stocktaking and develop a draft report on the ten targets. Documents reviewed for the process are listed in Appendix 1.

2.2 Types of activities undertaken and methods used for the assessment:

A one-day national stakeholders' consultation was held on the 19th of July, 2013. The first hours of the day were dedicated to presenting the findings of the stocktaking exercise in plenary session, and answering questions about the report and other concerns. The session was led by the consultant commissioned to carry out the exercise. Participants were then broken up into five groups to further discuss the ten targets. Each group was required to:

- Review and validate or modify the 2012 progress report on the ten targets
- Proposed recommendations to address the gaps and challenges identified in those cases where targets are not met
- Make suggestions for the development of a roadmap for getting the recommendations implemented through end of 2015 and beyond

The UNAIDS tool on Assessment of the Progress on Ten Targets of the Declaration of Commitment on HIV/AIDS was used to facilitate each group discussion. The Ten Target Tracking Tool was used to help summarise key findings and recommendations. Each group then reported back at the plenary convened at the end of the day. Each group presented their findings, answered questions and sought consensus on their presentation. The consultant compiled the outcome of the group works and shared this with a smaller group of representatives drawn from the participants. This group reviewed the final draft report and approved it for submission to UNAIDS.

3. Stocktaking Exercise

3.1 Scope of the stocktaking exercise:

The group reviewed and gave feedback on the following ten targets:

1. Reduce Sexual Transmission of HIV by 50% for the general population, female sex workers and men who have sex with men.

2. Reduce transmission of HIV among people who inject drugs (IDU) by 50% by 2015

3. Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths

4. Have 15 million people living with HIV on antiretroviral treatment by 2015

5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015

6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries.

7. Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV

8. Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms

9. Eliminate HIV-related restrictions on entry, stay and residence

10. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems

On the following pages, a chart is presented for each of these targets showing the relevant baseline, achievement and target data. After each chart is a brief summary of the stakeholders' take on the target issue, concluding with the consensus opinion: do you believe the country is on track to reach this target, yes or no.

Target 1: Reduce Sexual Transmission of HIV by 50%				
	2010 Baseline	**2012 Target**	**2012 Achievement**	**2015 Target**
General population				
Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	*24.2%*	*39.0%*	*25.4%* *27.0% ǂ22.3%	*60.0%*
Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15years.	*11.9%*	*10.2%*	*6.7%* *4.2% ǂ8.8%	*7.7%*
Percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	*27.3% ǂ2.9%	7.76%	*26.9% ǂ5.7%	2.3%
Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months and who report the use of a condom during their last intercourse @	*48.7%* *54.2% ǂ35.3%	*64.0%*	*54.8%* *61.2% ǂ43.0%	*80.0%*
Percentage of women and men aged 15- 49 who received an HIV test in the past 12 months and know their results	*11.7%*	*23.0%*	*26.3%* *23.5% ǂ29.2%	*40.0%*
Percentage of young people aged 15-24 who are living with HIV	*4.2%* 15-19: 3.0% 20-24: 4.6%	NAT	NAT	NAT
Female sex workers (FSW)				
Percentage of FSW who correctly identify ways of preventing the sexual transmission of HIV and who reject major miscon-ceptions about HIV transmission	35.0%	39.6%	No data	49.1%

Target 1: Reduce Sexual Transmission of HIV by 50%				
	2010 Baseline	**2012 Target**	**2012 Achievement**	**2015 Target**
Percentage of female sex workers reached with HIV prevention programmes	34.3%	-	9.1%	60.0%
Percentage of female sex workers reporting the use of a condom with their most recent client	98.7% (BBSW) 97.1% (NBBSW)	99.0% 99.0%	No data	99.0% 99.0%
Percentage of female sex workers who have received an HIV test in the past 12 months and know their results	46.2%	62.0%	No data	80.0%
Percentage of female sex workers who are living with HIV	24.0%	19.2%	No data	12.0%
Men who have sex with men (MSM)				
Percentage of MSM who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	33.1%	39.1%	No data	48.1%
Percentage of men who have sex with men reached with HIV prevention programmes	18.0%	-	97.8%	60.0%
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	54.7%	NAT	NAT	NAT
Percentage of men reporting the use of a condom in the last six months they had anal sex with a male partner	52.8%	62.8%	No data	80.0%
Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	30.2%	62.0%	No data	80.0%
Percentage of men who have sex with men who are living with HIV	17.0%	13.6%	No data	8.5%

* Male; ǂ Female; NAT – Not a target identified in the National Strategic Plan; BBSW: Brothel based sex worker; NBBSW: non brothel based sex worker; @This is a proxy indicator since in Nigeria why having multiple marital partners is legal, use of condoms in non-marital sex is used for measuring condom use in the general population

The three groups that account for most infections in the country are those in stable partnerships (considered as engaging in low-risk-sex), those with multiple heterosexual partners and sex workers and their clients. The country has multiple indicators to enable it to assess the impact of its multiple efforts to reduce the sexual transmission of HIV in the general population and amongst female sex workers and men who have sex with men. These targets are assessed through the conduct of the National HIV/AIDS and Reproductive Health Surveys (NARHS) for the general population, and the Integrated Behavioural and Biological Sentinel Survey (IBBSS) for MSM, FSW and IDU. The country just concluded its 2012 NARHS survey and will begin its 2013 IBBSS later this year.

