FROM THE DIRECTOR GENERAL

The national agency for the control of AIDS (NACA) was established in May 2007 by an enabling act of the Federal Republic of Nigeria and saddled with the responsibility of coordinating the multi sectoral response to HIV/AIDS. I wish to present the stewardship of the agency for the year 2012, in line with the national strategic plan 2010-2015.

The year 2012 recorded remarkable progress in the national response to the epidemic and currently the national median prevalence stands at 4.1% which indicates that the country has started to halt and reverse spread of the epidemic in line with the MDG goal 6 and targets for HIV.

Funding for the HIV/AIDS Response by government increased from 7.6% in 2008 to 25% in 2010. In an effort to reach Universal access targets the number of people counselled, tested and received their results in 2012 was 2,792,611 from 2391 sites. Number of pregnant women counselled, tested and know their results during the year was 1,289,791 from 1410 PMTCT sites, while a total of 491,021 are on treatment from 516 ART sites.

The Most at Risk Populations (MARPs) received high priority in the year under review, mapping of MARPs hotspots and size estimation for MARPs (FSW, IDU, MSM) was completed in 16 states. The mapping and size estimation will help to better target these populations with HIV/AIDS interventions. The PMTCT programme is being scaled up to the primary health care level to boost access and coverage to ARVs for pregnant women and eliminate MTCT.

The national response continued to grapple with challenges within the year despite the recorded achievements. The response continuous dependence on donor support to finance most of its programmes is a great challenge to sustainability and ownership. The inability of some states to transform into agencies has also post significant challenge to proper coordination of the response at the state level.

The national response would not have recorded these achievements without the support of our partners. I wish to thank all and solicit for your continued support and collaboration as we advance towards zero AIDS related deaths, zero discrimination and zero new infection in the national response.

Professor John Idoko

Director General, National Agency for The control of AIDs (NACA)
### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-Retroviral</td>
</tr>
<tr>
<td>CCE</td>
<td>Country Coordinating Entity</td>
</tr>
<tr>
<td>CCM</td>
<td>Country coordinating mechanism</td>
</tr>
<tr>
<td>CiSHAN</td>
<td>Civil Society for HIV/AIDS in Nigeria</td>
</tr>
<tr>
<td>CRIS</td>
<td>Country Response Information System</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>DRG</td>
<td>Debt Relief Gains</td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>FLHE</td>
<td>Family Life HIV/AIDS Education</td>
</tr>
<tr>
<td>FME</td>
<td>Federal Ministry of Education</td>
</tr>
<tr>
<td>FMoH</td>
<td>Federal Ministry of Health</td>
</tr>
<tr>
<td>FSW</td>
<td>Female sex worker</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GF</td>
<td>Global Fund</td>
</tr>
<tr>
<td>GIPA</td>
<td>Greater Involvement of Persons Living with HIV/AIDS</td>
</tr>
<tr>
<td>GTT</td>
<td>Global Task Theme</td>
</tr>
<tr>
<td>GoN</td>
<td>Government of Nigeria</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HCT</td>
<td>HIV Counselling &amp; Testing</td>
</tr>
<tr>
<td>IBBSS</td>
<td>Integrated Bio-Behavioral Surveillance Survey</td>
</tr>
<tr>
<td>ICAP</td>
<td>International Centre for AIDS Care and Treatment Programs</td>
</tr>
<tr>
<td>IDUs</td>
<td>Injecting Drug Users</td>
</tr>
<tr>
<td>JMTR</td>
<td>Joint Midterm Review</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
</tbody>
</table>
MDAs  Ministries Departments and Agencies
M&E  Monitoring and Evaluation
MSM  Men Having Sex with Men
MTCT  Mother to Child Transmission
NACA  National Agency for the Control of AIDS
NAPP  National Priority Action Plan
NARHS  National AIDS and Reproductive Health Survey
NARN  National AIDS Research Network
NASA  National AIDS Spending Assessment
NASCP  National AIDS and STI Control Programme
NAWOCA  National Coalition of Women against AIDS
NBTS  National Blood Transfusion Service
NCPI  National Composite Policy Index
NDN  Nigeria Diversity Network
NFACA  National Faith-based Advisory Council on AIDS
NEPWAN  Network of People Living with HIV/AIDS in Nigeria
NGO  Non-Governmental Organization
NIBUCCA  Nigerian Business Coalition against AIDS
NLNG  Nigeria Liquefied Natural Gas Project
NNRIMS  Nigeria National Response Information Management System
NPC  National Population Commission
NSF  National Strategic Framework
NTBLCP  National TB and Leprosy Control Programme
NTWG  National Monitoring and Evaluation Technical Working Group
NYNETHA  Nigerian Youth Network on HIV/AIDS
OVC  Orphans and Vulnerable Children
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>Presidential Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission of HIV/AIDS</td>
</tr>
<tr>
<td>SACA</td>
<td>State Action Committee on AIDS</td>
</tr>
<tr>
<td>SAPC</td>
<td>State AIDS Programme Coordinator</td>
</tr>
<tr>
<td>SFH</td>
<td>Society for Family Health</td>
</tr>
<tr>
<td>SME</td>
<td>Small and Medium Enterprises.</td>
</tr>
<tr>
<td>SPDC</td>
<td>Shell Petroleum Development Company</td>
</tr>
<tr>
<td>SR</td>
<td>Sub recipient</td>
</tr>
<tr>
<td>SSP</td>
<td>State Strategic Plan</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UA</td>
<td>Universal Access</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
</tbody>
</table>
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CHAPTER 1: INTRODUCTION

