

END-OF-TERM DESK REVIEW REPORT
OF THE
2010 -2015 NATIONAL HIV/AIDS STRATEGIC PLAN

JULY 2015

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretrovirus
ARVs	Anti-Retroviral Drugs
ATM	AIDS, Tuberculosis, Malaria
CSOs	Civil Society Organizations
DHIS	National (Integrated) HIV/AIDS data base 2.0 Platform.
EID	Early Infant Diagnosis
ENR	Enhanced National Response
FLHE	Family Life Health Education
FMLP	Federal Ministry of Labour and Productivity
FMoH	Federal Ministry of Health
FSW	Female Sex Workers
GFATM	Global Fund for AIDS Tuberculosis and Malaria
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
JAR	Joint Annual Review
LACA	Local Government Area Action Committee on AIDS
LGA	Local Government Area
MARPs	Most-at-Risk-Populations
MPPI	Minimum Prevention Package Intervention
MSM	Men who have Sex with Men
MTR	Mid Term Review
NACA	National Agency for the Control of AIDS
NARHS	National AIDS and Reproductive Health Survey
NASA	National AIDS Spending Assessment
NASCP	National AIDS Control Programme
NEPWHAN	Network of People Living with HIV
NGOs	Non-Governmental Organisations
NPSCMP	National Product Supply Chain Management Programme
NPTWG	National Prevention Technical Working Group
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PABA	People Affected by AIDS
PCRPP	Presidential Comprehensive Response Plan
PEPFAR	Presidential Emergency Plan for AIDS Relief
PHC	Primary Health Care

PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PWID	Person who Inject Drugs
RIF	Rifampicin
SACA	State Action Committee on AIDS
SASCP	State AIDs Control Programme
sdNVP	Niverapine
SMoH	State Ministry of Health
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendants
UNAIDS	Joint United Nations Program on HIV/AIDS
WHO	World Health Organisation

EXECUTIVE SUMMARY

This report is an end-of-the-term review of the Nigerian National and AIDS Strategic Plan (NSP 2010-2015), which Nigeria adopted in 2009 under the leadership of the National Agency for the Control of AIDS. The NSP encompasses the priorities outlined in the poverty-reduction strategy for Nigeria (Nigeria Vision 20:2020) and the National HIV Policy.

The review assesses the impact of the response to HIV in Nigeria and makes recommendations for priority actions to be taken in the future. The Review process is divided into two phases: Phase I, the subject of this document, is a desk review of all the existing documentation on the HIV response over the previous five years. This desk review compiled reports on progress made with the HIV response till date, assessed achievements against some 2015 indicators selected by the Steering Committee managing this process, identified gaps within the response, and made recommendations for the revision of the HIV response indicators for possible use for the NSP 2016-2020. Phase II will consist of an objective assessment of the impact of the response based on the outcome of field work and verification of outcomes reported in this desk review. Phase II would be completed by November 2015. The key findings for the six thematic areas of the NSP from the desk review are reported below.

Promotion of behavior change and prevention of new HIV infections: At the end of 2014, 26.3% of the general population had been counselled, tested for HIV, and received their test results; 46% of pregnant women had access to HIV counselling and testing services; 30.2% of the estimated 209,861 HIV-positive women who required PMTCT accessed PMTCT; 72.6% of HIV-exposed infants who were accessed at the facility level had access to ARV prophylaxis; and 12.4% of HIV-exposed infants who had their blood taken for EID within two months of birth and received their test results. Also, 25.4% of adults had comprehensive knowledge about HIV transmission; 24.4% of young persons (15-24 years) had comprehensive knowledge about HIV transmission; 85% of young women and men aged 15-24 years had not had sexual intercourse before the age of 15; 54.8% of sexually active young adults used a male condom at the last sexual intercourse with non-marital sex partner; 68.2% of those that had ever used a male condom were still using the condom at the time of the survey; 8.1% of young women and men aged 15-24 years had engaged in transactional sex; 16% of young women and men aged 15-24 years had more than one sex partner; and about 55% of sexually active males and females used condoms consistently with non-marital sex partners. It was difficult to assess the impact of the HIV response on adoption of appropriate HIV- and AID-related behavior by MARPs since the 2014 survey report has not been published. However, a survey conducted for MARPs in six states of Nigeria showed that in 2014, 92.3% of MARPS had used condoms in the previous month (97.7% FSW, 93.1% MSM, and 83.7% PWID). However, only 57.3% used condoms consistently (42.7% of PWID, 44.6% of MSM, and 75.1% of FSW). Also, 72.4% of MSM and 56.8% of PWID engaged in commercial sex activities.¹

The targets on HCT, PMTCT and some targets on Behaviour Change Communication had not been achieved by the end of 2014 and may not be achieved by the end of 2015. One of the main challenges is with condom uptake and its consistent use. An emerging new

¹ Heartland Alliance. EKPIN Project baseline report. 2015

area of emphasis for the HIV prevention programme is promoting HIV prevention programmes for adolescent, a population with increasing HIV incidence.

Treatment of HIV/AIDS and related health conditions: At the end of 2014, 51.4% of adults and children have access to ART coverage. However, the coverage for children is only 12%; 6.8% of clients were placed on isoniazide prophylaxis, and 83.5% were placed on co-trimoxazole prophylaxis; and 80.7% of those who were on HIV treatment were screened for tuberculosis. The number of clients screened for tuberculosis in 2014 exceeded the cumulative number in pre-ART care.

The 2015 target for HIV treatment coverage for adults and children had not been achieved and may likely not be achieved by the end of 2015. However, significant progress had been made with treatment coverage. The 2015 target for co-trimoxazole prophylaxis had been achieved and exceeded by 3.5%, and the screening for tuberculosis infection for patients suspected to have HIV is very high.

Care and support of people living with HIV (PLHIV), people affected by aids, and orphans and vulnerable children: The national care and support guidelines was developed in 2014 and so the impact of the guidelines on care and support response had not been assessed. However, as captured in the data accessible from the HIV treatment programme, 207,570 new clients were enrolled into Pre-ART care, and many treatment sites had also engaged PLHIV and community volunteers to provide support services for PLHIV clients within the facilities and at the community level. Programmes have promoted the development and operations of community-based and home-based care programmes for PLHIV by the Network of People Living with HIV. The hub-and-spoke model has helped facilitate linkage between newly diagnosed PLHIV and hospital facilities. Also, the Provider Initiated Testing and Counselling services have further enhanced the identification of PLHIV and facilitated their linkage to facility-based ART services. The care and support programme had also increased support for PLHIV: 72% of the general respondents were willing to care for relatives living with HIV. However, 60% would keep secret the fact that a family member is infected showing that a lot still needs to be done on stigma reduction.

There are still challenges with addressing the needs of OVC. About 20.3% OVC are not regularly attending school, and 18% have been victims of sexual abuse. Also, there is no in-country evidence to establish the value added by support groups and their activities to meet the needs of PLHIV. Little is also known about the progress being made with addressing stigma and discrimination.

Policy, advocacy, human rights, and legal issues: The anti-stigma law was passed by the National Assembly in 2015, and the law was in effect in eight states of the federation; all the National Technical Working Groups constituted by NACA have representatives of the Network of People Living with HIV (NEPWHAN) on each of the groups; NACA developed the Presidential Comprehensive Response Plan as an advocacy tool to facilitate the mobilization of resources for the HIV response at the national and state levels. The advocacy effort had resulted in significant improvement in the national and state Governments' investments in the HIV response.

Enforcement of the anti-stigma law is a challenge. PLHIV still face discrimination based on pre-employment HIV test results, or they lose their jobs due to a change in HIV status. There is, however, no dedicated budget for anti-stigma activities at the national level. A system of reporting and documenting violations of the rights of PLHIV is also absent. While the NSP identifies specific actions to address the needs and rights of

women and girls, it only partially includes activities to engage men and boys and transgenders. The anti-same sex marriage law enacted in 2013 has had unintended negative effects on the access of MSM to HIV treatment and care, and the newly passed Sexual Offence Act in 2015 may also have negative impact on HIV stigma.

Institutional architecture, systems, coordination, and resources: The human and institutional capacity of the states and the Local Governments to lead the national HIV response has been extensively strengthened by funding support from the World Bank, United State government, and DFID through the Enhanced National Response project; NACA had set up multiple platforms and reporting structures through which coordination of all partners engaged in the HIV response can be facilitated; the coordinating framework for the CSO HIV response is still poorly developed, with the Civil Society Network for HIV and AIDS Nigeria secretariat currently having operational challenges; systems for HIV commodity procurement and supply-logistics management have been developed. Reports of commodity stock-out are infrequent, with only 3.4% of facilities providing HCT services reporting test-kit stock-out in 2014. Over 21% of the financing of the HIV intervention in Nigeria was by the Government and 1.6% was from the private sector. Also, more states are investing funds in their State HIV response with up to 8.3% of States funding up to 30% of its State HIV response. Unfortunately, the HIV and AIDS resource-tracking process has been very slow.

Linkages of the national response to other government sectors/departments, such as the National Planning Commission, Vision 2020, the Millennium Development Goals and the overall national plans and budgets structures and sectors are not well defined in the NSP and the ability of LACAs to anchor the community HIV response remains weak. The HIV commodity procurements systems can still be improved to ensure it is cost effective. One way is to list HIV-related drugs and supply on the national Essential Drug lists In the absence of this, stakeholders need to continually re-negotiate the HIV budget at the state level. Unfortunately, the HIV/AIDS resource tracking has been poor due to poor reporting on HIV funding by partners engaged in the HIV response in Nigeria.

Monitoring and evaluation systems (comprising monitoring and evaluation systems, research, and knowledge management): There are evidences to suggest that the data collected at the national and state levels are analysed and used to inform strategic decision making. Evidence based-HIV programming in Nigeria has increased. The HIV response evaluation process has also improved significantly. Annual reviews of the HIV response were conducted, as was a mid-term review. The outcomes of the review inform the design and implementation of the stakeholders' programmes. The data quality has improved significantly through the adoption of the National (Integrated) HIV/AIDS data base (DHIS) 2.0 Platform. The state monitoring visits have helped enhance the date quality, as have the LGA, State, and National data verification exercises, which have averaged two exercises per each facility providing HCT services.

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

SECTION 1: BACKGROUND AND METHODOLOGY

1.0 Background

In 2009, under the leadership of the National Agency for the Control of AIDS (NACA), Nigeria adopted the National HIV and AIDS Strategic Plan (NSP 2010–2015). The plan was developed through an inclusive process involving the public and private sectors, community and faith-based organizations, People Living with HIV, and academia.

The NSP encompasses the priorities outlined in the poverty-reduction strategy for Nigeria (Nigeria Vision 20:2020) and the National HIV Policy. As a resource-mobilization tool for the national response, the NSP will help achieve universal access to HIV prevention, treatment, and care and will support the Millennium Development Goal Six on HIV in Nigeria.

The key HIV/AIDS priorities of the NSP 2010-2015 are related to the thematic areas identified by the National HIV/AIDS Policy 2010-2015. These areas are as follows:

- Promotion of Behavior Change and Prevention of New HIV Infections
- Treatment of HIV/AIDS and Related Health Conditions
- Care and Support of people living with HIV (PLHIV), people affected by HIV and AIDS (PABA), and orphans and vulnerable children (OVC)
- Policy, Advocacy, Human Rights, and Legal Issues
- Institutional Architecture, Systems, Coordination, and Resources
- Monitoring and Evaluation Systems (M&E) (comprising M&E, Research, and Knowledge Management)

Several broad interventions were identified as crucial to the success of the national response, and ambitious targets have been set for achieving universal access to HIV prevention, treatment, care, and support. These interventions include gender-mainstreaming; advocacy at all levels; capacity building for training and development of skills; and increased access to material goods, technical assistance, and sustainable funding.

After development of the NSP, NACA, in collaboration with its partners, had supported the development of State Strategic Plans for the 36+1 states over the same period (2010-2015). State plans are based on the national priorities and thematic areas.

Since the beginning of 2010, all responses to HIV and AIDS have been guided by these national and state strategic plans. NACA recognizes that the national response to the HIV epidemic faces a dynamic, changing environment. Periodic assessments of the response programmes are essential if the country is to stay on track. To this end, the country has completed two annual review processes: the 2011 and the 2012 Joint Annual Review of the NSP.

The Joint Annual Reviews measure progress made toward identified goals during the previous year. A midterm review also was conducted in 2013. As distinct from the annual reviews, the midterm review measured progress and made recommendations for adjustment of the NSP. Many of the recommendations were implemented in years 2013 and 2014, and they form the basis for the continued HIV response for 2015.

The End-of-Term Review of the NSP shall assess the impact of the HIV response in the past six years and make recommendations for priority actions to be taken over the next five years. The Review is divided into two phases: Phase I is a desk review of all the existing documentation on the HIV response over the previous five years, which assesses progress made until date; identifies gaps within the response; and makes recommendations for priority action to be taken over the next five years. Phase II will include collation of outcome and impact-level data from survey reports and other databases that become available later in the year. Phase II will also include rapid field work in order to assess the impact of the response on the quality of life of service recipients with the objective of making specific recommendations on how to improve delivery of HIV service for Nigerians.

1.1 Methodology for the Desk Review

The desk review process focused on reporting on the progress made with implementation of the NSP across all six of the thematic areas of the strategic plan, with the objective of assessing the following:

- The level of investment of resources
- The effectiveness of the activities to reach defined targets
- The efficiency of the systems and structures in place
- The level of integration of the activities when there are multiple service providers
- The level of engagement of project beneficiaries
- The outcomes at the end of 2014.

As appropriate, each program assessment identified challenges, constraints, best practices, and success stories. It also reported on the level of integration of the national program with the following:

- state-led responses
- other line ministries and parastatal organizations
- development partners
- civil society organizations
- the programmes and activities of regional and international partners

This desk review provides the foundation an assessment of the impact of the HIV response as guided by the NSP during phase II. The desk review is a review of all of the formal and informal documents made accessible by NACA and, through private sourcing, by the consultants for this project. Reviewed documents included evaluation reports, internet site documentation, procedures manuals, correspondence files, and study publications. The desk review illustrates how the programme perceives itself, its progress, and its impact. The document formed the basis for further questions and will serve as a basis for corroboration of information generated from other sources.

SECTION 2: SUMMARY OF THE 2013 MID-TERM REVIEW FINDINGS FOR THE NATIONAL HIV RESPONSE PROGRAMME

HIV Epidemiology. Nigeria has the second highest burden of HIV in the world—second only to that of South Africa. At the end of 2013, UNAIDS estimated that 3,200,000 Nigerians were living with HIV, and about 75 percent of those were not aware that they were infected. The number living with HIV will continue to rise due to the success with the country's treatment program. At the end of 2014, Nigeria had placed over 630,000 people on antiretroviral therapy (ART). Nigeria has the highest global burden of HIV-related orphans and vulnerable children (OVC), with 2,000,000 children age 0-17 years orphaned by AIDS. A large proportion of new HIV infections is also due to mother-to-child transmission (MTCT), which occurs at an estimated rate of 27.3%.²

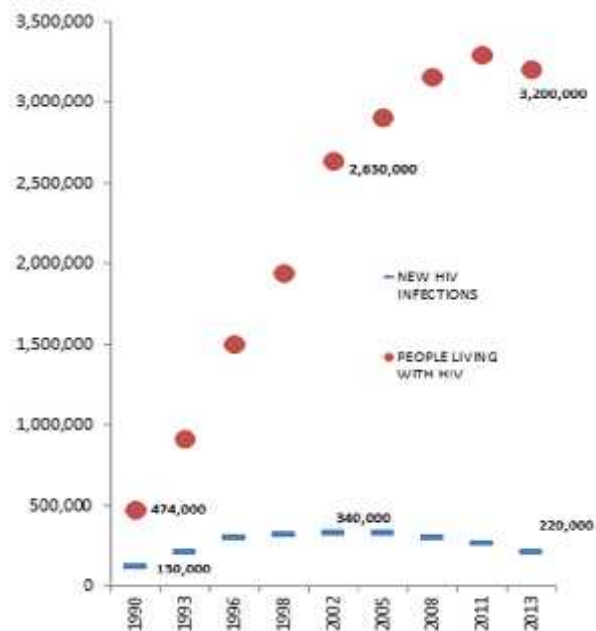


Figure 1: HIV Prevalence and New Infections, 1990 - 2013

Women are disproportionately affected by HIV in Nigeria: 58% of the population of PLHIV are women.