The national HIV prevention strategies include the use of ART for the prevention of mother to child transmission of HIV and for post-exposure prophylaxis. There are ongoing plans to conduct a demonstration study on the feasibility of using ARVs for the prevention of new HIV infection in serodiscordant couples (as PreP and as TasP). Other strategies include tailored behaviour change programs addressing multiple partnerships, promoting condom distribution and use, and tailored intensive programmes for key target populations especially MSM and FSW (prompt management of sexually transmitted infections).

Spending for HIV prevention programming was 12.5% in 2010. However, the new PCRP plans to allocate 29.8% and 33.8%, of its N77.6 billion to HCT and prevention of sexual transmission of HIV respectively. Spending for these HIV prevention programmes has been increasing over the years.

By the end of 2012, 24,910 of the estimated 25,476 MSM and 41,747 of the estimated 459,887 FSW had been reached with prevention interventions. However, the retention of sections of the Nigerian Criminal Code that criminalise commercial sex work and same-sex sexual relations between consenting adults and the passage of the anti-same sex bill may hamper further progress with these HIV prevention programmes. They may prevent engagement and recognition of these groups, they increase stigma and discrimination and they may threaten efforts made at providing effective prevention, treatment, care and support for key target populations.

DO YOU BELIEVE THE COUNTRY IS ON TRACK TO REACH TARGET 1? **YES**

Target 2: Reduce transmission of HIV among people who inject drugs (IDU) by 50%				
	2010 Baseline	**2012 Target**	**2012 Achievement**	**2015 Target**
Percentage of IDU who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	30.7%	36.7%	No data	45.7%
Percentage of IDU reached with HIV prevention programmes	-	-	No data	60.0%
Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	NAT	NAT	NAT	NAT
Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	52.5%	NAT	NAT	NAT
Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	70.9%	NAT	NAT	NAT
Percentage of people who inject drugs who have received an HIV test in the past 12 months and know their results	23.2%	-	No data	80.0%
Percentage of people who inject drugs who are living with HIV	4.0%	3.2%	No data	2.4%

NAT – Not a target identified in the National Strategic Plan

Prevention of new HIV infection among IDU is a priority target for the country. However, there have been very few concerted efforts designed to address the source of HIV transmission in the population. Records in 2010 show that 83% of IDU use clean sterile needles (JAR, 2011). Widespread availability of sterile needles/syringes at pharmacies makes needle sharing not a major route of HIV transmission in the community (Tun et al, 2011). Transmission of HIV appears to be mainly through the risky practice of sharing drug cooking equipment. There is a gender difference in the risk for HIV infection among IDUs with female IDUs having a prevalence that is five times higher than that of their male peers. The main route of HIV transmission for female IDUs is sex, with sex work being a major source of income to sustain habit (Karyn et al, 2011). The HIV prevention programme targeting IDU include HCT,

prevention and prompt management of STIs, condom programming, and targeted information, education and counseling.

The estimated size of the IDU population in Nigeria is 11,692. The number of new HIV infections among IDU in 2012 is unknown. There is no national target for reducing HIV infection among IDUs by 2015, neither are there national strategies identified for the prevention of HIV infection from needle sharing. There are also no special programmes designed to address the peculiar needs of female IDU who are more at risk for HIV infection. Current prevention efforts are focused on reaching IDU with HIV prevention messages. An estimated USD 4.55 million was invested in HIV programming for IDU in 2012.

DO YOU BELIEVE THE COUNTRY IS ON TRACK TO REACH TARGET 2? **NO**

Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths				
	2010 Baseline	**2012 Target**	**2012 Achievement**	**2015 Target**
Percentage of pregnant women counseled and tested for HIV and received results	14.0%	28.0%	17.0%	50.0%
Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	11.0%	50.0%	20.2%	80.0%
Percentage of infants born to HIV infected women receiving antiretroviral prophylaxis to reduce the risk of mother to child transmission	6.0%	23.0%	6.2%	41.0%
Percentage of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth	8.0%	23.0%	4.1%	41.0%

The national PMTCT guideline outlines a comprehensive plan for the prevention of HIV infection in children. However, the PMTCT scale up plan seeks to reduce new HIV infections among children by 90% in line with the Political Declaration Target. The roadmap for this 'elimination' plan is well defined in the plan. Due to various challenges, it is estimated that 56,681 children were newly infected with HIV in 2012 due to mother to child transmission (National PMTCT guideline, 2010).