1.1 The global and regional overview of HIV Epidemic

THE GLOBAL EPIDEMIC OF HIV/AIDS

More than 25 years into the HIV/AIDS pandemic, it remains one of the most serious public health concerns. As of 2011, 34 million people approximately were living with HIV; 17.2 million men and 16.8 million women. Globally, 2.5 million people were newly infected with HIV in 2011, down from 3.2 million in 2001. 7000 new infections occurring each day and at least 95% of all new infections occur in less developed countries. Almost a quarter of people living with HIV are under the age of 25 and an estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, however the burden of the epidemic continues to vary consistently between countries and regions. The majority of people with HIV do not know their HIV status.

Sub-Saharan Africa is the hardest hit region, followed by the Caribbean. In 2010, an estimated 68% (22.9 million) of all HIV cases and 66% (1.2 million) of all the deaths occurred in this region. HIV infection is becoming endemic in sub-Saharan Africa, which is about 12% of the world’s population but with two-third of all people infected with HIV. More women are infected than men, with 13 women infected for every 10 infected men. Adult HIV prevalence rate is 5.0% and between 21.6 million and 24.1 million total are affected. However, the actual prevalence varies between regions.

Eastern Africa also experiences relatively high level of prevalence with estimates above 10% in some countries, although there are signs that the pandemic is declining in this region. West Africa on the other hand has been much less affected by the pandemic. Several countries reportedly have prevalence around 2 to 3% and no country has rates above 10%. In Nigeria and Cote d’ Ivoire, two of the region’s most populous countries, between 5 and 7% of adults are reported to carry the virus.

South and South East Asia (a region with about 2 billion people as of 2010, over 30% of the global population) have an estimated 4 million cases (12% of all people living with HIV/AIDS) with about 280,000 deaths in 2010. Approximately 2.5 million of these cases are in India; however the prevalence is only about 0.3%. The prevalence is lowest in East Asia at 0.1%.

In in Latin America 1.4 million people are living with HIV with 83,000 people newly infected with the diseases compared to 900,000 in western and Central Europe.
The pandemic is not homogeneous within the regions, with some countries more affected than the others even at the country level, there are wide variations in infection levels between different areas. However, the number of people infected with HIV continues to rise despite the implementation of prevention strategies.

### 1.2 HIV/AIDS in Nigeria

Nigeria with an estimated population of 160 million, has an HIV prevalence of 4.1% (ANC, 2010), 281,181 new infections occur annually. An estimated 3.5 million Nigerian are living with the virus, out of which 1.5 million persons are eligible for antiretroviral. The country ranked second to South Africa in the number of people living with HIV/AIDS in the world, representing 9% of the global burden of the disease.