Young women between the ages of 20 and 24 years have a higher prevalence and are infected earlier in life than are men in the same age group.³ Even among key target populations, women have a higher prevalence rate than do men. The prevalence of HIV among females who inject drugs is almost seven times higher than that of male who inject drugs [21% vs 3.1%] and higher amongst female police officers [4.5% vs 2.0%] than among their male colleagues.⁴ The feminization of the HIV epidemic in Nigeria underscores the critical need for primary prevention of HIV infection in women of reproductive age and their partners.

Rate of New Infections. The estimated number of new HIV infections in Nigeria in 2013 is 220,000, a significant drop from an estimated 352,000 in 2003. This represents a 54% decline in the HIV incidence over a period of ten years (from 0.46% in 2003 to 0.21% in 2013). The predominant mode of transmission of HIV from one person to another is through heterosexual intercourse, although a range of social and economic factors places other Nigerians at increased risk of HIV infection. Figure 2 shows the estimated number of new HIV infections by age; adolescents are most at risk. The drop in new HIV infection rates is a result of sustained and concerted prevention, care, and treatment efforts deliberately targeted at the sources of new infections. This concerted effort is articulated in the 2010-2015 National HIV and AIDS Strategic Plan.

² NACA. Global AIDS Response Progress Report. 2014

³ Federal Ministry of Health: National HIV /AIDS and Reproductive Health Survey, Nigeria. 2007

⁴ Federal Ministry of Health: Integrated Biological and Behavioural Surveillance Survey. Abuja: FMOH, HIV and AIDS Division. Nigeria. 2010

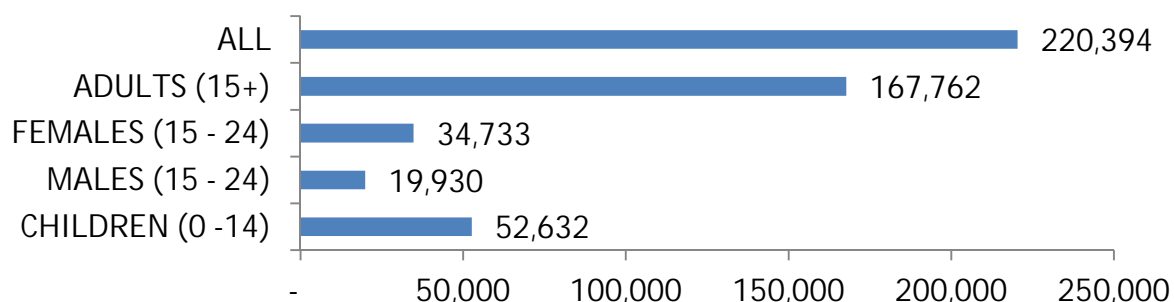


Figure 2: Estimated number of New HIV Infections by age and sex, 2013

The 2010-2015 National HIV and AIDS Strategic Plan. The plan identified several mutually re-enforcing strategies to prevent new HIV infections and promote behaviour change in Nigeria. These strategies are broadly classified as HIV counseling and testing (HCT); prevention of MTCT (PMTCT) of HIV; prevention of biomedical transmission of HIV; early detection, treatment, and control of sexually transmitted infections (STIs); promotion of condom use; communication interventions targeting both the general population and most-at-risk populations (MARPs); and integration of sexual and reproductive health (SRH) and HIV Services. These strategies were further refined through the development of the National HIV/AIDS Prevention Work Plan for 2010–2012, with updated version for 2013-2015; the 2013 female sex workers' (FSW) programme implementation guidelines; and the revised gender policy.

HIV Prevention Programme. The national HIV prevention programme used an approach called the Multiple Prevention Package Intervention (MPPI), introduced in the national response between 2007 and 2010 by the National Prevention Technical Working Group (NPTWG). The MPPI is a combination prevention approach, which simultaneously uses different classes of prevention activities (behavioural, biomedical, structural) that operate on multiple levels (individual, community, and societal/structural), to respond to modes of HIV transmission and the needs of particular audiences. All three classes of prevention activity are needed in order to have a comprehensive programme: the

PMTCT summary Nigeria, 2013	
Mothers needing PMTCT	192,507
Mothers receiving PMTCT	57,871
Single dose nevirapine	5,425
Dual ARV	0
Option A - maternal	3,377
Option B - triple prophylaxis from 14 weeks	26,488
ART started before current pregnancy	15,277
ART started during current pregnancy	7,304
PMTCT coverage	30.06
MTCT rate at 6 weeks	14.2
Final transmission rate including breastfeeding period	26.5
Number of new child infections due to mother-to-child transmission	
Total	51,012
Male	26,237
Female	24,775
HIV+ pregnant women with CD4 counts < 350	72,634
Treatment coverage for HIV+ pregnant women	11.73

behavioural interventions are conducted through peer outreach and peer education programmes, using national guidelines. The biomedical interventions include STI screening and treatment; HIV counselling and testing (HCT); PMTCT; condom distribution; tuberculosis screening and linkages to tuberculosis treatment; use of universal precautions by health-care providers; and access to post-exposure prophylaxis for persons who are unduly exposed to HIV infection through such circumstances as rape, occupational hazards, or unprotected sex. Structural

interventions address stigma and discrimination of PLHIV; promote gender equity; facilitate formation of new policies that promote HIV prevention; review existing policies that might be barriers to HIV prevention; investigate socio-cultural norms that could promote HIV infection; and empower individuals with programmes such as girl-child education.

Prevention of Mother-to-Child Transmission of HIV. One of the main national strategic interventions to increase access of pregnant women to PMTCT was to scale up the number of PMTCT service points. By 2015, the country should have about 14,480 sites providing comprehensive PMTCT services in Nigeria. The 2013 statistics on PMTCT show that 51,012 babies were born with HIV infection, representing about a quarter of the number of new infections in Nigeria.

At the end of 2013, the PMTCT coverage in Nigeria was only 30%, and Nigeria contributed 32% of the global MTCT burden. The country has, however, made significant efforts to address this issue. For example, the number of facilities through which PMTCT services are provided rose from six tertiary outlets in 2001 to 5,622 by the end of 2013. PMTCT services are now decentralised to primary health-care centres. The Federal Ministry of Health reports that a total 3,924,109 pregnant women have been tested for HIV and received their results over the three-year period of 2011 to 2013. The rate of HIV transmission from mother to child was estimated to be 26.5%.

HIV Treatment. The HIV and AIDS treatment programme in Nigeria is guided by the 2010 National Guidelines for Adult and Pediatrics access to ART, wherein HIV treatment

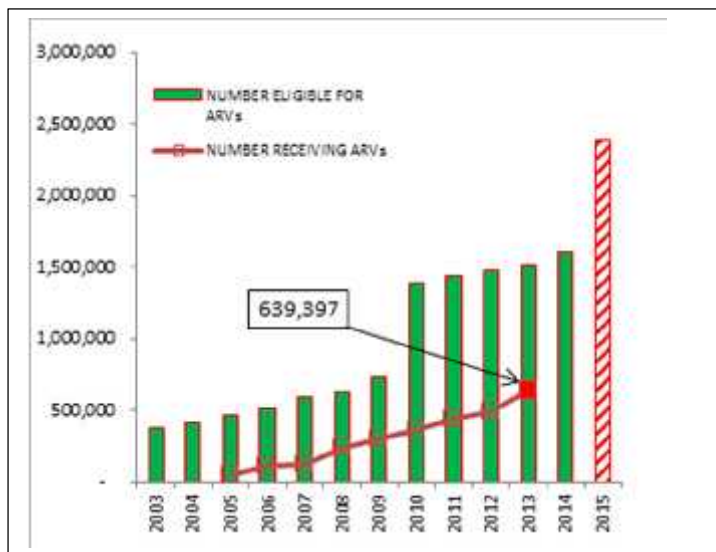


Figure 3: Number of people on ART vs people eligible, 2003 - 2015

is commenced when the CD4 count is 350/mm or below. However, all HIV-positive partners in sero-discordant relationships can commence ART as soon as possible, irrespective of the CD4 count. The revised National Guidelines for Adult and Pediatrics access to ART, wherein HIV treatment is commenced when the CD4 count is 500/mm, became operational in 2014. Currently, about 37.4% of the HIV response budget is allocated to treatment,⁵ representing the largest portion of the HIV response budget.

Treatment is not limited to ART access. Management of opportunistic infections, screening of those with tuberculosis for HIV infection and vice versa, and the placement of PLHIV on co-trimoxazole and isoniazid are efforts targeted at reducing the risk for opportunistic infections in PLHIV and are part of the overall treatment programme. One effort aimed at increasing population access to ART is the decentralization of ART service delivery with the introduction of task shifting and task sharing. This program designates Primary Health-Care centres (PHCs) as ART refill centres and integrates the delivery of this service into

⁵ NACA: National AIDs Spending Assessment. 2010

the routines of healthcare workers already employed at the PHCs. Nurses and Community Health workers at these PHCs do not initiate ART but do perform rapid HIV screening and can provide support services for those already receiving ART. Point-of-care HIV treatment monitoring tools have been introduced on only a very small scale, but sample transfer from the spokes to the hubs is used to ensure treatment monitoring. Despite the recorded reductions in numbers of new HIV infections, the country still faces a challenge from the large number requiring treatment. At the eligibility criteria for treatment of CD4 of 350/mm, it is estimated that a little over 1.4 million Nigerians needed ART at the end of 2013. The number of persons placed on treatment is increasing (see Figure 3). At the end of 2013, up to 43% of the total eligible population were receiving ART. Coverage for children below 15 years is poor. It is estimated that less than 12% of children in need of ART are receiving treatment, meaning that nearly 9 out of 10 children in need of HIV treatment⁶ are not receiving it. Once the eligibility for treatment is increased to CD4 <500/mm, the number of persons eligible will rise to over 2.3 million, representing a 60% increase in the number of PLHIV eligible for treatment.

HIV Care and Support Programme. The NSP planned to improve the access to quality care and support services for at least 50% of PLHIV; establish links to Income Generating Activities (IGA) and poverty alleviation programmes for at least 50% of PLHIV and people affected by AIDS (PABA), especially females and marginalised people with special needs; and improve referrals and linkages within and between health care facilities and community-based services to 80%. The programme also planned to address the abuses of the rights of PLHIV, including stigma and discrimination. The national response also recognized that poverty exacerbates morbidity and mortality and therefore identified the need for interventions that reduce the effects of poverty by increasing access to economic resources through linkages of support groups to IGA.

The Hub-and-Spoke Network Model, also known as a cluster system, has been adopted by the country for the provision of a continuum of care and support in the communities. The model consists of a network of one treatment centre; two HCT centres and two support groups providing treatment adherence, stigma reduction and generating uptake for HCT services; five CBOs providing HBC services; and one CBO providing OVC services. Within the communities and outside of the cluster model there are other CSOs, trained HBC officers, PHC officers, youth groups, and PLHIV support groups that all help to mobilize PLHIV to receive care. Members of the Civil Society Network for HIV and AIDS Nigeria and the Network of People living with HIV and AIDS in Nigeria worked with their members to implement community home-based care. The passage of the National HIV Anti-stigma Act by the national assembly in 2014, and the passage of the same by nine states in Nigeria, is a success story. The Federal Ministry of Women Affairs also developed the National Plan of Action on OVC (NPA, 2006-2010) to provide guidance on OVC response.

Strategic redirection. In an attempt to strategically redirect the national HIV response in order to ensure it is more cost effective, the country took two actions. First, it concentrated its efforts in the 12+1 states in Nigeria that contribute 70% of the country's HIV burden. Second, it developed the Presidential Comprehensive Response Plan in an effort at increasing the internal financing of the national HIV response. The Presidential Comprehensive Response Plan served as an advocacy and resource

⁶ About 240,000 children, aged 0 to 14, were estimated to be in need of HIV treatment. This figure is projected to remain this high over the coming two or more years.

mobilization tool for accelerating the national response and to fast-track on-going efforts at implementing the NSP 2010-2015. Also, the United States Government, in collaboration with NACA, undertook a rationalization exercise in 2012; the exercise resulted in one lead International Partner managing the entire response in one state. These efforts at enhancing the cost-effectiveness of the national response had measureable impacts in 2014. The next few pages summarise the reports on the HIV response in Nigeria, with focus on achievement until date measured against the 2015 targets and the challenges faced.

SECTION 3: FINDINGS FOR THE NATIONAL HIV PREVENTION PROGRAMME

3.1 HIV Counseling and Testing

HIV Counseling and Testing (HCT) is universally acknowledged as the entry point to prevention, treatment, care, and support.⁷ A US study (HPTN 043) at four sites in Africa attributes an overall reduction of 14% in HIV incidence to a community-oriented programme of HCT.⁸ A study funded by NACA also highlighted that there was a significant correlation between poor access to HCT and high HIV prevalence in the community.⁹

The 2012 National HIV and AIDS Reproductive Health Survey clearly showed gaps in access to HCT¹⁰: Although 76.0% of Nigerians were interested in having HCT, by 2012, only 26.3% had taken an HIV test (29.2% of females and 23.5% of males); fewer rural respondents (20.0% males and 25.0% females) and those with a lower education background reported having ever been tested for HIV compared with urban populations (29.0% males and 37.0% females).

Multiple strategies were deployed in order to increase access of Nigerians to HCT. The strategies included efforts to increase the number of HCT sites; promotion of client- and provider-initiated HCT in all facilities; promotion of couple counselling at all facilities that provided PMTCT services; support of community outreach programmes and door-to-door promotions by public health facilities in collaboration with WHDC members in the community; the provision of mobile HCT services in rural communities and other hard-to-reach areas and populations; and support of media campaigns and promotion of the Heart-to-Heart logo as a means of facilitating easy recognizable HCT-supportive facilities by community members. Also, Nigeria's national Day for HIV testing was set to coincide with the World AIDS' Day.

3.1.1 Achievements at the end of 2014

- The number of facilities providing HCT services had increased from 1,064 in 2010 to 1,357 in 2011; 2,624 in 2012;¹¹ 7,075 in 2013;¹² and 8,114 in 2014.¹³
- The total number of 0-64 year olds who took a HCT and received their results was 6,616,482.¹⁴ This figure includes 772,989 (11.7%) 0-14 year-olds and 5,361,716 (81.0%) 15-49 year-olds.

⁷ FMOH: National Guidelines on HIV Counseling and Testing. November 2011

⁸ NIMH Project ACCEPT (HPTN 043). A cluster-randomized trial of community mobilization, mobile HIV testing, post-test support services, and real-time performance feedback for HIV prevention in entire communities.

<http://www.hsrb.ac.za/uploads/pageContent/3266/ProjectAcceptCROI.pdf> (accessed 28th October, 2013)

⁹ Onazi M, Enemuoh J. HIV Counselling and Testing (HCT) Service Up-take and the Epidemiology of HIV/AIDS among Women Attending Ante Natal Care (ANC) in High and Low Prevalence States. Phase 1 Global Fund Funded Operations Research, NACA presentation. 25th October, 2013.

¹⁰ FMOH: 2012 National HIV and AIDS Reproductive Health Survey. 2013

¹¹ NACA: 2012 Midterm review: implementation of the 2010-2015 National HIV and AIDS Strategic Plan

¹² Ogungbemi K *et al.* An overview of the current national HIV response, investments, achievements and challenges: 2010 to 2013. Nigerian Journal of Health Sciences 2014; 14: 12-18.

¹³ FMOH: 2014 ART, PMTCT and HCT DHIS 2.0 data.

¹⁴ FMOH: 2014 ART, PMTCT and HCT DHIS 2.0 data.

- Of the 5,361,716 15-49 year-olds who tested for HCT in 2014, 2,845,796 (53.1%) were female and 2,515,920 (46.9%) were male. The gender disparity in HCT access identified in 2011¹⁵ is reducing.
- State officials, consultants, and technical advisers conducted supervisory visits (an average of two visits per facility providing HCT services) in order to help ensure provision of quality facilities.
- Also, 3,607 new staff were trained, and 4,749 existing staff were retrained on provision of HCT service.