Currently, the number of pregnant women living with HIV in 2012 was estimated to be 200,000 (Spectrum modeling, 2012) with only 58.5% of them likely to have attended ANC services at least once (NARHS, 2012). In 2012, 40,465 women received antiretrovirals to reduce the risk of mother-to-child transmission (FMoH, 2013). This is a 45.5% increase in the number of women who have received antiretrovirals to reduce the risk of mother-to-child transmission in 2011. However, the figure is still short of the 2012 national target and considerably low.

The national PMTCT guidelines encourage the use of triple-antiretroviral therapy for pregnant women to prevent HIV transmission to children. The use of single-dose Nevaripine as the main ARV prophylaxis has been phased out. The National Policy recommends the use of options A and B, though there is ongoing debate about the feasibility of switching to option B+. In 2012 alone, 17% of pregnant women living with HIV who are eligible for ART for their own health were placed on ART (FMoH, 2013). Also, 15% of pregnant women living with HIV were on ART for their own health prior to pregnancy. The number of pregnant women receiving HAART has been increasing over the years.

DO YOU BELIEVE THE COUNTRY IS ON TRACK TO REACH TARGET 3? **NO**

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015				
	2010 Baseline	**2012 Target**	**2012 Achievement**	**2015 Target**
Percentage of eligible adults currently receiving antiretroviral therapy (2010 Guideline)	32.0%	53.0%	35.3%	80.0%
Percentage of eligible children currently receiving antiretroviral therapy (2010 guideline)	13.0%	53.0%	12.1%	80.0%
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	77.6%	NAT	73.4%	NAT
Number of adults and children with HIV newly enrolled on treatment	109,226	184,591	195,031	405,548

NAT – Not a target identified in the National Strategic Plan

Providing antiretroviral therapy for adults and children living with HIV is a national priority, with targets set to ensure 80% of all eligible children and adults who require ART will receive them by 2015. The current estimate of the number of adults more than fifteen years-old who need antiretroviral therapy, based on 2010 WHO guidelines, is 1.3 million (Spectrum modeling 2012). However, as of 2012, 459,456 adults (+15) were receiving antiretroviral therapy. This is a 3.3% increase in the proportion of those receiving ART when compared to 2010. Of those on ART, 471,024 patients were on first-line therapy, 19,962 patients were on second-line therapy and 35 patients were on salvage therapy. In 2012 alone, 103,173 patients were newly enrolled on ART. In 2011, 73.4% of patients were on treatment 12 months after initiation of antiretroviral therapy, and in 2012 estimates place this figure at 75%-78%. Stavudine-based regimes have been phased out. Fixed-dose combination ART is used by less than 20% of the patients.

There are plans to do a lot more task shifting. This includes engaging nurses and other cadres of health workers in ART service provision. Currently, nurses cannot initiate patients on ART but can provide supportive services to maintain them on ART. Also, Community Health Workers are allowed to perform rapid HIV tests and re-supply patients with ARVs. Point-of-care HIV treatment monitoring tools have only been introduced on a very small scale.

It is estimated that the total cost of treatment per patient per year is about $130 for adults and $70-$80 for children. Currently, about 37.4% of the HIV response budget is allocated to treatment. This represents the largest portion of the HIV response budget.

DO YOU BELIEVE THE COUNTRY IS ON TRACK TO REACH TARGET 4? **NO**

Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015				
	2010 Baseline	**2012 Target**	**2012 Achievement**	**2015 Target**
Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	10.0%	60.0%	56.0%	80.0%
Percentage of adults and children enrolled in care screened for TB	45.0%	-	72.0%	100.0%
Percentage of TB in care screened for HIV	66.8%	80.0%	86.0%	100.0%
Percentage of TB/HIV patients receiving CPT	26.0%	70.0%	80.0%	80.0%
Percentage of new adults and children enrolled in care receiving IPT	1.0%	32.6%	1.2%	80.0%

While there is no national target for HIV related TB death, reducing HIV related TB death is a national priority with multiple indicators identified in the national HIV response to capture the progress made with respect to TB/HIV co-infection management. These include the institution of policies that promote the use of Isoniazid for the prevention of TB infection in PLHIV newly enrolled in care, and TB screening of all PLHIV in care. The country follows the (i) WHO policy on TBHIV activities: guidelines for national programme and other stakeholders (ii) Guidelines for Intensified Tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings, and (iii) Treatment of Tuberculosis guidelines for national programme for preventing TB among PLHIV.