3.1.2 Achievement against 2015 NSP indicators

- *Target 1 – At least 80% of adults (men and women 15 years and older) had access to HCT services in an equitable and sustainable way by 2015:* Only 26.3% of the general population had been counselled, tested for HIV, and received their test results.¹⁶

3.1.3 Challenge with HCT access

- The number of sites in Nigeria providing HCT is still too low to meet the demand; the number of sites is 58.8% less than the proposed 23,640 facilities needed to provide saturated coverage for HCT in Nigeria by the end of 2015.
- The stock-out of HCT test kits is still a challenge. Of the 8,114 sites providing HCT services, 279 (3.4%) reported stock-outs of test kits in 2014. Stock out of HCT test kits is however, less of a problem in 2014 than it was in previous years.

3.2 Prevention of Mother-to-Child Transmission of HIV

Up to 58% of people living with HIV are women. Young women between the ages of 20 and 24 years have a higher prevalence and are infected earlier in life than are men in the same age group.¹⁷ Even among key target populations, women have a higher prevalence rate than do men; the prevalence of HIV among female who inject drugs is almost seven times higher than that of male who inject drugs [21% vs 3.1%] and higher amongst female police officers [4.5% vs 2.0%] than amongst their male colleagues.¹⁸ The feminization of the HIV epidemic in Nigeria underscores the critical role of primary prevention of HIV infection in women of reproductive age and their partners. MTCT accounts for about 10% of new infection in Nigeria. One of the efforts to increase access of pregnant women to PMTCT includes the scale-up of PMTCT-service locations. Also, a PMTCT scale-up plan was developed in 2012 to support the acceleration of PMTCT programming at the state level, starting with the 12+1 priority states: Abia, Akwa Ibom, Anambra, Bayelsa, Benue, Cross-Rivers, Kaduna, Kano, FCT, Lagos, Nassarawa, Plateau and Rivers, which together bear 70% of the burden of the epidemic and have consistently had a high HIV prevalence. It was anticipated that by 2015, Nigeria should have about 14,480 sites providing comprehensive PMTCT services.

¹⁵ NACA. Joint Annual HIV and AIDS response review. 2011

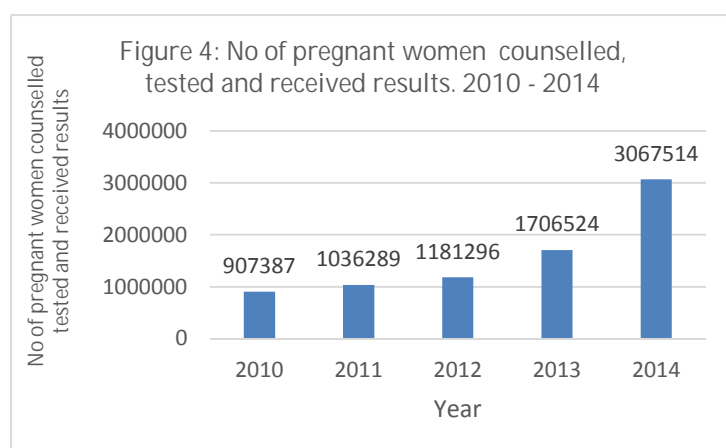
¹⁶ Federal Ministry of Health: National HIV /AIDS and Reproductive Health Survey Plus, Nigeria. 2012.

¹⁷ Federal Ministry of Health: National HIV /AIDS and Reproductive Health Survey, Nigeria. 2007

¹⁸ Federal Ministry of Health: Integrated Biological and Behavioural Surveillance Survey. Abuja: FMOH, HIV and AIDS Division. Nigeria. 2010

3.2.1 Achievements at the end of 2014

- The number of sites providing PMTCT services had increased to 5,622 sites by 2013 and to 6,548 by 2014. Many of these services are provided by primary health-care centres.
- A number of states, Anambra and Enugu especially, have actively and successfully engaged private-sector sites in the provision of PMTCT services.
- A cumulative total of 3,067,514 pregnant women were tested for HIV and received their results in 2014. This figure is estimated to be 46% of all pregnant women in Nigeria (Spectrum Modelling, 2015). Figure 4 illustrates the increasing number of pregnant women who have been tested for HIV and received their test results since 2010.



- Also, 107,957 (51.4%) of the estimated 209,861 HIV-positive pregnant women (Spectrum 2014) were accessible through the health-care facilities in 2014.
- Of the 107,957 HIV-positive pregnant women who accessed healthcare facilities in 2014, 63,350 (58.7%) had access to PMTCT prophylaxis drugs. The

PMTCT coverage, therefore, was 30.2%. See Figure 5.

- Of the 63,350 women who received PMTCT prophylaxis drugs in 2014, 34,372 (54.3%) were on triple therapy; 1,127 (1.8%) were on AZT, and 1,157 (1.8%) were on sdNVP only. Also, 19,074 (30.1%) pregnant women seen in 2014 had initiated triple therapy for their own health prior to accessing PMTCT services, while 6,382 (10.1%) were started on triple therapy for their health purposes during the same year.
- Of the 31,262 live births born to HIV-positive mothers within facility settings, 22,566 (72.2%) received the first dose of NVP, while 22,691 (72.6%) received antiretroviral (ARV) prophylaxis while breastfeeding.
- Of the 31,262 live births born to HIV-positive mothers within facility settings, 8,802 (28.2%) had their blood taken for early infant detection (EID) within two months of birth. Of these, only 1,614 (12.4%) received the test results.
- The HIV transmission rate is estimated to be as high as 28%.

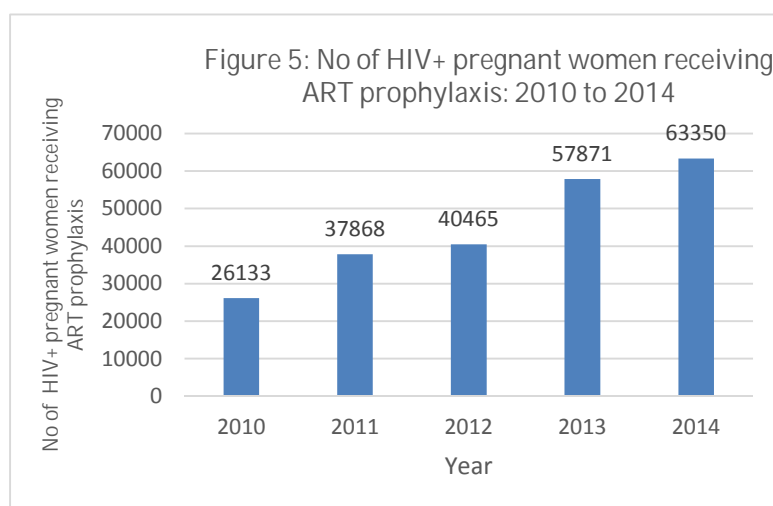
3.2.2 Achievement against 2015 NSP indicators

- *Target 1 – At least 80% of all pregnant women have access to HCT by 2015.* 46% had access in 2014 (Spectrum Modelling, 2015).
- *Target 2 – At least 80% of all HIV-positive pregnant women have access to ARV prophylaxis by 2015:* 30.2% of the estimated 209,861 HIV-positive women who required PMTCT accessed PMTCT by the end of 2014.

- *Target 3 – At least 80% of all HIV-exposed infants have access to ARV prophylaxis by 2015: 72.6% of HIV-exposed infants who were accessed at the facility level had access to ARV prophylaxis in 2014.*
- *Target 4 – At least 80% of all HIV-exposed infants have access to early infant diagnosis services: 12.4% of HIV-exposed infants who had their blood taken for EID within two months of birth and received their test results.*

3.2.3 Challenges

- The number of HIV-positive pregnant women visiting facilities is still low. Innovative interventions are required to facilitate access of pregnant women to health facilities.



This includes incentivising pregnant women to attend facilities, incentivising traditional birth attendants to refer clients to health care facilities, improving the quality of care pregnant women receive, providing mother and child care services at a single service point, and reducing cost of services for pregnant

women. Private health sector engagement and community mobilisation are also essential. Poor access of pregnant women to PMTCT is a significant risk factor for HIV transmission from mother to child.

- The number of facilities providing PMTCT services is still too low. Federal Ministry of Health notes that 14,480 sites are required for adequate PMTCT service coverage.¹⁹ At the end of 2014, only 45.2% of the estimated number of sites needed to provide saturated PMTCT coverage had been activated. Yet, the country has 21,808 Primary Health Centres (PHC)²⁰ and 22,850 public health facilities (21,808 primary, 969 secondary and 73 tertiary) with the potential to provide PMTCT services if activated. Rapid scale up of PMTCT services is possible. Delta State scaled up its PMTCT service points from 8% of its public health facilities to 72% in eight months.
- Active engagement of the private-health sector and traditional-birth attendants (TBA) is required for successful PMTCT coverage. Active private-health sector and TBA engagement with PMTCT is poor or non-existent in majority of the states in Nigeria. The 'Agbebiye' programme in Ondo State incentivised TBA to refer clients to public health facilities providing quality mother and child care services. At the end of 2014, 91% of the 45,000 pregnant women in the State now access ANC services in the public health facilities in the state.

¹⁹ FMOH: Post validation meeting data. Health sector key indicators. SI-NASCP. 2013

²⁰ FMOH and Measures Evaluation: Health facilities mapping report. 2011

- Not all HIV positive pregnant women who accessed health care facilities also accessed PMTCT services. One of the obstacles to PMTCT access is the poor use of facilities for delivery. Challenges to use of facilities for delivery by pregnant women include delay in seeking care, delay in reaching care centres when refer and emergencies, poor access to quality care. Innovative approaches need to be designed at the state and local government levels to address these barriers to access of mothers to skilled attendance during pregnancy and post-delivery to be able to promote PMTCT access.
- Also, not live births born to HIV-positive mothers within facilities had access to ARV prophylaxis. This is mainly due to the mother not following up. An innovative approach used by the Institute of Human Virology, Nigeria is the employment of mentor mothers (HIV positive women who had successfully used PMTCT services, have negative children and are willing to be open about their HIV Status) to provide support and follow up to specific number of women in the facilities. This approach had resulted in extremely high number of retention of mother and child pair enrolled in the PMTCT programme.
- The low number of children who receive their EID results is also a challenge. The number sites providing EID services are too few. This results in the delay in the turn-around time of EID results with many patients not collecting test results. Also, because of the need to pool samples before transporting them to EID service point, a few samples get damaged and need to be repeated. This creates further delay in access to EID results. These challenges result in EID turn-around time being as long as 3-6 months. Innovative approaches need to be taken to reduce the turn-around time. For example, in Enugu State, the project transports its EID samples from all PMTCT site in the state daily to the state EID facility. The turn-around time for EID results had been reduced to 4-6 weeks in the state.
- The incessant strike in the public-health sector had also resulted in interference with clients' access to PMTCT services. Staff at HIV service delivery sites may need to be incentivised to continue to provide HIV related services even during strike actions in view of the potential consequences for the national HIV response.

3.3 Behaviour Change Communication

One of the main drivers of the HIV/AIDS epidemic is early sexual debuts. Early initiation of sexual activity increases the prospect for multiple-sex partnering and other high-risk behaviours. Unprotected anal sex is a factor known to increase considerably the risk for HIV infection--8-10-fold increased risk compared with vaginal intercourse. The low use of condoms also continues to constitute a risk for HIV infection, as is engagement in transactional sex.

To address these challenges, the national Behaviour Change Communication (BCC) strategy guides BCC interventions. The BCC programme uses two national toolkits: the national SBCC coordination toolkit, developed in 2013, and the draft National community conversation toolkit, yet to be made public. The BCC programme targets FSW; men who have sex with men (MSM); people who inject drugs (PWID); health-care workers; OVC; PLHIV; people with disabilities; transport workers and other men who travel often (including all mobile itinerant, uniformed-service personnel); women and men of childbearing age; and, young people. Strategic interventions include media

communication on these themes, using all channels, such as peer/mentoring with life skills; community transformation (communities, workplaces, places where people meet) to support reduction of stigma, address harmful gender and cultural norms, and increase community involvement; strengthening provider–client interaction for education and adherence so as to increase access to products and services; and advocacy to address the wider policy environment that determines access, protects fundamental rights, and promotes linkages between sectors.

The HIV pandemic disproportionately affects young people, making the task of providing adolescent and youth-friendly services more urgent.^{21,22} The Federal Ministry of Education responded to this problem by adopting a two–pronged approach to HIV prevention among in-school youth: a curriculum-based strategy, using the Family Life HIV&AIDS Education (FLHE) training curriculum, and the Co-Curriculum strategy, using peer education. The goal of the FLHE curriculum is to improve awareness and prevent the spread of HIV. The contents of the curriculum were integrated into the Basic Education curriculum, and it is now examinable.

The national workplace programme aims to promote workers' access to HIV and AIDS information and services, both so that they can take appropriate action to protect themselves from HIV infection and to combat discrimination based on real or perceived HIV status of workers. The HIV-prevention intervention in the workplace emphasises the need to develop a gender-sensitive workplace policy and implement HIV workplace programmes. The national HIV/AIDS workplace programme has been anchored by Federal Ministry of Labour and Productivity (FMLP) and NIBUCAA, with some support from Hope Worldwide since inception of the programme.

Great efforts are being made to coordinate STI control and Sexual and Reproductive Health (SRH) services and to integrate STI management with HIV-related services. This coordination is indicated because most women who are infected, or are at risk for becoming infected with HIV and STIs, are also of reproductive age. Women seeking SRH, STI, and HIV services share common needs and concerns. Integration of these services would improve the education of women, help prevent unwanted pregnancies, and help protect women from contracting an infection or transmitting it to their partners. These issues also highlight the importance of spousal counseling.

3.3.1 Achievements at the end of 2014

- The 2012 National AIDS and Reproductive Health Survey (NARHS) Plus report showed some positive changes in behaviour of adolescents and young adults. The percentage of those who had their sexual debut before the age of 15 years had decreased significantly (6.7%) and had exceeded the 2015 target of 12.0% for males and 23.0% for females.
- The 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 is 24%.²³
- The FLHE curriculum has been implemented in the 36+1 states, with more than 8,989 implementing the FLHE, more than 1,824, 421 students reached through

²¹ NACA: Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. April 2013

²² A National Survey conducted with the support of UNICEF, CUBE Project, and UNFPA on the Knowledge Attitude Behaviour, Practice and Skills of students with regards to sexuality, reproductive health and HIV/AIDS. 2006

²³ NACA. 2014 Global AIDS response country progress report. 2014.

Global Fund support,²⁴ and 411,266 reached through the World Bank support.²⁵ The number of schools reached with FLHE in 2012 (41,786) exceeded the number targeted for the year (27,576). Subsequently, the number of students reached with FLHE had declined to 1,271,222 in 2012 and 755,272 in 2013.

- The number of female adolescents who became sexually active decreased significantly, and use of condom at last sexual act with non-marital sexual partners significantly increased.²⁶
- By September 2012, of the 742 (599 primary, 109 secondary and 34 private) health facilities supported by the Global Fund, 485²⁷ were providing integrated HIV and SRH services. Most clients who received integrated HIV/SRH services were satisfied with the quality of service they received.
- Through the FMLP, NIBUCAA, and Hope Worldwide, with support from the Global Fund, more than 25 multinational corporate organisations, 127 small- and medium-scale enterprises, and 25 ministries, departments and government agencies had developed and were implementing an HIV work place intervention programme.²⁸ Workplace intervention programmes help demystify HIV infection among the employees of many companies and have contributed to increasing the number of persons seeking an HIV test, adopting less risky behaviours, and accessing HIV-related services.²⁹
- In an effort to reach adolescents through sports, UNAIDS, in collaboration with NACA, United Nations Population Fund (UNPF), National Sport Commission (NSC), Nigeria Football Federation (NFF), and Nollywood, officially launched the "*Protect the Goal Campaign*" campaign for adolescents in May, 2014. The campaign aims to raise awareness of HIV/AIDS and to mobilize young people to commit to HIV prevention

3.3.2 Achievement against 2015 NSP indicators

- *Target 1 – At least 80% of all persons have comprehensive knowledge on HIV and AIDS by 2015.* 25.4% of adults have comprehensive knowledge about HIV transmission 24.4% of young persons (15-24 years) have comprehensive knowledge about HIV transmission.
- *Target 2 – At least 80% of young people 15-24 years adopt appropriate HIV- and AIDS-related behavior.* 85% of young women and men aged 15-24 years had not had sexual intercourse before the age of 15; 54.8% of sexually active young adults used a male condom at the last sexual intercourse with non-marital sex partner; 68.2% of those that had ever used a male condom, were still using the condom at the time of the survey; 8.1% of young women and men aged 15-24 years had engaged in transactional sex; 16% of young women and men aged 15-24 years had more than one sex partner.

²⁴ NACA: Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. Table 15. April 2013

²⁵ NACA: Draft midterm review of the HPDP-2 Project.

²⁶ Aboki H et al. Changes in HIV Sexual Risk Behaviour among Adolescents: - Is the HIV Prevention Programme in Nigeria Yielding Results? *Afr J Reprod Health* 2014; 18[3]: 108-116

²⁷ NACA: Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. April 2013

²⁸ Taylor W et al. HIV Mainstreaming in Nigeria. Bethesda, MD: Health Systems 20/20 project, RTI International and Abt Associates Inc. October 2011.

²⁹ NACA: Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. Table 15. April 2013

- *Target 3 – At least 80% of sexually active males and females use condom consistently with non-regular sex partners by 2015.* About 55% of sexually active males and females used condom consistently with non-marital sex partners.

3.3.3 Challenges

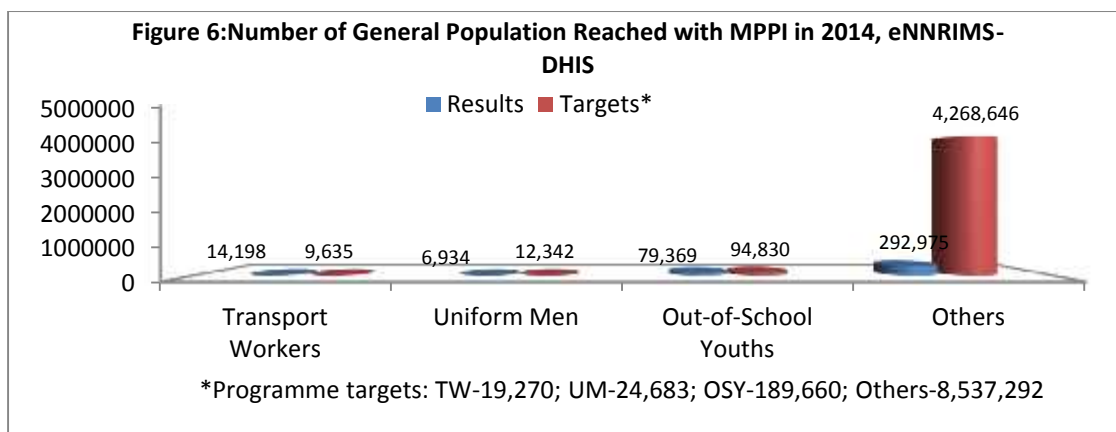
- The proportion of young adults with adequate knowledge of ways of preventing the sexual transmission of HIV by young people had hovered around 24% since 2007 despite the increased investment in FLHE and the public messaging about HIV infection. It is important to identify the reason for this to be able to make any meaningful changes.
- Adolescents have become an important emerging age group. The HIV prevalence of 15-19 year old had increased significantly between 2007 and 2012 especially for female while the HIV prevalence in the country is declining. There was an insignificant increase in the proportion of males and females who engaged in transactional sex and who had multiple sex partners over the study period.³⁰
- The use of condoms by sexually experienced individuals is still low, although there has been substantial improvement in condom use over the last five years. Only 11.2% of sexually experienced females age 15-19 years and 35.6% of their male counterparts use condoms when having sex with casual partners.³¹ Also, only about a third of women aged 15-24 years and half of men aged 15-24 years who engaged in higher-risk sexual intercourse used condoms at their last higher-risk sex encounter.³² Identified barriers to the wide spread use of condoms include high costs to users, limited availability and accessibility, and resistance to condom promotion by religious and cultural groups.³³
- There is limited data available for 10-14 year-old adolescents making evidence based preventive programming for adolescents challenging. Stakeholders consider it important to generate data on sexual behaviour and for other HIV indicators for adolescents 10–14 years of age for appropriate HIV prevention programming.
- Figure 6 below shows the number of people in the general population reached with the MPPI. Consistently, the number of persons reached through the World Bank Credit support exceeded the targets for the project, except for transport workers.

³⁰ Aboki H et al. Changes in HIV Sexual Risk Behaviour among Adolescents: - Is the HIV Prevention Programme in Nigeria Yielding Results? *Afr J Reprod Health* 2014; 18[3]: 108-116

³¹ Federal Ministry of Health. National HIV /AIDS and Reproductive Health Survey, Nigeria. 2007

³² National Population Commission. ORC Micro. Nigeria Demographic and Health Survey 2008. Calverton, Maryland: National Population Commission and ORC Macro. 2008

³³ National Prevention Technical Working Group Meeting. Draft 2013 – 2015 National Prevention Plan



3.4 HIV Prevention Intervention for most-at-risk-populations

The most-at-risk populations (MARPs) for HIV infection - FSW, PWID and MSM – also referred to as key populations, contribute 32% of new HIV infection cases in Nigeria, although they constitute only 3.4% of the population.³⁴ Assessment of the impact of the HIV prevention programmes on knowledge attitude and practice of the key target populations have been routinely captured through the Integrated Behavioural and Biological Sentinel Survey reports available in 2007 and 2010. The 2014 report was not yet available for this review.

The 2010-2015 National HIV Strategic Plan emphasizes behaviour change communication for HIV prevention among MARPs. NACA and its partners developed the Peer Education Plus model for peer educator training among these populations. Part of this model is the Minimum Prevention Package Intervention, which uses social networking approaches to reach hidden and stigmatized groups and establishes referral systems to health services in MARP-friendly clinics. Specialized MARPs-friendly training and capacity building are conducted for private and public sector healthcare service providers.

3.4.1 Achievements at the end of 2014

- Local epidemic appraisals were conducted to strengthen the evidence base for prevention programming at the community level. Twenty-two states estimated the sizes and completed geographical mapping of MARPs. Seven states conducted venue profiling, which provided information on venues where people meet new sexual partners. Five states conducted rural appraisals, which provided information on the level of risk in rural areas. The results are currently being used by states to roll out their prevention programmes for MARPs. The target is for all states to conduct the full complement of epidemiology appraisals.
- The national MARPs project created multiple channels for education and messaging about HIV. The project also brought HCT services closer to the community and facilitated access to and regular supply of male and female condoms and lubricants. The peer education approach engaged cohorts of peers to access HIV prevention education for three months, while also allowing for socialisation among the peers

³⁴ NACA, UNAIDS, World Bank: Modes of HIV transmission in Nigeria: analysis of distribution of new HIV infections in Nigeria and recommendations for prevention. 2009; 2010.

themselves, which itself is empowering and informs changes in behaviour beyond the education alone.

- FSW reported a reduction in the frequency of alcohol usage, more regular and consistent use of condoms, avoidance of sharing sharps, a decrease in number of concurrent partners, and regular visits to the hospital for self-care. In addition, there is a sense of increased perception of risk for HIV infection as the number of FSW who had repeated HIV tests was high.³⁵
- In 2014, 5,103 FSW were reached with the MPPI through World Bank credit. National HIV response programme for FSW is clearly well defined in the national guidelines for FSW programming.
- A standard national programme and implementation guidelines that guides programming for FSW has been developed.
- At the end of 2013, there was a reported increase in the likelihood of MSM staying with one sex partner, reduced number of MSM drinking alcohol, increase in the number of MSM who now perceive themselves at risk for HIV infection and increase in the uptake of HCT services when compared to the 2010 data.³⁶ Also, the number of MSM reached with the minimum HIV intervention package had exceeded the 2015 PCR target by 1.6%. Also, analysis of pooled data from the programmes for MSM conducted by Population Council Nigeria and IHVN shows that 45%³⁷ of MSM could correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. This result exceeds the national 2012 target by 5.9%. Also, the percentage of MSM who took an HIV test and received their results was 81.7%, thereby exceeding the national 2012 target by 19.7%.³⁸
- At the end of 2013, there was a reduction in the number of PWID who share needles, reduction in frequency of drug injection, and reduction in the repeated use of a needle when compared to the 2010 data.³⁹ Significant efforts were made to reach PWID with the minimum HIV intervention package with the Presidential Comprehensive Response Plan 2015 target exceeded by 71.2% by the end of 2013.
- A draft national HIV response guidelines' document for PWID was developed in 2015 with support of UNODC. Staff of the National Drug Law Enforcement Agency and some 11 Civil Society Organisations working with PWID were also trained on HIV response for PWID.
- In 2014, 4,382 MSM and 1,646 PWID were reached with the MPPI through World Bank credit. A national HIV action plan for adolescents and youths was developed and disseminated in 2014.

³⁵ National Agency for the Control of AIDS. Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. 2013

³⁶ National Agency for the Control of AIDS. Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. 2013

³⁷ Population council programme in FCT, Kaduna, Lagos and Oyo showed 2110 of 4731 while IHVN showed 1462 of 3200. Thus total of 3572 MSM of 7931 MSM reached met the target indicator in 2012.

³⁸ Population council programme in FCT, Kaduna, Lagos and Oyo showed 4731 of 4731 while IHVN showed 330 of 1462. Thus total of 2485 MSM of 5087 MSM reached met the target indicator in 2012

³⁹ National Agency for the Control of AIDS. Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. 2013

3.4.2 Achievement against 2015 NSP indicators

- *Target 1: At least 80% of MARPs adopt appropriate HIV- and AID-related behavior.* Awaiting the 2014 Integrated Biological and Behavioural Sentinel Survey report. A survey conducted for MARPs in six states of Nigeria showed that in 2014, 92.3% of MARPS had used condoms in the previous month (97.7% FSW, 93.1% MSM, and 83.7% PWID). However, only 57.3% used condoms consistently (42.7% of PWID, 44.6% of MSM, and 75.1% of FSW). Also, 72.4% of MSM and 56.8% of PWID engaged in commercial sex activities.⁴⁰

3.4.3 Challenges

- Lubricant access continues to be a challenge for the population. In 2014, 96.6% of MSM, 14.8% of FS, and 12.5% of PWID engaged in anal sex, yet condom use during anal sex was only 93.5% by MSM, 96.0% FSW, and 68.4% PWID. The proportion of MARPS who used lubricants was also low; only 45.9% of respondents used lubricants with a condom consistently (51.3% of MSM, 43.3% of FSW and 23.8% of PWID)⁴¹. The low use of lubricants may not be unconnected with the poor access to the commodity.
- More attention needs to be paid to the needs of PWID. As high as 52.7% of PWID exchange needles and syringes; 7.3% exchanged needles and syringes all the time in the last one month while, 36.4% exchanged needles and syringes some of the time.⁴²
- Attention also needs to be paid to address the use of psychoactive substances by MSM and FSW. A significant number drink alcohol all the time and use drugs, which can inhibit good judgement regarding critical decisions about HIV risk and reduction measures.
- Several behavioural and structural patterns contribute to increase the vulnerability of MSM and the potential for transmission. A large proportion of MSM have multiple male and female partners, and this population also has high rates of STI infections and high numbers having never been tested for HIV.⁴³ High prevalence of bacterial STIs, notably *Trichomonas vaginalis*, gonorrhoea, and hepatitis B are reported.⁴⁴ Poor access to existing HIV services is compounded by fear, societal homophobia, and negative attitudes of health-care staff towards MSM.⁴⁵ Hidden identity, stigmata, discrimination, and homophobic attacks are some issues that have led to difficulty in mapping and reaching MSM. This issue is particularly difficult for married MSM and those above 30 years of age. Studies also reveal high levels of social marginalization and hostile media, coupled with a legal environment that criminalises homosexuality and non-conforming gender expressions.

⁴⁰ Heartland Alliance. EKPIN Project baseline report. 2015

⁴¹ Heartland Alliance. EKPIN Project baseline report. 2015

⁴² Heartland Alliance. EKPIN Project baseline report. 2015

⁴³ Federal Ministry of Health, Nigeria. Integrated Biological and Behavioural Surveillance Survey. 2010

⁴⁴ Lung Y, Andrinopoulos, Waimar T, Adebajo S. High levels of unprotected anal intercourse and never testing for HIV among men who have sex with men in Nigeria. *Sexually Transmitted Infections*. 2013; 89(8) 659-665.

⁴⁵ Enhancing Nigeria's HIV/AIDS Response (ENR) Programme (2012): An Ethnographic Study of Injecting Drug Users and Men who have Sex with Men in selected States in Nigeria 2012.

SECTION 4: THE NATIONAL HIV TREATMENT PROGRAMME

The HIV and AIDS treatment programme in Nigeria is guided by the 2010 National Guidelines for Adult and Pediatrics access to ART. Of the estimated 3,200,000 PLHIV of all ages living in Nigeria in 2014, 1,400,000 adults and 260,000 children were eligible for ART treatment. The estimated cost of treatment per patient per year is about \$130 for adults and \$70-\$80 for children. Currently, about 33.2% of the HIV response budget is allocated to treatment,⁴⁶ representing the largest portion of the HIV response budget.

Treatment is not limited to ART access. Management of opportunistic infections, screening of those with tuberculosis for HIV infection and vice versa, and the placement of PLHIV on co-trimoxazole and isoniazide are efforts targeted at reducing the risk for opportunistic infections in PLHIV and are part of the overall treatment programme.

One effort aimed at increasing access to ART is the decentralization of ART service delivery. The ease of access to ART services had also been enhanced with the introduction of task shifting and task sharing. This program designates PHCs as ART refill centres and integrates the delivery of this service into the routines of healthcare workers already employed at the PHCs. Nurses and Community Health workers at these PHCs do not initiate patients on ART, but they do perform rapid HIV screening and can provide support services for those already started on ART. Point-of-care HIV treatment monitoring tools have only been introduced on a very small scale, but sample transfer from the spokes to the hubs is used to ensure treatment monitoring.

4.1 Achievements at the end of 2014

- At the end of 2014, 1,057 (4.1%) health facilities in Nigeria were providing ART, which is a 104.8% increase over the 516 providing ART services in 2012. These sites, located in tertiary, secondary, and primary health care facilities, are spread across the 36 states of Nigeria and the FCT.
- The national treatment programme had reached 747,382 (703,358 adults and 44,024 children) of the 1,454,565 people living with HIV by the end of 2014. The ART coverage is therefore about 51.4%. Treatment coverage for children is still low, estimated at 12.0% coverage at the end of 2014.
- The number of PLHIV on second line therapy (3.3%) and salvage therapy (0.02%) remains low.
- Of the 207,570 new clients enrolled into Pre-ART care in 2014 and the 145,053 new clients who started ART in 2014, 23,899 (6.8%) were placed on isoniazide prophylaxis and 294,497 (83.5%) were placed on co-trimoxazole prophylaxis.
- Of the 4,534 individuals exposed to HIV (exclusive of MTCT exposure) in 2014, 4,142 (91.4%) were provided with pre-exposure prophylaxis.⁴⁷
- The number of PLHIV screened for tuberculosis was 966,705. This exceeds the cumulative number of clients on ART treatment and in pre-ART care (954,952). Of the 207,570 clients in pre-ART care, 363,877 (75% in excess of clients in pre-ART)

⁴⁶ NACA: National AIDS Spending Assessment. 2012

⁴⁷ FMOH: data on ART for 2014

were screened for tuberculosis. Of the 747,382 clients on ART, 602,828 (80.7%) were screened for tuberculosis.