In 2012, a total of 5,714 HIV-positive persons were given isoniazid prophylaxis therapy (IPT). Also, 582,098 PLHIV were screened at least once for TB and 10,866 HIV-positive TB patients were started or continued on ART. While there was an increase in the number of HIV positive patients started in ART and TB management, and an increase in number of HIV positive persons started on IPT in 2012 compared to 2011, there was a significant decrease in the number of HIV positive persons screened for TB in 2012 when compared to 2011.

DO YOU BELIEVE THE COUNTRY IS ON TRACK TO REACH TARGET 5? **YES**

Target 6: Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries.			
	2010 Baseline	**2012 Target**	**2012 Achievement**
Domestic and international AIDS spending by categories and financing sources	Private: $850,547.00 Public: $125,139,587.00 International: $370,927,337.00 Total: $496,917,471.00	NAT	NAT

NAT – Not a target identified in the National Strategic Plan

Closing the gap in needed resources to fund its HIV response is a key priority for the country. The resource gap in the national HIV response is estimated to be $216,599,453 for 2013, $776,944,453 for 2014 and $874,623,953 for 2015. In view of this, the national government launched the PCRP and seeks to invest ₦120,604,016,851, ₦140,227.891,010, and ₦122,512,678,560 in the HIV response in 2013, 2014 and 2015 respectively to close these gaps and reduce its donor dependency for its HIV response. The plan addresses innovative financing of the HIV response through establishment of a financing pool, active private sector engagement, and increased financial prudence.

The nation's current domestic funding for the HIV response is estimated to be between 20 - 40%. The total budget for the year 2012 was ₦103,642,461,273 while international partners invested $579,790,837.00. The national domestic budget allocation has been slower than the national economic growth during the last 3 years. Between 2011 and 2012, the national economic growth had increased by 6.8% while the budgetary allocation to the HIV response had only increased by 4.9%.

The expenditure profile shows that the HIV budget allocations do not match the distribution of infection by population group and regional distribution. The USG funding support for MARPs related programmes has been the major source of funding to address the HIV needs of populations highly affected by the HIV epidemic. The 2012 World Bank and USAID Assisted Epidemic Appraisal for MARPs will also enable cost-effective planning and investment of resources for MARPs in the country.

Estimates of HIV commodity prices in the country is higher than international prices in other low and mid income countries. Efforts underway to reduce commodity prices include plans to harmonise procurement mechanisms by the Nigerian Government in collaboration with USG and GFATM, as well as exploring the voluntary pooled procurement mechanism. Different HIV service delivery model options (e.g. integrated, decentralized, community based) are also being explored with the view to making services more accessible at lower costs.

DO YOU BELIEVE THE COUNTRY IS ON TRACK TO REACH TARGET 6? **YES**

Target 7: Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV				
	2010 Baseline	**2012 Target**	**2012 Achievement**	**2015 Target**
Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	17.5%	NAT	No data	NAT
Specific budget for HIV-related programmes for women and girls	NAT	NAT	NAT	NAT
Programmes in place to engage men and boys in efforts to eliminate gender-based violence	NAT	NAT	NAT	NAT

NAT – Not a target identified in the National Strategic Plan

The country considers the elimination of gender inequalities and gender-based abuse and violence to be important, and prioritises efforts at increasing the capacity of women and girls to protect themselves from HIV. It promotes community level intervention or service that explicitly addresses the legal rights and protection of women and girls impacted by HIV. There is an on-going mapping of policies and laws on Gender Based Violence and its intersections with HIV/Women with Disabilities/Sexual & Reproductive Health and engagement of men and boys as partners for gender equality. The outcome of this mapping exercise will inform the review of the National HIV strategic plan (NSP) during its midterm review exercise. While the NSP identifies specific actions to address the needs and rights of women and girls, it does not include a specific budget to address its gender related activities, neither does it address the needs and rights of transgender people. It partially includes activities to engage men and boys.

There is no national mechanism to track Gender Based Violence but there are isolated structures and programmes domiciled with the Ministry of Women's Affairs to capture data and respond to some of the issues. Data on women who have experienced physical or sexual violence from a male intimate partner was captured in the 2008 DHIS report and the data is used by some organisations in the country to plan programmes and develop proposals. The NSP has multiple indicators that measure gender sensitivity in programme planning and implementation. In addition, the national HIV related data is disaggregated by sex to enable analyses for gender patterns and trends in the national response. There are policies and laws in the country that promote the prosecution of perpetuators of sexual assault. These policies and laws have informed the actions of multiple NGOs in the country who have helped and supported a number of women to seek redress.

DO YOU BELIEVE THE COUNTRY IS ON TRACK TO REACH TARGET 7? **NO**

Target 8: Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms				
	2010 Baseline	**2012 Target**	**2012 Achievement**	**2015 Target**
Percentage of PLHIV who report experience of social exclusion in past 12 months	33.9%	23.7%	No data	NAT
Percentage of PLHIV who face violence (e.g. verbally insulted, assaulted or threatened, physically harassed or assaulted because of HIV status).	NAT	NAT	NAT	NAT
Percentage of PLHIV who face discrimination in health care settings (e.g. denied services, including dental care, SRH and FP services)	20.0%	14.0%	No data	NAT
Percentage of PLHIV who face discrimination in the work place (e.g. loss of job or income, employment opportunity refused)	29.0%	20.3%	No data	NAT
Number of states with anti-stigma an discrimination law	4	17	4	37

NAT – Not a target identified in the National Strategic Plan

The country seeks to eliminate discrimination against people living with HIV through the promotion of policies that ensure equality before the law for everyone. In 2010, measures of HIV related social stigma and discrimination was conducted. There are plans to conduct another assessment in 2013.

The Network of People Living with HIV in Nigeria has mechanisms in place to document human rights violations related to HIV. Other NGOs are engaged in similar work, monitoring the rights of MSM and FSW. There has been some progress. At the national level, for example, there is an anti-stigma bill that has seen two readings and one revision in the National Assembly and, in 2012, the National Agency for the Control of AIDS in Nigeria supported some activities intended to promote the enactment of the bill.

The National HIV-prevention Response Programme promotes activities specifically to prevent stigma. These activities are identified as a core structural programme in the prevention package for three key audiences: the general population, in-school youths and Most-At-Risk Populations (MARPs). There is, however, no dedicated budget for anti-stigma activities.

At the local level, four states in Nigeria (Lagos, Enugu, Cross-Rivers and Nassarawa) have enacted similar anti-stigma laws. Even with anti-stigma laws in place, however, there is the issue of enforcement. PLHIV still face discrimination based on pre-employment HIV test results, or lose their jobs due to a change in HIV status.

In summary, there is at the moment no co-ordinated programme aimed solely at HIV-related discrimination. There are, however, many separate efforts. National government, local government, NGOs and professional societies have addressed stigma and discrimination as they perceive it and as they encounter it. It is difficult to measure the their individual effects, but the consensus is that, overall, HIV-related stigma and discrimination against PLHIV has diminished as a result of all these efforts. There is progress, much more needs to be done, but overall the outlook is positive.

DO YOU BELIEVE THE COUNTRY IS ON TRACK TO REACH TARGET 8? **YES**

Target 9: Eliminate HIV-related restrictions on entry, stay and residence				
	2010 Baseline	**2012 Target**	**2012 Achievement**	**2015 Target**
Removal of restriction on entry, stay and residence	NA	NA	NA	NA

NA – Not Applicable

The country has never had restrictive laws on entry, stay and residency in the country based on HIV status, gender, colour and sexual orientation. This non-discriminatory stance of the national government is remarkable and a highlight in its global HIV response. The country has furthermore endeavoured to keep the spirit of the Economic Community of West African States (ECOWAS), as such has no intentions of placing any such and/or similar restrictions on entry, stay and residence based on HIV status now and in future.

DO YOU BELIEVE THE COUNTRY IS ON TRACK TO REACH TARGET 9? **YES**

Target 10: Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts, as well as to strengthen social protection systems

	2010 Baseline	2012 Target	2012 Achievement	2015 Target
Number of schools implementing the FLHE	22,980	27,576	-	34,470
Alignment with MGDs 4 and 5	Yes			
Integration of HIV with health and development plan	Yes			
Integration with HIV financing	Yes			
Integration of ART and Tuberculosis	Yes			
Integration of ART and chronic Non-Communicable Diseases	Yes			
Integration of PMTCT with Antenatal Care/Maternal & Child Health	Yes			
Integration of HCT with SRH services	Yes			

The country actively seeks to eliminate parallel systems for HIV-related services as well as to strengthen social protection systems. The national HIV response is integrated with the national health and development plans, and its AIDS planning and budget cycles are properly aligned. The national health policy provides for free access to ART, HCT, PMTCT and CPT. The national health insurance scheme supports the management of opportunistic infection.

The HIV M&E system is integrated with the Health Information System through joint staffing and common warehousing of goods and commodities. Some states have joint data health indicator collection systems and a common database for all health disease measures.

The integration process had increased the burden of care for many health care providers as staff number in most of the facilities have not increased commensurately with the growing responsibilities. Staff providing HIV service do not receive special remuneration.