- As at the end of 2014, 11,153 of HIV-positive individuals received treatment for both HIV and tuberculosis.
- The installation and use of the Gene Xpert mtuberculosis/rifampicin for the diagnosis of tuberculosis/HIV co-infection since 2011 has helped improve tuberculosis/HIV co-management. The diagnostic tool was installed in 33 sites in Nigeria by the end of 2012.
- The number of patients lost to follow-up within 12 months of beginning therapy was 63,589 (8.5%). This is a significant improvement when compared with the 22.4% reported in 2012. Active engagement with communities through the WHDC, and the use of innovative strategies to follow up clients has helped enhance hospital attendance and reduce the loss of clients on ART to follow up in the facilities.⁴⁸
- The quality of HIV services has improved with the institution of supervisory programmes by many HIV programmes in the state. The involvement of PLHIV as adherence counsellors for PLHIV, mentor mothers for HIV-positive mothers in many of the treatment facilities, and engagement of community-based workers and volunteers to work with PLHIV have significantly helped to improve care and support services for PLHIV.

4.2 Achievement against 2015 NSP indicators

- *Target 1 – At least 80% of adults (men and women 15years and older) and children have access to ART:* 51.4%, of adults and children have access to ART coverage. However, the coverage for children is only 12%.
- *Target 2 – At least 80% of adult (men and women 15years and older) and children have access to opportunistic Infection management by 2015:* 6.8% of clients were placed on isoniazide prophylaxis, and 83.5% were placed on co-trimoxazole prophylaxis.
- *Target 3 – To ensure all PLHIV patients have access to tuberculosis services by 2015:* 80.7% of those who were on HIV treatment were screened for tuberculosis. The number of clients screened for tuberculosis in 2014 exceeded the cumulative number in pre-ART care.

4.3 Challenges

- To a large extent, the rate of uptake of ART services depends not only on the number of ART service sites but also on the rate of uptake of HCT for diagnosis and the effectiveness of referrals to ART sites from sites of HCT services. When ART clinics are few and far apart, referring clients for ART can result in their defaulting if they cannot afford the cost of travel, or of stopping treatment until they have enough funds.

⁴⁸ NACA: Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. April 2013

- Although evidence indicates some benefit to starting ART at a CD4 of 500cells/mm³,⁴⁹ and recent evidence shows that starting ART as soon as a client is diagnosed significantly reduces morbidity associated with HIV⁵⁰, the Federal Ministry of Health is concerned about the huge financial burden of placing the large number of PLHIV in Nigeria on treatment. With evolving evidence on the significant benefit of starting ART on the health of PLHIV,⁵¹ the cost implications and cost-effectiveness of rolling out ART as soon as HIV diagnosis is made needs to be assessed.
- The change in the modalities for donor funding of the HIV response in Nigeria has resulted in a few sites having to institute payment for some HIV services. This payment regime had affected access of a few PLHIV to HIV services. It has also significantly reduced the rate of scale-up of programmes in states not listed as one of the six HIV intervention priority states.
- The data generated on tuberculosis/HIV management is not disaggregated by age and sex. Thus, it is difficult to quantify the number of pediatric patients co-infected with tuberculosis and HIV.
- Making the diagnosis of tuberculosis in children is difficult due to atypical presentations, poor sputum production, and even negative culture results. Unfortunately, the score chart for the diagnosis of tuberculosis in children is not widely utilized by physicians, which results in an artificially low diagnosis in them.
- Most private hospitals are averse to providing Direct Observation Therapy services within their institutions because of limited space for long-term tuberculosis patients and because of the hospitals' inability to provide the safety precautions required for laboratory management. These challenges have limited integrated tuberculosis/HIV services in the private health facilities. Furthermore, poor communication between the public and private-health sectors results in loss of clients during referrals.

⁴⁹ HPTN 052 study

⁵⁰ START study

⁵¹ START study result

SECTION 5: FINDINGS ON THE NATIONAL CARE AND SUPPORT PROGRAMME

The NSP planned to 1) improve the access to quality care and support services for at least 50% of PLHIV; 2) establish links to income-generating activities and poverty alleviation programmes for at least 50% of PLHIV and people affected by AIDS, especially females and marginalized people with special needs; and 3) improve referrals and linkages within and between health care facilities and community-based services to 80%. The programme also planned to address the abuses of the rights of PLHIV, including stigmata and discrimination. The national response also recognized that poverty exacerbates morbidity and mortality, and therefore identified the need for interventions that reduce the effects of poverty by increasing access to economic resources through linkages of support groups to income-generating activities.

The Hub-and-Spoke Network Model, also known as a cluster system, has been adopted by the country for providing of a continuum of care and support in the communities. The model consists of a network of one treatment centre; two HCT centres; two support groups providing treatment adherence, stigma reduction and generating uptake for HCT services; five CBOs providing HBC services; and one Community Based Organisation providing Orphan and Vulnerable Children's (OVC) services. Within the communities and outside of the cluster model there are other CSOs, trained Home Base Care officers, PHC officers, youth groups, and PLHIV support groups that all help to mobilize PLHIV to receive care. Members of the Civil Society Network for HIV & AIDS Nigeria and the Network of People Living with HIV and AIDS in Nigeria worked with their members to implement community home-based care.

Community leaders were also asked to nominate existing volunteers to take formal training in support of the community home-based care programme. The volunteers were drawn from both health facilities and community support groups, and they undertook a six-day intensive training to equip them with knowledge and skills to provide home-based care services to PLHIV, conduct community sensitization programmes and campaigns for HIV & AIDS prevention and stigma reduction, and follow up clients who missed their appointments. Usually, the health care providers from the facility serve as a link to register sick clients who wish to be visited at home. They also provide technical assistance on health-related issues to the volunteers.

5.1 Achievements at the end of 2014

- In 2011, the Federal Ministry of Health released comprehensive guidelines on nutritional care and support for PLHIV. In 2014, NACA also developed and released comprehensive guidelines on provision of care and support for PLHIV.
- In 2014, 207,570 new clients were enrolled into Pre-ART care, and many treatment sites had also engaged PLHIV and community volunteers to provide support services for PLHIV clients within the facilities and at the community level. Programmes have promoted the development and operations of community-based and home-based care programmes for PLHIV by the Network of People Living with HIV. The Institute of Human Virology, Nigeria promoted the institutionalization of their home-based care programme for PLHIV in teaching hospitals.

- Efforts were made at the States to improve the quality of care for PLHIV through the training of health care providers, institution of supervisory visits to health care facilities and the improvement of infrastructure and supply of equipment for health care provision. Also, services integration was enhanced with many health care institutions integrating HIV service access into routine health care provision.
- Where the Community Home Based Care programme was operational, it contributed to increased access to ARV and treatment of opportunistic infections as volunteers made referrals to hospitals. There was reduced morbidity and mortality of PLHIV as there were fewer defaults from ART, increased public awareness about the challenges PLHIV face, and increased public and community support for PLHIV and their families. For example, there are multiple reports of communities taking up responsibilities of ensuring food security for PLHIV.⁵²
- Seventy-two percent of the general population is willing to care for male or female relatives living with HIV; 66% are willing to work with an HIV-infected colleague; 67% are willing to allow an HIV-infected student or child in school; and 65% are willing to allow a female HIV-infected teacher to continue teaching in school. About 48% of the respondents are also willing to share meals with HIV-infected persons, and almost half (42%) are willing to buy food from a shopkeeper known to be HIV infected. These proportions show some marginal improvements in attitude towards non-family members who were infected with HIV compared with the findings from 2007 NARHS.⁵³
- Anecdotal evidence through the Global Fund project evaluation showed that the OVC programme resulted in increased school enrolment and retention, reduction in the lost time out of school, and improved psychosocial development of the children. Also, the programme has improved food security for the family, as household heads are able to make some savings and redirect costs to other income-generating activities.⁵⁴ However, OVC services coverage declined from 761,105 in 2012 to 483,800 in 2013.
- The 2013-2020 National Priority Agenda for Vulnerable Children in Nigeria and the Vulnerable Children Standard of Services in Nigeria were developed. This strategic framework will guide the multi-sectoral operationalization of the Vision 20:2020 as it affects vulnerable children through integration and linkage of systems.
- The 2003 Child Rights Act, in combination with the National Plan of Action for OVCs and the National Child Policy, provides a legal framework for the implementation of services for OVC in Nigeria. Implementation of OVC programmes have also been supported by external support from PEPFAR and the Global Fund Rounds 5 and 9, with PEPFAR supported International Partners providing legal assistance and protective-care services to OVCs in 2012 /2013. A Child Protection Network, funded by UNICEF, has been established in 23 states and the FCT. The network engages a diverse range of interested organizations in monitoring, reporting, and responding to child protection abuses, as well as providing legal aid for children in conflict and in contact with the law.

⁵² NACA: Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. April 2013

⁵³ NARHS 2012 survey report

⁵⁴ NACA: Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. April 2013

5.2 Achievements against 2015 NSP indicators

- *Target 1 – To improve access to quality care and support services to at least 50% of PLHIV by 2015.* The Care and support guidelines were developed in 2014. There are no documentation on the impact of the guidelines on quality of care and support received by PLHIV in 2014.
- *Target 2 – To improve referral and linkages within and between health facilities and community-based services by 80% by 2015:* The hub-and-spoke model has helped facilitate linkage between newly diagnosed PLHIV and hospital facilities. Also, the Provider Initiated Testing and Counselling services have further enhanced the identification of PLHIV and facilitated their linkage to facility-based ART services.
- *Target 3 – To reduce stigma and discrimination of PLHIV by at least 60% of the baseline value by 2015:* 72% of the general respondents were willing to care for relatives living with HIV while 60% would keep secret the fact that a family member is infected.

5.3 Challenges

- There are still challenges with addressing the needs of OVC. Of 17.5million vulnerable children, an estimated 7.3 million have lost one or both parents due to various causes. Of these, 2.23 million were orphaned by HIV/AIDS, while about 260,000 children are living with HIV/AIDS. About 20.3% OVC are not regularly attending school, and 18% have been victims of sexual abuse.⁵⁵
- There is no in-country evidence to establish the value added by support groups and their activities to meet the needs of PLHIV.
- Religious leaders could play a significant role in reducing stigma and discrimination against PLHIV; however, national efforts at engaging religious leaders have little visibility and the Interfaith Council of Religious Leaders on HIV appears inactive.
- The composite indicator in the NSP is not effective in assessing progress against stigma and discrimination. Disaggregating data would help identify challenges and perhaps suggest programmes that can address specific forms of stigma and discrimination faced by PLHIV.
- The dwindling investment of resources from international partners into the national HIV response in 2014 adversely affected the quality of care received in many states not listed as priority intervention states by donors. There were cut backs in the number of staff engaged in community programmes, and costs attached to some monitoring services accessed by PLHIV. These has had significant negative impact on PLHIV in the affected states.

⁵⁵ NACA. 2014. GARPR

SECTION 6: FINDINGS ON NATIONAL HIV POLICY, ADVOCACY, HUMAN RIGHTS, AND LEGAL ISSUES

From the early phase of the national response, policies and guidelines have been developed to guide the national response. One gap identified early in the national response to HIV was the need for a legal instrument to protect the rights of PLHIV. The 1999 Nigeria Constitution serves as the instrument that provides for and protects the human rights of all citizens, but the sections of the constitution that could address human rights violations are broad and not specific to HIV issues. Efforts were invested to build the capacities of Network of Civil Society Address HIV, Network of Youths Working on HIV programmes and network of people living with HIV (NEPWHAN) to spearhead advocacy efforts for the passage of an anti-discriminatory bill and to facilitate the use of developed guidelines to protect PLHIV.

In addition to concerns about PLHIV, concerns have been raised about other vulnerable populations, such as sex workers, PWID, and MSM. Although the country has no non-discrimination laws or regulations that specify protections for most-at-risk populations or other vulnerable subpopulations, certain laws and regulations present obstacles to effective HIV prevention, treatment, care, and support for MSM, sex workers, and people who inject drugs. As literal outlaws, members of these groups cannot be publicly recognized and engaged.

The FMoH has the legal responsibility to develop national health policies and issue guidelines for their implementation. The National Health Bill also provides for collaboration with state and local governments to ensure that appropriate mechanisms are set up to implement national policies. With the increased scope of the National HIV/AIDS response, relevant policies, standards, protocols, and guidelines were developed to provide the enabling environment for coordination and planning to ensure the effective and quality implementation of programs in line with global best practices.

Women in Nigeria are affected by a multitude of negative structural and environmental factors, such as poverty and patriarchy, which bring with them special problems in accessing HIV/AIDS prevention, treatment, care, and support services. CSOs and line ministries are expected to work directly with women's groups, such as market-women associations, women religious groups, and women professional organisations. The public sector work plan also is expected to incorporate activities directed at women. These activities will be supported through the HPDP2 project, and NACA has engaged a gender specialist to contribute to policies and practices and ensure the inclusion of women.

6.1 Achievements by the end of 2014

- Multiple guidelines were developed to further strengthen the HIV response. These include the 2010 National HIV Policy; the 2010-2012 National Prevention Plan; the 2013-2015 National Prevention Plan; the 2010 PMTCT Guidelines; the 2012 National Guideline for the Implementation of HIV Prevention Programs for Female Sex Workers; the 2012 National Vaccine Plan; the 2010 HIV Research Policy and the HIV Research Agenda; the 2011 Women, Girls, Gender Equality and HIV 5-year Strategic Plan and Programme Implementation Framework; the 2014 Gender-based Violence National Guidelines & Referral Standards; and the 2014 eMTCT Strategic Frame Work.

- NEPWHAN has mechanisms in place to document human rights violations against those with a positive HIV status. Other Non-Governmental Organisations are engaged in similar work, which includes monitoring the rights of MSM and FSW.
- At the national level, the anti-stigma bill was passed into law on November 27, 2014. Eight states in Nigeria (Lagos, Enugu, Cross-Rivers, Kaduna, Nassarawa, Edo Plateau, and Ondo) have enacted anti-stigma laws, and in Akwa Ibom, Ogun and Benue states, anti-stigma bills have passed through the second readings.
- The passage of the Child Care, Protection and Justice Act was a major achievement, as was the government's recruitment of 300 Community Child Protection Workers. As part of the implementation of the law, 861 law enforcement agents were trained in the enforcement and protection of children's rights.
- There has been significant improvement in the mainstreaming of gender issues into the national response. A review of all national HIV policies in the country was conducted and gaps were identified. A gender focal person in NACA supports this process. One active process was the mainstreaming of gender issues into the Global Fund New Funding Mechanism process. The gender management system guidelines were developed and had become operational in several states. For example, Akwa Ibom TWG developed a state-specific gender policy that provides direction for gender mainstreaming in the state⁵⁶.
- The Nigeria House of Representatives passed the Violence against Persons Prohibition (VAPP) Bill on 14th March, 2013. The bill is awaiting passage at Senate. Imo State domesticated the VAPP bill; its signing into law has been delayed by criticisms from the public, especially religious groups, who tagged it 'abortion law'.
- NACA led multiple consultations with state leadership on "ownership and sustainability" of the national response. As a result, many states of the federation have included HIV as a budget line item. The president also invested xxx to address the objectives of the PCRP, and SURE-P invested xxx into the national response.

6.2 Achievement against 2015 NSP indicators

- *Target 1 – To advocate for the protection of the right of PLHIV:* The anti-stigma law was passed by the National Assembly in 2015, and the law had been domestication in eight states of the federation.
- *Target 2 – To facilitate greater involvement of PLHIV in decision making at the national level.* All the National Technical Working Groups constituted by NACA have representatives of NEPWHAN on the group.
- *Target 3 – To advocate for progressive increased funding for the HIV response by all level of government:* The Presidential Comprehensive Response Plan was developed as an advocacy tool to mobilise resources for the HIV response at the National and State levels. At least 8.3% of states have up to 30% of their HIV response cost being funded by the state government.