DO YOU BELIEVE THE COUNTRY IS ON TRACK TO REACH TARGET 10? **YES**

4.0 Summary of findings and recommendations

	Ten Key Questions	Target 1	Target 2	Target 3	Target 4	Target 5
1	Is this a priority target for the country?	Yes	Yes	Yes	Yes	Yes
2	Does the National Strategic Plan or equivalent address this target?	Yes	Yes	Yes	Yes	Yes
3	What key actions have been taken to reach this target since 2011?	Peer education of general public, FSW and MSM Integration of HIV education into secondary school curriculum Training of health care providers to identify and address needs of FSW and MSM Application of programme science approach to targeting MARPs and the general population with comprehensive HIV prevention package	Peer education on HIV prevention Training of health care providers to identify and address needs of IDU	PMTCT scale up Focus investment in 12 + 1 state that account for about 60% of the PMTCT burden Increased efforts at engaging the private health sector	Decentralization of ART services, Use the cluster model for referral, linkages and delivery of ART services Development of the PCRP No stock-out of ARVs Training and retraining of staff Harmonization of HIV data capturing tools	Reviewed guide-lines; adopted new strategy Increased access to TB services at ART sites and to ART services at TB sites Built capacity of health care workers to provide integrated TB/HIV services Increased micro-scopic diagnosis centers Adopted new tech-nology for diagnosis of TB eg Genxpert

	Ten Key Questions	Target 1	Target 2	Target 3	Target 4	Target 5
4	What key challenges or constraints have been encountered in addressing this target?	Punitive laws for MSM, sex work Anti-same sex bill that criminalises working with key target population Low use of condom by the general pop-ulation Unrevised National Prevention Plan	Low awareness of the needs of the population Hard to reach community. National policy does not support needle exchange pro-grammes or use of Methadone Criminalization of IDU making them difficult to reach	Low coverage for ANC Inadequate human resources to facilitate PMTCT Poor programme coverage especially in rural and hard to reach areas Poor engagement of the private health sector Poor community involvement Poor treatment seeking behavior of the population Poor health service infrastructure	Inadequate infra-structure capacity at facility level Inadequate training of health care providers Poor involvement of private health sector Challenges with ART adherence among PLHIV Poor tracking and follow up of clients on ART Poor ART coverage for children and adolescents who need	Inadequate funding for TB and HIV collaboration Low HIV:TB service site ratio trained staff attrition Irregular supply of tools and stock out of Rapid Test Kits Inability to provide ART in TB clinics and TB medication in ART clinics and so patients get lost during referrals
5	Is the country on track to reach this target?	Yes	Target not set	No	No	Yes

	Ten Key Questions	 Target 1	 Target 2	 Target 3	 Target 4	 Target 5
6	What are the key programmatic actions necessary to stay on track and/or achieve this target?	Update the content of the FLHE curriculum Target and capture the out of school youth who fall within the age bracket (15-24yrs) Research to identify what works well for the target population.	Set targets and develop indicators in the NSP for IDU to address their specific needs Develop comprehensive programmes on harm reduction Develop programmes that target female IDU who are more at risk for HIV	PMTCT scale up Increased community involvement to create demand Empower the private health sector to provide PMTCT Decentralization of the PMTCT service centres	ART scale up through decentralization of services Increased community involvement to create demand Involve the private health sector in ART service delivery ART refilling can be done at primary health care levels including NGO facilities	Increase the number of TB and HIV services facilities Increase integration of TB/HIV service delivery at single site Improve referral and follow-up of clients between facilities Invest in training and re-training of staff
7	What policy / enabling environment changes are necessary to keep on track and/or achieve this target?	Enact the anti-stigma law at state and national level Train and support law officers to reduce harassment of FSW, MSM Improve access of adolescents to SRH services including HIV services	Formulate harm reduction policy	Free ANC, PMTCT, EID and HCT services for women Routine PITC for all children Explore effectiveness of cash transfers to promote ANC and PMTCT access	Engage other health care providers and systems (pharmacy) in provision of ART refill Use of fix dose therapy Increase community treatment literacy so as to facilitate support for ART	Advocate that trained staff in specialist areas be retained in clinic units for a minimum of 2yrs Include training on TB/HIV integration in pre-service training of all cadre of health care workers

	Ten Key Questions	Target 1	Target 2	Target 3	Target 4	Target 5
8	What new investments are necessary to keep on track and/or achieve this target?	Fund and implement the President's Comprehensive Response Plan Engage the private education sector in the HIV response Research effective models that reduces sexual transmission of HIV Scale up and strengthen a robust HMIS	Increased funds from partners and donor agencies to programme for IDU	Global Fund, Sure-P, PCRP Increased private-public sector engagement Institutie workplace policies that promote access of pregnant women to PMTCT services	Implementation of the PCRP Increased private-public partnership and public health sector engagement	Invest in community engagement and participation in TB and HIV service delivery Invest in stronger M&E especially on data capturing and reporting Invest in research on TB/HIV treatment collaboration Invest in and involve the private sector

	Ten Key Questions	 Target 1	 Target 2	 Target 3	 Target 4	 Target 5
9	What are your recommendations to ensure the implementation of suggested changes?	Full implementation and annual review of the PCRP. Provide continued technical support from implementing partners Scale up FLHE to public, private and youth friendly centers	Advocacy to government and relevant stakeholders to support programming for IDU	Task shifting to enable nurses to initiate ART for PMTCT use. Develop integration of TBAs into the public health system and facilitate referrals for PMTCT Develop community initiatives promoting access to PMTCT Research the effectiveness of cash transfers in promoting PMTCT	Support retention of staff trained in HIV management in clinics that require their skills Include ART in the training curriculum of all health care providers. Revise ART policy to support ARV refill in various health care service provision centres including pharmacies Conduct research to identify facilitators and barriers to public sector engagement in ART	Revise existing health policies to address HIV/TB management integration Revise training curriculum of health care providers to address TB/HIV integration Promote HIV/TB service provision in line with the National Plan and guidelines Improve coordination of the health sector response

	Ten Key Questions	 Target 1	 Target 2	 Target 3	 Target 4	 Target 5
10	What are your recommendations for sustaining progress along this target beyond 2015?	Prompt release of budgetary allocations Effective use of all limited human and financial resources Integration of HIV prevention initiatives into routine programming Support development of community structures to promote HIV prevention interventions	Implementation of the developed harm reduction policy	Integrate PMTCT into routine health care services at all levels of health care delivery Promote private health sectors engagement in PMTCT service delivery Support community structures that facilitates access of women to ANC services	Government ownership and sustainability at all levels for HIV program Facilitate the engagement of all tiers of government on HIV/AIDS prevention, treatment, care and support Active involvement of private sectors in all HIV/AIDS services Promote community support for prompt management of HIV infection	Increased and sustained funding Encourage state ownership and involvement in funding and service delivery Engage the private health sector in the provision of integrated HIV/TB services

	Ten Key Questions	 Target 6	 Target 7	 Target 8	 Target 10
1	Is this a priority target for the country?	Yes	Yes	Yes	Yes
2	Does the National Strategic Plan or equivalent address this target?	Yes	Partially	Yes	No
3	What key actions have been taken to reach this target since 2011?	Development of the PCRP for HIV World Bank Credit to support National and State level Programmes National priority setting for resource mobilisation	Ongoing mapping of policy and laws Re-inauguration of National gender technical working group	Continued discussion on the anti-stigma bill with the national assembly	Integrated HIV/TB service delivery Integrated PMTCT/ANC/MCH at the primary health care level Integrated SRH/HIV at the primary health care level

	Ten Key Questions	Target 6	Target 7	Target 8	Target 10
4	What key challenges or constraints have been encountered in addressing this target?	Non-allocation of resources for HIV by state government Delayed release of budgetary allocations Decreasing donor funds to support the response	Cultural and religious values that promote gender inequality Poor enforcement of laws that promote gender equality Poor engagement of men and boys in the response	Cultural values that hinder public and open disclosure about health Myths and miscon-ceptions about HIV causes and management Weak implementation or enforcement of the anti-stigma laws Punitive laws and the anti-same sex marriage bill that hinder outreach to key target populations Low level of women's empowerment	Training and capacity building of health care workers to learn new skills to facilitate integration Non-inclusion of integrated health care management approach in the curriculum of health care providers
5	Is the country on track to reach this target?	No	Yes but slow	Yes	Yes

	Ten Key Questions	 Target 6	 Target 7	 Target 8	 Target 10
6	What are the key programmatic actions necessary to stay on track and/or achieve this target?	Adherence to PCRP Allocation of funds at State level to the HIV response Continued prioritization of HIV funds investment to the 12+1 high burden states Redistribution of fund allocation to meet needs of populations with high HIV burden	Conclusion and dissemination of the Mapping exercise	Revision of punitive laws Revision of the anti-same sex bill that distracts from provision of health care services to MSM Track human right violations of PLHIV and MARPs	Identify best practices or integration models that can be adapted into the national health plan Advocate for stronger political commitment to the process Training and retraining of health care workers on new health manage-ment approaches
7	What policy / enabling environment changes are necessary to keep on track and/or achieve this target?	Political will by Government at the three level of governance levels Budget lines for HIV at all levels of Government Active engagement of the private sector for investment in response	Mainstream into all the national HIV policy documents	Revision of punitive laws Revision of the anti-same sex bill that distracts from provision of health care services to MSM Track human right violations of PLHIV and MARPs	Engage private health non-health sectors in sharing warehousing of drugs Advocate for pool funding