⁵⁶ ENR Annual Review Report. An internally conducted assessment of the enhancing Nigeria's response to HIV & AIDS programme. 2012

6.3 Challenges

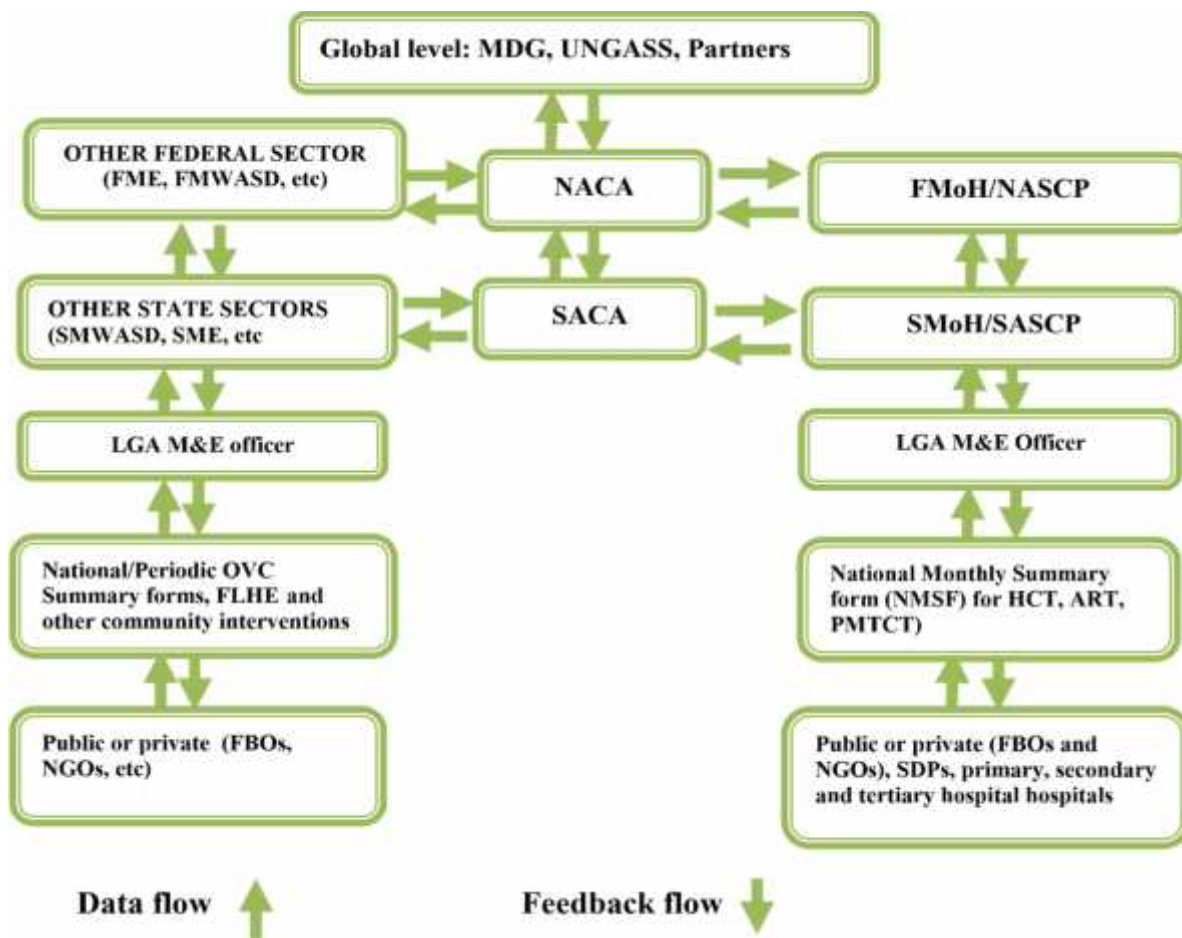
- Enforcement of the anti-stigma law is a challenge. PLHIV still face discrimination based on pre-employment HIV test results, or they lose their jobs due to a change in HIV status.⁵⁷ Currently, the National HIV-prevention Response Programme promotes activities specifically to prevent stigma. These activities are identified as a core structural programme in the prevention package for three key audiences: the general population, in-school youths, and MARPs. There is, however, no dedicated budget for anti-stigma activities at the national level. There has also been no assessment of the impact of the HIV-prevention Response Programme on stigma reduction.
- A system of reporting and documenting violations of the rights of PLHIV is absent. However, an effort to address this gap is the ongoing support for NEPWHAN by the Enhanced National Response (ENR) programme to develop a “Stigma Diary Tool” for reporting stigma cases.
- Gender mainstreaming is still a growing concept. The poorly disaggregated national data on HIV prevention, treatment, care, and support makes it difficult to assess the gender dimension for the national response.
- While the NSP identifies specific actions to address the needs and rights of women and girls, it only partially includes activities to engage men and boys. It also does not address the needs and rights of transgender people or include a specific budget to address these gender-related activities.
- The anti-same sex marriage law enacted in 2013 has had unintended negative effects on the access of MSM to HIV treatment and care. These effects include fear of seeking health care, avoidance of health care, and loss to HIV-positive MSM to follow-up.⁵⁸ The law is also used by law enforcement officials to harass and sometimes incarcerate MSM.
- In 2015, the Senate passed the Sexual Offence Act, with the intent to criminalize intentional transmission of HIV infection. Concerns have been raised about the potential negative impact of this Act on HIV stigma: the law may increase the unwillingness to test. The law is also seen as draconic in the absence of any law requiring Nigerians to test and know their HIV status.

⁵⁷ UNAIDS Report on the Global HIV Epidemic. 2012

⁵⁸ Schwartz SR et al. The immediate effect of the Same-Sex Marriage Prohibition Act on stigma, discrimination, and engagement on HIV prevention and treatment services in men who have sex with men in Nigeria: analysis of prospective data from the TRUST cohort. *Lancet* 2015; June 2,

SECTION 7: FINDINGS ON INSTITUTIONAL ARCHITECTURE

The national response in Nigeria is coordinated through a three-tier administrative system. NACA leads the coordination at the national level. At the state level, the State Agencies for the control of AIDS are responsible for coordinating the multi-sectoral response on HIV and AIDS. SACAs also coordinate joint planning at the state level by all the relevant stakeholders. At the LGA level, the Local Action Committee on AIDS (LACA) have broad mandates, similar to those of NACA and SACAs, to coordinate the HIV/AIDS response. As of 2013, 603 of 774 (77.9%) LGAs in the country have established LACAs to coordinate the response at that level. Figure 7⁵⁹ below shows the recommended pathway of data flow, and the various institutions and systems



NACA

Figure 7: Data flow pathway for the national HIV response in Nigeria

represented in the national HIV response interfaces with stakeholders in various coordinating platforms: NACA-SACA, NACA-Civil Society Organizations (CSOs), NACA-

⁵⁹ MDG-Millennium Development Goals; UNGASS - United Nations General Assembly Special Session; FMWASD -Federal Ministry of Women and Sports Development; NASCP-National AIDS and STI control Programme; FBO - Faith Based Organisations

private sector, NACA-public sector and NACA-development partners. Nine technical working groups (TWG) were established to plan and provide technical advice on thematic areas.

The health sector response is highly dependent on the NACA-NASCP platform at the national level and SACA-SASCP at the state level, which provides opportunity for the coordination of the health sector response at those levels. These platforms ensure that all health sector interventions on the prevention to care continuum continue to be effective and responsive to the needs of those requiring services. Furthermore, along with NASCP/SASCP, the national and state tuberculosis and leprosy control programs are involved in the integration of HIV and tuberculosis services.

Constituency Coordinating Entities (CCE) were established to work with CSOs. Line ministries also established HIV/AIDS responses, and the private for-profit business sector was organised into a response entity called the Nigeria Business Coalition against AIDS (NIBUCAA). The response entity is accountable to the National AIDS Council, which meets annually with all SACAs, Sectors, and Country Coordination Entities in accordance with the mandate in the 2007 Act that set up NACA. These bodies all play roles as coordination and accountability structures for the response, and relate to NACA, which is the central coordinating agency. The HIV/AIDS Committee in the National Assembly and the AIDS Tuberculosis and Malaria Committee of the House of Representatives play oversight roles.

In recognition of the grave consequences that infrastructure deficiency has for the achievement of results and the need for quality assurance of service delivery, during the last three years, the Government of Nigeria, through the World Bank Credit facility and the Global Fund, have invested extensively in the renovation of health facilities, training, and retraining of personnel, and the construction of new infrastructure. These organisations have also invested huge resources in strengthening the health management system, financial management systems, human resources management systems, logistics and Management Information Systems of the national response.

Table 2: Outcome Indicators for Institutional Arrangement and Architecture

	2010 Baseline	2012 Target	2012 Achieved	2015 Target	2014 Achieved
Percentage of states that have SACA	33.0%	67.0%	⁶⁰ 94.6%	80.0%	100.0%
Percentage of SACA that have 80% of their budget funded by the government	-	40.0%	⁶¹ 8.3%	50.0%	8.3%
Percentage of LGAs with LACA	19.5%	-	70.0%	80.0%	77.9%
Percentage of SACA that submit reports to NACA biannually	-	50.0%	74.6%	80.0%	89.0%
Percentage of the CSO coordinating entities who submit reports to NACA biannually	-	50.0%	67.0%	80.0%	67.0%
Percentage of line ministries, departments and agencies implementing HIV/AIDS work plan	-	-	24.0%	80.0%	30.7%
Percentage of LACAs implementing HIV/AIDS workplan	-	-	⁶² 20.6%	80.0%	94.0%

⁶⁰ NACA: Presidential Comprehensive HIV and AIDS Response Plan. 2013

⁶¹ Data collected from SACA programme officers during the 2012 JAR and MTR validation meeting held on the 6th of November, 2013 at Best Western Hotel, Abuja. Three states note their HIV spending is funded up to 80.0% by the state government.

⁶² 78 of the 538 LACAs are implementing their HIV workplans

Percentage of LACA that submit reports to SACA biannually	-	50.0%	⁶³ 95.0%	80.0%	-
Percentage of IPs that submit reports to NACA biannually	-	40.0%	100.0%	80.0%	100%

7.1 Achievements by the end of 2014

- The capacity of the 36+1 SACAs were strengthened so they could play their role as state coordinators of the response through funding support from the World Bank grants and technical support provided by donor partners in the state. All the 36+1 SACAs are now agencies, and 603 of 774 (77.9%) LGAs have LACAs.
- NACA has also established interactive platforms with SACAs, such as the NACA-SACA forum, the NACA-SACA Resolution Workshops on state issues.
- Functional Technical Working Groups (TWGs) are the National HIV Research Reference Group; the National Biomedical HIV Prevention Working Group; Care and Support TWG; PMTCT scale-up Technical Committee; the Policy TWG; TWG on Human Rights/Anti-stigma Bill; the HIV Treatment TWG; the Gender TWG; HIV Prevention Technical Working Group; the Behaviour Change Communication TWG; Procurement TWG; Strategic Knowledge Management TW; and the HCT task team.
- A Standard Operational Manual and Guidelines for the National Agency for Control of AIDS (NACA), the State Agencies for Control of AIDS (SACAs), Local Agencies for Control of AIDS (LACAs), and Coordination Platforms and Technical Working Groups (TWGs) was developed. These documents clearly spell out the Terms of Reference of all the coordinating entities.
- NACA has forged partnerships with donors and implementing partners (such as CIHP, CHAI CIDA, DFID, ENR, FHI360, Global Fund, IHVN, JICA, PATH2, PEPFAR, Population Council, SFH, UN system, WHO, World Bank) to create multi-donor resource streams for many critical planning and program-management activities, such as the development of the NSF, Nigeria National Response Information Management System, HIV/STI Integrated Biological and Behavioural Surveillance Survey, and the National HIV/AIDS and Reproductive Health Survey (NARHS).
- The US government rationalization efforts promoted state data ownership and reporting. It has also enabled States and their lead International Partners to concentrate on the state-specific challenges and their resolution. This rationalization exercise has enabled International Partners to ensure that whilst strengthening the capacity of healthcare workers, the same individuals are not recycled during trainings.
- Through the Global Fund New Funding Model concept note-development process, the need for active engagement of the Key Affected Populations (KAP hitherto referred to as MARPS) led to extensive and rapid support for the development of a Civil Society Strengthening framework for the KAP. By the end of 2014, a KAP secretariat had been established, and a national coordinating framework for FSW (the National Sex Workers Association) and for PWID had been defined. The coordinating structure of the KAP at the national secretariat had also been identified. Similarly, the Global Fund New Funding Model concept-note development

⁶³ Data collected from SACA programme officers during the 2012 JAR and MTR validation meeting held on the 6th of November, 2013 at Best Western Hotel, Abuja. 511 LACA submit reports biannually to SACA

process facilitated the development of the national CSS framework from which the national HIV CSS framework was derived.

- National programmes had been developed to address the capacity training needs on monitoring and evaluation, results-based monitoring and evaluation for key HIV/AIDS, Tuberculosis and Malaria (ATM) officers at state and national levels; capacity-development needs were addressed through the 2011-2014 Technical Support Plan, which was developed in response to the many urgent problems at the national, state, and LGA levels.
- State officials, consultant, and technical advisers conducted supervisory visits to sites to help ensure provision of quality service. In 2014, 16,335 supervisory visits were made to the facilities (an average of two per facility providing HCT services).
- The National Product Supply Chain Management Programme (NPSCMP) was established within the Department of FDS, Federal Ministry of Health. The NPSCMP is the organ through which all of the key players at all levels of government come together to solve supply chain-management problems. The goal of the NPSCMP is to strengthen the capacity of facilities that manage drugs and other health products to deliver optimal PSM services that prevent stock outs, minimize waste and save costs.
- The GFATM, PEPFAR and NACA aligned the ATM procurement processes in accordance with the national procurement policy and the procurement act.
- The Central Medical Store at Oshodi has been strengthened with the facilities and infrastructure for handling HIV- and AIDS-related drugs and supplies. Eight zonal/sub-central stores have also been strengthened with resources provided through the Global Fund and PEPFAR.
- NACA took over the HIV response in two states of Nigeria, namely Taraba State and Abia State. The Federal Government of Nigeria released the sum of N8 billion through the SURE-P project to support the HIV response in these States.
- Discussion with the National Health Insurance Scheme on how to incorporate comprehensive HIV and AIDS services as part of the basic benefit package of the national health insurance programme is ongoing. The proposal on how to source for additional premium to cater for this need is being worked out by NHIS actuary unit in collaboration with NACA.
- The Country Coordinating Mechanism (CCM), the National Agency for the Control of AIDS (NACA), HIV/AIDS Division of the Federal Ministry of Health, and National Tuberculosis and Leprosy Control Program of the Federal Ministry of Health led other stakeholders to develop and submit a joint concept note for HIV/AIDS and tuberculosis to the Global Fund. The feedback was positive.
- The national HIV response has consistently exceeded targets for received donor funds invested in the HIV response. Figure 7 below shows the performance.

7.2 Achievement against 2015 NSP indicators

- *Target 1 – NACA, SACA and LACA capacity to coordinate a multi-sectoral response is strengthened.* The human and institutional capacity of the states and the LGAs to lead the national HIV response has been extensively strengthened by funding support from the World Bank, US government, and DFID through the ENR project. There are stills gaps with the human-capacity need for the national HIV response as

highlighted in the 2013 review of the 2011-2014 technical support plan implementation.⁶⁴

- *Target 2 – Strengthened coordination mechanisms of development partners at all levels to harmonise support for the national response.* NACA had set up multiple platforms and reporting structures through which coordination of all partners engaged in the HIV response can be facilitated.
- *Target 3 – Strengthened coordination mechanisms for CSOs.* This is the weakest of the coordination linkages. The coordinating framework for the CSO HIV response is still poorly developed, with the Civil Society Network for HIV & AIDS Nigeria secretariat currently having operational challenges.
- *Target 4 – Efficient logistic systems in place for uninterrupted supply of ARVs, drugs for management of opportunistic infections, and other HIV/AIDS-related commodities by 2015.* Systems for HIV commodity procurement and supply-logistics management have been developed. Reports of commodity stock-out are infrequent, with only 3.4% of facilities providing HCT services reporting test-kit stock-out in 2014.
- *Target 5 – Increase in financial contribution of all level of government to at least 30% of financial resources required for HIV intervention by 2015.* Over 21% of the financing of the HIV intervention in Nigeria is by the Government.
- *Target 6: Improve HIV/AIDS resource tracking and enhance the efficiency of HIV/AIDS funds management.* The HIV and AIDS resource-tracking process has been very slow.

7.3 Challenges

- Linkages of the national response to other government sectors/departments, such as the National Planning Commission, Vision 2020, the Millennium Development Goals and the overall national plans and budgets structures and sectors are not well defined in the NSP II. This is a missed opportunity for leveraging national development resources for the national response. The National Planning Commission has developed a new guideline on reporting of donor investment in Nigeria. NACA and its partners would need to study this document to understand how it can comply accordingly.
- The ability of LACAs to anchor the community HIV response remains weak. LACAs face considerable resource challenges. Most LACAs are not adequately staffed, and there is a huge problem in getting the right persons to lead LACAs.
- There is poor coordination of the supply chain across programmes and across the country due to poor management of commodity procurements. This problem leads to inefficient use of limited national resources. The national capacity for forecasting and quantification still remains weak.
- The procurement of HIV-related drugs and supply needs to become listed on the Essential Drug lists in order to enhance State Governments' investment in HIV drugs, which are essential commodities for the health response. In the absence of this, stakeholders need to continually re-negotiate the HIV budget at the state level.
- While the total HIV funding from all sources increased from USD 415,287,430 in 2009 to USD 577,432,903 in 2012, domestic HIV funding of the response remains

⁶⁴ NACA. 2013 Midterm review report.

very low and unstable. HIV spending by both public and international sources had declined, with increasing out-of-pocket expenditure for HIV over the last two years. HIV expenditure by the private sector remains low. The total funding gap increased from USD50 million in 2010 to USD 87.5 million in 2011 and then decreased to USD51.6 million in 2012.⁶⁵

HIV/AIDS resource tracking has been poor due to poor reporting on HIV funding by partners engaged in the HIV response in Nigeria.

⁶⁵ NACA. The National HIV/AIDS Epidemiological and Impact Analysis (NHEIA). 2014

SECTION 8: FINDINGS ON NATIONAL HIV RESEARCH, MONITORING AND EVALUATION

There is a 2010 National Policy on HIV and AIDS Research and a 2010 National HIV Research Agenda. The objectives of the National Policy include: the establishment of national structures to effectively set priorities in the management, coordination and resourcing of HIV/AIDS and related research activities; the development of research capacity at institutional and community levels; the promotion of needs-oriented basic, applied, and operational research in HIV and AIDS in Nigeria; and the promotion of the ethical conduct of HIV and AIDS research by ensuring compliance with relevant standards.

The Strategic Knowledge Management Department of NACA and the Department of Planning, Research and Statistics (DPRS) of the FMOH are responsible for the oversight of research, monitoring, and evaluation for the HIV response. The Nigerian Institute of Medical Research (NIMR) and Nigerian Institute of Pharmaceutical Research and Development (NIPRD) are responsible for carrying out nationally relevant research. NIMR conducts HIV-related clinical research, while NIPRD does research into herbal remedies for HIV and opportunistic infections like tuberculosis.

Operational guidance for the conduct of research and for the monitoring and evaluation of the national HIV response is provided by the National Biomedical HIV Prevention Working Group. The National HIV Research Reference Group and the national technical Working Groups are functional. The National Biomedical HIV Prevention Working Group produced the National HIV Vaccine Research Plan. The National HIV Research Reference Group commissioned nine studies that will provide evidence of programming for the response.

The National AIDS Research Network (NARN) disseminates research findings and serves as a platform for the networking of data producers, data users, and other critical workers in HIV/AIDS research. NARN is also a potentially powerful medium for promoting essential research in HIV and AIDS, and creating synergy between various researchers and research organizations. Regulatory agencies for the conduct of HIV research include the National Health Research Ethics Committee (NHREC), domiciled in the DPRS; the Health Research Ethics Committees (HREC), domiciled mainly in health institutions in the country; and the National Agency for Food and Drug Administration and Control (NAFDAC). NHREC is vested with the responsibility for coordinating the regulation of the ethical conduct of research, while NAFDAC is vested with the responsibility of coordinating the conduct of clinical trials of drugs and medical devices.

8.1 Achievements by the end of 2014

- Capacity building for community engagement and participation in HIV research by community representatives, researchers, ethicists, advocates, activists, academia, and journalists was conducted extensively.⁶⁶
- The National Health Management Information System (NHMIS) was strengthened, and the capacity of facilities in the public and private-health sectors to provide data had improved. The monthly M&E review meetings at the level of some LGAs and the states had helped improve the quality and quantity of data generated for the HIV response.

⁶⁶ Folayan et al. Debating ethics in hiv research: gaps between policy and practice in Nigeria. DWB: 15(1): 1-7

- The establishment of the DHIS 2.0 at Federal, State, and LGA Ministries of Health has also enabled the system to coordinate information for other disease areas beyond HIV.
- In 2013, efforts to strengthen the country's NHMIS also commenced, with all disease program areas (malaria, tuberculosis, HIV) supporting the process of DHIS migration and integration.
- NACA and DPRS also commenced the implementation of health data reporting, using a DHIS mobile application for PHCs. In 2013, a pilot of the DHIS mobile application was conducted in 16 States and 80 PHCs. After an evaluation of the DHIS mobile pilot, the application was rolled out to additional 217 PHCs. The DHIS mobile was rolled out to 110 other PHCs in Delta and Kebbi States in 2015. More states with funding from the World Bank credit have completed plans to roll out the application to additional PHCs.
- Harmonization of the HIV and AIDS indicators, data collection, and reporting tools for health sector was concluded in 2012. Also, the training of trainers on the use of the harmonized tool has been conducted in 36 +1 States. The tools have been printed and deployed to the states. Efforts are ongoing to facilitate the step-down training of M&E officers in the states and LGAs.
- Similarly, harmonization of HIV and AIDS indicators, data collection, and reporting tools for non-health sector was concluded in 2013, and the prevention-data reporting tools were customized unto the DHIS 2.0. Training on the use of the tools and the DHIS 2.0 for data collecting and reporting of HIV/AIDS-prevention activities was concluded in 29 states in 2014.
- As of 2014, a total of 25 states hold regular monthly M&E meetings with the intent of implementing partners to review data for the month from service-delivery points in the state and to discuss ways of overcoming challenges of data quality. Similarly, all states hold quarterly data-validation meetings aimed at building consensus on data generated in the state before reporting the data as part of the national data.
- Data verification and data quality assurance involving all the relevant donors and partners are conducted consistently twice every year. Data quality-assurance review is conducted jointly by all partners sponsored by USAID, GFATM-NACA with funds from the Nigerian government under the leadership of the FMOH and NACA. In 2012, all states participated in this process.
- In 2011, seven Enhancing National HIV and AIDS Response (ENR) states conducted their State HIV and AIDS Reproductive Health Survey (SHRHS). The outcomes of these studies have been used for the planning of the HIV prevention programmes in the states as well as being used as an advocacy tool for state resourcing of the HIV response.
- In 2011, the World Bank supported the conduct of the impact evaluation of the community response to HIV/AIDS in Nigeria. The report showed that strong CBO engagement has the potential to add value to the national response to HIV/AIDS. The study findings suggest that CBOs have a greater impact in rural areas, most likely because they are the only service providers there, whereas in urban areas, community members have more access to a greater range of service providers,

including public health-care facilities, and the value added by CBOs is lower than in rural areas.

- In 2012, the Ford Foundation supported nationally representative research on the sexual and reproductive health needs of adolescents living with HIV and AIDS (ALHIV). The outcome of this study has helped highlight the needs of ALHIV and promoted the development of programmes targeting ALHIV by NACA and UNICEF.
- In 2012, WHO commissioned two operational studies on PMTCT. The operational research focused on identifying ways that community engagement could improve access to PMTCT. One of the studies promoted support for the use of mentor mothers to enhance retention of HIV-positive pregnant women and their babies in care.
- In 2012, NACA implemented the PrEP formative research⁶⁷ and has since commenced the design and implementation of the PrEP demonstration research. The development of the implementation is supported by WHO and the Bill and Melinda Gates Foundation through Georgetown University, USA.
- NACA issued nine HIV research grants in 2013 and another nine in 2015. The grants issued in 2013 tried to identify mechanisms for enhancing HCT access, models for ART decentralization, and to address drivers of the HIV epidemic. The grants for 2015 focused on generating evidence to improve the PMTCT response in Nigeria.
- In 2010-2014, the Institute of Human Virology, Nigeria (IHV-N) implemented the HIV vaccine demonstration project. The purpose of the project was to develop the capacity of the community, NHREC, NACA, and NAFDAC to conduct a phase III HIV vaccine clinical trial.
- Other national studies conducted during the reporting period were the Integrated Biological Behavioural Surveillance Survey; the second round of the Mode of Transmission Studies; the audio-computer assisted self-interviewing (ACASI) study; ethnographic studies of PWID and MSM; the National and State AIDS Spending Assessment studies; the ANC sentinel survey; and 16 state epidemic appraisals.
- The National HIV & AIDS Resource Centre was launched in 2012, and the process of integrating the virtual and physical component will take place in 2013. It is hoped that the centre will eventually host all HIV- and AIDS-related publications, thus facilitating access to HIV-related publications in Nigeria.
- The 2011–2014 Global AIDS Response Country Progress Report, the UNAIDS Ten Target report, the Joint Annual Review for 2011 and 2012 reports, the 2013 Mid-term Review report, and the 2011-2014 NACA Annual reports were developed.
- By December 2014, NACA had developed an operational work plan and had supported about 80% of SACA and the FSACA to do the same.

8.2 Achievement against 2015 NSP indicators

- *Target 1 – Improve the coordination and cost effectiveness of data collection, analysis, and use of programme data and information to inform decision making by stakeholders by 2015:* There are evidences to suggest that the data collected at the

⁶⁷ Idoko J et al. BMC prep

national and state levels are analysed and used to inform strategic decision making. Evidence based-HIV programming in Nigeria has increased.

- *Target 2 – Improve HIV evaluation, research, and learning agenda and use the information to enhance the national response.* The HIV response evaluation process has improved significantly. Annual reviews of the HIV response were conducted, as was a mid-term review. An End-of-Term review is also being planned. The outcomes of the review inform the design and implementation of the stakeholder programmes.
- *Target 3 – Improve data quality and supportive supervision at all levels by 2015.* The data quality has improved significantly through the adoption of the DHIS 2.0 Platform. The state monitoring visits have helped enhance the data quality, as have the LGA, State, and National data verification exercises, which have averaged two exercises per each facility providing HCT services.

8.3 Challenges

- Efforts at integrating the existing DHIS platforms in the country started in 2013. Progress has been slow.
- There is still a significant gap in the collection of data from the non-health sector. Many CSOs receive grants to implement HIV response in Nigeria independent of the funders who support the national response. The data of these independent HIV programmes are not captured.
- The HIV-response activities of the private-health sector are also not captured by the national response.
- No formal mechanism is in place in Nigeria for in-country dissemination of HIV results. There should be national meetings, forums, or conferences where lessons learnt, best practices, and research findings can be shared. For example, mentor mothers help with data entry at ANC clinics for IHVN sites, and in Lagos State, the health care.
- While there are still challenges with record keeping of health data at all levels of health care, many states have developed innovative approaches to tackle these challenges, especially those associated with daily data entry.
- The ability to do data analysis and reporting is still weak in many LGAs. This problem affects the ability of LGAs to submit timely reports or to use the reports for evaluation.
- Data flow from local community intervention groups and health facilities still needs improvement. Although there is now a national standard in DHIS 2.0, many local facilities do not have the personnel and systems needed to support electronic data transfer.
- Data collection and collation process has improved significantly during the NSP II implementation period. This improvement has, however been largely driven through the support of IPs, who have provided, training, technical support, and incentives for generation, collation, and submission of data. It is important now to explore how to sustain this process in the absence of donor funding.

- The DHIS 2.0 for collection and collation of the health-sector data is progressing well. However, the data generation process at the provider's point-of-service still needs to be improved, as is the timely reporting of data.

8.4 Appraisal of the NSP performance indicators

- As the HIV response matures, there is need to revise the HIV response performance indicators to focus more on impact assessment and less on process. This review has approached the review of the NSP performance indicators in that context.
- Each of the NSP performance indicators was reviewed for its ability to measure progress in the intervention implemented by stakeholders, its compliance with the focus of the NSP, and its alignment with the UNAIDS standards for measuring core national indicators and the PCRPs strategies during the 2013 Mid-term review. The appraisal was based on the outcomes in the 2011 and 2012 Joint Annual Review reports, the outcome of the 2013 Mid-Term Review, and the appraisal of impact of HIV response programmes in 2014. The proposals made during the 2013 Mid-term review should be adopted.

ANNEX 1: REVISED INDICATORS WITH 2012 ACHIEVEMENTS FOR THE NSP

It is imperative to review, reduce and clearly define the indicator set for monitoring the next round of NSP to measurable indicators, so they are aligned with both the national and global reporting requirements. The table below is a suggested list, which will be subjected to further review during the development of the 2016-2020 NSP.

Indicators: Promotion of Behavior Change and Prevention of New HIV Infections	2014 Baseline	2020 Target
Objective 1: At least xx% of the national population access HCT services by 2020		
⁶⁸ Percentage of children (0-9) who have been counselled, tested and received results in the past 12 months	NA	
Percentage of children (10-14) who have been counselled, tested and received results in the past 12 months	NA	
⁶⁹ Percentage of adolescents (15-19) who have been counselled, tested and received results in the past 12 months	Male: - 356,003 Female: - 418,426	
Percentage of young adults (20-24) who have been counselled, tested and received results in the past 12 months	Male: - 591,903 Female: - 717,358	
⁷⁰ Percentage of adults (25 -49) who have been counselled, tested and received results in the past 12 months	⁷¹ 17.5% ⁷² Male: 1,568,014 ⁷³ Female: 1,709,985	
Percentage of adults (\geq 50) who have been counselled, tested and received results in the past 12 months	Male: - 279,196 Female: - 302,608	
Percentage of health facilities providing HCT	⁷⁴ 31.2%	
Objective 2: At least xx% of sexually active persons in Nigeria with STIs have access to services by 2020		
Percentage of sexually active males and females with STI symptoms who accessed treatment services	Male: 65.0% Female: 47.0%	
Percentage of pregnant women counseled and tested for HIV and received test result	46.0%	
Objective 4: At least xx% of all HIV-positive women access ARV prophylaxis by 2020		
Percentage of HIV-positive pregnant women who received ARV prophylaxis to reduce the risk of mother to child transmission of HIV	30.2%	

⁶⁸ Number of 0-14 year old children as at July 2012: male 38,232,053; female 36,483,243 (Index Mundi)

⁶⁹ Number of 15-19 year old children as at July 2012: male 38,232,053; female 36,483,243 (Index Mundi)

⁷⁰ Number of 25 year old and above as at July 2012: male 30,430,703; female 32,201,716 (Index Mundi)

⁷¹ The total population of study participants 25 – 49 years was 106,042. NARHS 2012

⁷² 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

⁷³ 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

⁷⁴ Only 8,114 of the 26,000 facilities are providing HCT in 2014.

Percentage of HIV-infected pregnant women who were assessed for ART eligibility through either clinical staging or CD4 testing during the period	34.8%	
⁷⁵ Percentage of health facilities providing PMTCT services	25.2%	-
Objective 5: At least xx% of all HIV-exposed infants have access to ARV prophylaxis by 2020		
⁷⁶ Percentage of HIV-exposed infants who received ARV prophylaxis	72.6%	
Percentage of HIV-exposed infants who were started on co-trimoxazole prophylaxis within two months of birth	83.5%	
Objective 6: At least xx% of all HIV-exposed infants have access to early infant diagnosis services by 2020		
⁷⁷ Percentage of HIV-exposed infants who received a virological test for HIV within 2 months of birth	12.4%	
Objective 7: At least xx% of all persons in Nigeria have comprehensive knowledge on HIV and AIDS by 2020		
Percentage of persons who correctly identified ways of preventing and rejected major misconceptions the sexual transmission of HIV	25.4%	
Percentage of adolescents aged 15–19 who correctly identified ways of preventing and rejecting major misconceptions the sexual transmission of HIV	Male: 19.5% Female: 16.6%	
Percentage of young adults aged 20–24 who correctly identify ways of preventing and rejecting major misconceptions the sexual transmission of HIV	Male: 32.3% Female: 22.2%	
Objective 8: At least xx% of young persons 15 – 24 years old adopt appropriate HIV and AIDS related behaviour by 2020		
Percentage of 15-19 year olds who have had sexual intercourse before the age of 15 years	Male: 22.2% Female: 42.9%	
Percentage of 15-19 year olds who reported the use of a condom during their last intercourse with non-marital sex partner	Male: 47.8% Female: 28.7%	
Percentage of 20-24 year olds who reported the use of a condom during their last intercourse with non-marital sex partner	Male: 54.2% Female: 38.7%	

⁷⁵ There were 6,548 of the 26,000 healthcare facilities providing PMTCT services.