	Ten Key Questions	Target 6	Target 7	Target 8	Target 10
8	What new investments are necessary to keep on track and/or achieve this target?	Explore private sector engagement and investment in the response Explore innovative tax mechanism to generate funds to support the HIV response	Design programmes that will promote active engagement of men and boys as partners for gender inequality	Sensitization of the judiciary and law enforcement agencies on the rights of PLHIV and key target populations	Strengthen health systems to help institutions make the changes that support the integration process Improve management of the health commodity supply chain
9	What are your recommendations to ensure the implementation of suggested changes?	Promote political support of government at all levels Put budget tracking mechanisms in place Empower CSO to advo-cate with government for adherence to commitments Conduct mid-term and end year reviews of commitments	Highlight gender based violence, engagement of men and boys during the MTR of NSP and SSP review as well as JAR so that they can be mainstreamed into the policy document	Develop mechanisms that enable the stigmatized to have prompt judiciary redress	Capacity development and a national strategy that will cascade to the states and local government on integration
10	What are your recommendations for sustaining progress along this target beyond 2015?	Operationalise the investment case for 2015-2025	Development of action plans with budgets for implementation	Promote national dialogue on HIV and the law for review of punitive laws Track and address human right violations of PLHIVand MARPs	Develop national guidelines on AIDS, maternal and child care

Implementation Road Map													
Activity	**2013**				**2014**				**2015**				**Partner**
	Qrt 1	**Qrt 2**	**Qrt 3**	**Qrt 4**	**Qrt 1**	**Qrt 2**	**Qrt 3**	**Qrt 4**	**Qrt 1**	**Qrt 2**	**Qrt 3**	**Qrt 4**	
Integrate HIV prevention initiatives into routine health care service	x	x	x	x	x	x	x	x	x	x	x	x	FMoH
Support development of community structures to promote HIV prevention interventions	x	x	x	x	x	x	x	x	x	x	x	x	NACA/GFATM
Development of harm reduction policy for IDU			x										NACA/NDLEA
Implementation of harm reduction policy for IDU				x	x	x	x	x	x	x	x	x	IPs, hospitals
Integrate PMTCT into routine health care services at all levels of health care delivery	x	x	x	x	x	x	x	x	x	x	x	x	FMoH

Implementation Road Map													
Activity	**2013**				**2014**				**2015**				**Partner**
	Qrt 1	**Qrt 2**	**Qrt 3**	**Qrt 4**	**Qrt 1**	**Qrt 2**	**Qrt 3**	**Qrt 4**	**Qrt 1**	**Qrt 2**	**Qrt 3**	**Qrt 4**	
Promote private health sectors engagement in PMTCT service delivery	x	x	x	x	x	x	x	x	x	x	x	x	FMoH/NIBUCAA/AGPMPN
Support community structures that facilitates access of women to ANC services	x	x	x	x	x	x	x	x	x	x	x	x	NACA/IP/CSOs
Encourage investment of the private sector in the HIV response	x	x	x	x	x	x	x	x	x	x	x	x	Presidency/NACA/NIBUCAA
State government investment in the HIV response to increase to 30%	x	x	x	x	x	x	x	x	x	x	x	x	NACA/Presidency
Develop national guidelines on AIDS, Maternal and child care				x									FMoH

Implementation Road Map													
Activity	**2013**				**2014**				**2015**				**Partner**
	Qrt 1	**Qrt 2**	**Qrt 3**	**Qrt 4**	**Qrt 1**	**Qrt 2**	**Qrt 3**	**Qrt 4**	**Qrt 1**	**Qrt 2**	**Qrt 3**	**Qrt 4**	
Implement national guidelines on AIDS, Maternal and child care					x	x	x	x	x	x	x	x	FMoH/hospitals
Promote national dialogue on HIV and the law for review of punitive laws		x				x				x			NACA/Ministry of Justice/CSOs
Advocacy for passage of national and State anti-stigma bills	x	x	x	x	x	x	x	x	x	x	x	x	NACA/legislature
Track and address human right violations	x	x	x	x	x	x	x	x	x	x	x	x	NACA/CSOs/judiciary

Appendix 1

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Appendix 2

List of stakeholders at consultative and validation meeting

NATIONAL AGENCY FOR THE CONTROL OF AIDS

UNAIDS/NACA 10 TARGETS REVIEW MEETINGS AT CHELSEA HOTEL ABUJA.

19/07/2013

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