⁷⁶ NACA: Report of the UNAIDS Ten Target, July 2013
⁷⁷ FMOH 2014 data

Percentage of 15-19 year olds who engage in transactional sex	Male: 8.8% Female: 6.9%	-
Percentage of 20-24 year olds who engage in transactional sex	Male: 6.1% Female: 10.3%	-
Percentage of 15-19 who have had sexual intercourse with more than one partner in the last 12 months	Male: 26.4% Female: 4.7%	-
Percentage of 20-24 who have had sexual intercourse with more than one partner in the last 12 months	Male: 28.8% Female: 4.8%	-
Percentage of 15 to 19 who are living with HIV	1.7% Male: 2.1% Female: 1.3%	-
Percentage of 20 to 24 who are living with HIV	3.2% Male: 1.9% Female: 4.5%	-
Objective 9: At least xx% of sexually active adults use condom with non-marital partners by 2020		
Percentage of adults 15 -19 years who reported the use of a condom during their last intercourse with non-marital sex partner	Male: 56.4% Female: 48.0%	-
Percentage of adults 20 -24 years who reported the use of a condom during their last intercourse with non-marital sex partner	Male: 64.8% Female: 58.1%	-
Percentage of adults 25 -49 years and above who reported the use of a condom during their last intercourse with non-marital sex partner	Male: 62.9% Female: 40.8%	-
Percentage of adults 50 years and above who reported the use of a condom during their last intercourse with non-marital sex partner	Male: 37.7% Female: 37.7%	-
Objective 10: Reduce transmission of HIV among MSM 50% by 2020		
Percentage of MSM who reached with minimum HIV prevention package	NA	-
Percentage of MSM who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	NA	-
Percentage of MSM who have been counselled, tested and received results in the past 12 months	NA	-

Percentage of MSM who reported use of condom during last anal sexual intercourse with a male partner	NA	
Percentage of MSM who reported the use of lubricant during last anal sexual intercourse with a male partner	NA	
Percentage of MSM with STI symptoms who accessed treatment services in health facilities	NA	
Percentage of MSM living with HIV	NA	
Objective 11: Reduce transmission of HIV among FSW 50% by 2020		
Percentage of FSW reached with minimum HIV prevention package	NA	-
Percentage of FSW who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	NA	
Percentage of FSW who have been counselled, tested and received results in the past 12 months	NA	-
Percentage of FSW who reported use of condom during last sexual intercourse	NA	
Percentage of FSW with STI symptoms who accessed treatment services in health facilities	NA	
Percentage of FSW living with HIV	NA	
Objective 12: Reduce transmission of HIV among PWID 50% by 2020		
Percentage of PWID reached with minimum HIV prevention package	NA	-
Percentage of PWID who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	NA	
Percentage of PWID who have been counselled, tested and received results in the past 12 months	NA	
Percentage of PWID who reported use of condom during last sexual intercourse	NA	
Percentage of PWID who used sterile injecting drug equipment the last time they injected	NA	
Percentage of PWID with STI symptoms who accessed treatment services in health facilities	NA	

Percentage of PWID living with HIV	NA	-
Objective 13: Reduce acquisition of HIV infection among general population by 50% by 2020		
Percentage of reported HIV exposure who received post-exposure prophylaxis	91.4%	
Percentage of HIV negative clients using PrEP	NA	
Percentage of health facilities providing post-exposure prophylaxis and PrEP	-	
Percentage of People living with HIV	3.4%	

Indicators: Treatment of HIV/AIDS and Related Health Conditions	2014 Baseline	2020 Target
Objective 1: At least xx% of adults and children who are eligible have access to antiretroviral treatment by 2020		
⁷⁸ Percentage of eligible adults and children receiving ART at CD4 350/mm ³	48.0%	
⁷⁹ Percentage of eligible children (0-9 years) receiving ART at CD4 350/mm ³	NA	
Percentage of eligible adolescents (10-14 years) receiving ART at CD4 350/mm ³	NA	
Percentage of eligible adolescents (15-19 years) receiving ART at CD4 350/mm ³	Male: Female:	
Percentage of eligible young adults (20-24 years) receiving ART at CD4 350/mm ³	Male: Female:	
Percentage of eligible adults (≥50 years) receiving ART at CD4 350/mm ³	Male: Female:	
Objective 2: At least xx% of adults and children eligible for ART are retained on treatment by 2020		
⁸⁰ Percentage of adult and children with HIV known to be on treatment 12 months after initiation of therapy	81.5%	
Percentage of children (0-9 years) with HIV known to be on treatment 12 months after initiation of therapy		
Percentage of eligible adolescents (10-14 years) with HIV known to be on treatment 12 months after initiation of therapy	Male: Female:	
Percentage of eligible adolescents (15-19 years) with HIV known to be on treatment 12 months after initiation of therapy	Male: Female:	
Percentage of eligible young adults (20-24 years) with HIV known to be on treatment 12 months after initiation of therapy	Male: Female:	
Percentage of eligible adults (≥50 years) with HIV known to be on treatment 12 months after initiation of therapy	Male: Female:	
Percentage of health facilities providing ART	⁸¹ 4.1%	-

⁷⁸ FMOH: 2014 report

⁷⁹ NACA: Report of the UNAIDS Ten Target, July 2013

⁸⁰ NACA: Report of the UNAIDS Ten Target, July 2013

⁸¹ 1057 of the 26,000 facilities provide ART treatment

Objective 3: At least xx% of adults and children retained on antiretroviral treatment after initiation are virally suppressed by 2020		
82Percentage of adult and children on ART that are virally suppressed	Male: NA Female: NA	
Percentage of children (0-9 years) with HIV on ART that are virally suppressed	Male: NA Female: NA	
Percentage of eligible adolescents (10-14 years) with HIV on ART that are virally suppressed	Male: NA Female: NA	
Percentage of eligible adolescents (15-19 years) with HIV on ART that are virally suppressed	Male: NA Female: NA	
Percentage of eligible young adults (20-24 years) with HIV on ART that are virally suppressed	Male: NA Female: NA	
Percentage of eligible adults (≥50 years) with HIV on ART that are virally suppressed	Male: NA Female: NA	
Objective 4: At least xx% of adults and children enrolled in care have access to IPT by 2020		
Number of adults and newly enrolled in HIV care	Male: 41,253 Female: 94,365	-
Number of children newly enrolled in HIV care	Male: 4,729 Female: 4,706	
Percentage of children (0-9 years) newly enrolled in HIV care receiving IPT		
Percentage of eligible adolescents (10-14 years) newly enrolled in HIV care receiving IPT		
Percentage of eligible adolescents (15-19 years) newly enrolled in HIV care receiving IPT		
Percentage of eligible young adults (20-24 years) newly enrolled in HIV care receiving IPT		
Percentage of eligible adults (≥50 years) newly enrolled in HIV care receiving IPT		
Objective 5: At least xx% of adults and children enrolled in care have access to co-trimoxazole by 2020		
Number of adults enrolled in care (Pre-ART and ART)	Male: 265,346 Female: 628,184	

⁸² NACA: Report of the UNAIDS Ten Target, July 2013

Number of children enrolled in care (Pre-ART and ART)	Male: 27,305 Female: 32,578	
Percentage of adults and children enrolled in care receiving co-trimoxazole prophylaxis	83.5%	
Percentage of children (0-9 years) enrolled in care receiving co-trimoxazole prophylaxis		
Percentage of eligible adolescents (10-14 years) enrolled in care receiving co-trimoxazole prophylaxis	-	-
Percentage of eligible adolescents (15-19 years) enrolled in care receiving co-trimoxazole prophylaxis	-	-
Percentage of eligible young adults (20-24 years) enrolled in care receiving co-trimoxazole prophylaxis		
Percentage of eligible adults (≥ 50 years) enrolled in care receiving co-trimoxazole prophylaxis		
Objective 6: At least 100.0% of PLHIV have access to comprehensive TUBERCULOSIS services by 2020		
⁸³ Percentage of adults and children with HIV in care screened for TUBERCULOSIS	80.7%	
Percentage of children (0-9 years) with HIV in care screened for TUBERCULOSIS		
Percentage of eligible adolescents (10-14 years) with HIV in care screened for TUBERCULOSIS		
Percentage of eligible adolescents (15-19 years) with HIV in care screened for TUBERCULOSIS		
Percentage of eligible young adults (20-24 years) with HIV in care screened for TUBERCULOSIS		
Percentage of eligible adults (≥ 50 years) with HIV in care screened for TUBERCULOSIS		
⁸⁴ Percentage of estimated HIV-positive incident TUBERCULOSIS cases that received treatment for both TUBERCULOSIS and HIV		
Percentage of ART facilities with integrated ART and chronic non-communicable diseases services	NA	-

⁸³ Ditto

⁸⁴ Ditto

Indicator: Care and Support of PLHIV, PABA, and OVC	2015 Baseline	2020 Target
Objective 1: At least xx% of pre-ART adults and children are enrolled in care by 2020		
Percentage of PLHIV who have received care and support services	Male: 66,950 Female: 139,620	
Percentage of health facilities linked with community based programmes for PLHIV and PABA	-	
Objective 2: Reduce stigma and discrimination faced by adults and children living with HIV by 50% by 2020		
Percentage of PLHIV who report experience of social exclusion in the past 12 months	⁸⁵ 33.9%	
Percentage of PLHIV who face violence (e.g. verbally insulted, assaulted or threatened, physically harassed or assaulted because of HIV status).	-	
Percentage of PLHIV who face discrimination in health care settings (e.g. denied services, including dental care, SRH and FP services)	⁸⁶ 20.0%	
Percentage of PLHIV who face discrimination in the work place (e.g. loss of job or income, employment opportunity refused)	⁸⁷ 29.0%	
Objective 3: Increase State protection of OVC by 100% by 2020		
Percentage of states with legal framework for protection of OVC	23+1 States	
Number of states with established OVC coordinating structures		

⁸⁵ NEPWHAN: People Living With HIV Stigma Index. 2010

⁸⁶ NEPWHAN: People Living With HIV Stigma Index. 2010

⁸⁷ NEPWHAN: People Living With HIV Stigma Index. 2010

Indicators: Policy, Advocacy, Human Rights, and Legal Issues	2010 Baseline	2012 Target
Objective 1: xx% of State protect the rights of PLHIV		
Percentage of states with anti-stigma law	10.8%	
Objective 2: Facilitate greater involvement of PLHIV on HIV/AIDS national decision making bodies		
Percentage of national technical working groups with PLHIV on its membership	100.0%	-
Percentage of national HIV related policies that address the needs of PLHIV	-	-
Objective 3: Compliance with ethical standards in HIV/AIDS		
Number of HRECs trained on ethical consideration of HIV research		
Percentage of health facilities providing ART services with trained staff on ethics of HIV clinic service delivery	-	-

Indicators: Institutional Architecture, Systems, Coordination, and Resources	2010 Baseline	2012 Target
Objective 1: xx% of SACA and LACA has capacity to coordinate the multi-sectoral response by 2020		
Percentage of SACA that have 80% of their budget funded by the government		
Percentage of LGAs with LACA	77.9%	-
Percentage of NACA and SACA with annual HIV work-plan		-
Objective 2: xx% of SACA and LACA has coordination mechanism for all partners by 2020		
Percentage of SACA that submit reports to NACA biannually	90%	
Percentage of LACA that submit reports to SACA biannually		
Percentage of the CSO coordinating entities who submit reports to NACA biannually		
Percentage of international partners that submit reports to NACA biannually	80%	
⁸⁸ Percentage of SACA that have partnership coordination frameworks		-
Objective 3: 100% of CCE have coordination mechanism by 2020		
Percentage of CSO coordinating entities implementing at least 80.0% of their workplan		
Objective 4: 100% of national and state response mechanisms have logistic management system to ensure supply of HIV prevention and treatment commodities by 2020		
Percentage of facilities that do not experience ARV stock-out annually		
Percentage of facilities that do not experience HIV test kit stock-out annually	96.9%	
Percentage of facilities that do not experience male and female condom stock-out annually	-	
Percentage of States with Logistics Technical Working Group	-	

Number of LGAs that have a Planned Preventive Maintenance (PPM) program established	-	
Objective 5: At least 80.0% of the HIV response is financed by government by 2020		
Percentage of Government contribution to annual HIV spending		-
Percentage of states contributing 50.0% of the financial resources to implement their State HIV/AIDS strategic plans	-	40.0%
Percentage of target (12+1) States resourcing 80% of their funding allocation in line with the PCRPP requirement	-	-

⁸⁸ This is developed in view of the requirement of the PCRPP: Table 7

Indicators: Monitoring and Evaluation Systems	2015 Baseline	2020 Target
Objective 1: 100% of NACA, SACA and LACA have M&E framework by 2020		
Percentage of States with M&E partnership framework (TWG)	⁸⁹ 64.7%	100%
Percentage of States with M&E systems and structure	⁹⁰ 82.3%	100%
Percentage of line ministries with M&E systems and structure	⁹¹ 15.4%	100%
Percentage of CSO coordinating bodies with M&E systems and structure	⁹² 22.2%	100%
Percentage of States M&E unit having personnel with skills (epidemiologist, biostatistics, evaluation, modeling and documentation)	⁹³ 44.1%	100%
Objective 2: 100% of SACA using HIV data for decision making by 2020		
Percentage of State analyzing and using HIV programme data and information to decision making	⁹⁴ 79.4%	100%
Objective 3: 100% of SACA have HIV evaluation, research and learning agenda by 2020		
Percentage of States commissioning evaluation research to enhance national response	⁹⁵ 20.5%	100%
Percentage of States commissioning operations research to enhance response	⁹⁶ 32.3%	100%
Percentage of HIV programmes/project with periodic evaluation Plan	⁹⁷ 52.9%	100%
Objective 4: 100% of States undertake supportive supervision by 2020		
Percentage of States conducting supportive supervision	⁹⁸ 79.4%	100%
Percentage of States conducting data validation meetings	⁹⁹ 79.4%	100%
Percentage of states submitting data in a timely fashion	¹⁰⁰ 61.7%	100%

Objective 5: 100% of state have costed M&E plans by 2020		
Percentage of NACA and SACA with multi-sectorial costed HIV M&E plan	¹⁰¹ 65.7%	100%
Percentage of states that completed M&E activities	¹⁰² 11.4%	100%
Percentage of line ministries that completed M&E activities	0.0%	100%
Percentage of CSO networks that completed M&E activities	0.0%	100%
Objective 6: 100% of State submit data to the DHIS by 2020		
Percentage of states submitting data into the national (integrated) HIV/AIDS database (DHIS)	¹⁰³ 73.5%	100%

⁸⁹ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 22 States reported they has state M&E framework

⁹⁰ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 28 States reported they has institutionalized M&E framework

⁹¹ Possibly two MDAs out of the 13 MDAs

⁹² Two network has some form of M&E system

⁹³ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 15 States reported they had personnel trained in at least one of the enquiry areas

⁹⁴ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 27 States reported analyzing and using their data for decision making

⁹⁵ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 7 States reported commissioning evaluation research to enhance state response

⁹⁶ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 11 States reported commissioning operation research to enhance state response

⁹⁷ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 18 States reported their HIV response had period evaluation conducted

⁹⁸ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 27 states reported that they conduct data validation meetings

⁹⁹ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 27 states reported that they conduct data validation meetings

¹⁰⁰ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 21 State reported submitting timely data

¹⁰¹ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 22 State and NACA had multi-sectorial costed HIV M&E

¹⁰² A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 3 States and NACA completed their M&E activities

¹⁰³ A survey was conducted during the training of the 34 + 1 states on the JAR, MTR, HPDP2. October 2013. 25 States submit data to the DHIS