The Chart below shows the trend of HIV prevalence in the country

The HIV/AIDS prevalence varies from state to state in the various geopolitical zones of the country, with prevalence ranging from 1.0% in Kebbi State to 12.7% in Benue State. A total of 16 States and FCT had prevalence above 5%. Five of the six States in the South South Zone, three of the five in the South East Zone, five of the seven in North Central Zone, two of the six in North East Zone, and one of the six in South West Zone had prevalence of 5% and above. The three States with the highest prevalence are Benue, Akwa Ibom and Bayelsa. The prevalence was generally higher in urban than rural areas except in eight States, namely Benue, Adamawa, Kaduna, Akwa Ibom, Yobe, Jigawa, Kebbi and Ondo where the reverse was the case. The highest site prevalence of 21.3% in the country was
reported in Wannune (Benue State) while the lowest prevalence of 0.0% was reported in four sites, namely Kwami (Gombe State), Rano (Kano State), Owhelogbo (Delta State) and Ganawuri (Plateau State). The prevalence rose with increasing age-group and peaked at age 30-34 years (5.7%) after which it declined. A higher HIV prevalence among singles than married was observed

**States that have shown consistent increase in HIV prevalence from 2003 to 2010**

The Mode of Transmission (MOT) study reported that 62% of new infections occur among persons perceived as practicing ‘low risk sex’ in the general population including married sexual partners, while the persons practicing high risk sex including drug users (IDUs), female sex workers (FSWs) and men who have sex with men (MSMs) accounts for 32%. The leading route of transmission is heterosexual intercourse accounting for over 80% of HIV infections. Therefore evidence-based preventive interventions should be funded to ensure that higher numbers of Nigerians remain HIV negative. These new infections are fuelled by: low personal risk perception, multiple and concurrent sexual partnerships, intense transactional and intra-generational sex, ineffective and inefficient services for sexually transmitted infections (STIs), inadequate access to and poor quality of healthcare services. Entrenched gender inequalities and inequities, chronic and debilitating poverty, and
persistence of HIV/AIDS-related stigma and discrimination. The nation in fighting new HIV infections has constituted and mandated the new Prevention Technologies Technical Working Group (NPTTWG) to lead in the development of an updated, forward-looking and action-oriented National HIV vaccine plan that advances Nigeria’s capacity to contribute to vaccine research and development, in addition to the PMTCT scale up plan.

**Geographic Distribution of HIV Prevalence by State**

The National AIDS Spending Assessment (NASA) 2010 showed that the national response to HIV/AIDS in Nigeria was highly dependent on international funds accounting for 74.65% and government accounts for 25% of the total expenditure in 2010. The study revealed that 37.44% of the total amount went to care and treatment, 12.45% to prevention, 0.42% to research and 0.04% to social protection and social services.
The nation through NACA is doing a lot to combat the scourge of the epidemic, through Promotion of Behavior Change and Prevention of New HIV Infections, Treatment of HIV/AIDS and Related Health Conditions, Care and Support of PLHIV, PABA, and OVC, Policy, Advocacy, Human Rights, and Legal Issues, Institutional Architecture, Systems, Coordination, and Resourcing, Monitoring and Evaluation Systems comprising M&E, Research, and Knowledge Management as spelt out in the NSP 2010-2015. These processes are supported by HPDII, Global Fund and other donor agencies.
CHAPTER 2: AN OVERVIEW OF NATIONAL AGENCY FOR THE CONTROL OF AIDS (NACA)

The government of the federation established the National Committee on Aids in Year 2000 to coordinate the multi-sectoral response to HIV/AIDS. This committee became an agency in May 2007 by an enabling act of the Federal republic of Nigeria.

2.1 VISION
To make Nigeria a nation of people with functional knowledge of HIV/AIDS who provide care and support to individuals, families and communities confronted with the epidemic and the Agency is solely authorized to facilitate all stakeholder HIV/AIDS activities in the country.

2.2 Mission of NACA
To provide an enabling policy environment and stable ongoing facilitation of proactive multi-sectoral planning coordinated implementation, monitoring and evaluation of HIV/AIDS prevention and impact mitigation activities in Nigeria.

2.3 Mandates of NACA
- Coordinate and plan identified multi-sectoral HIV&AIDS activities of the National Responses;
- Facilitate the engagement of all tiers of government on issues of HIV&AIDS;
- Advocate for the mainstreaming of HIV&AIDS interventions into all sectors of the society;
- Develop and periodically update the strategic plan of the National Response programme;
- Provide leadership in the formation of policies and sector specific guidelines on HIV&AIDS;
- Establish mechanisms to support HIV&AIDS research in the country;
- Mobilize resources (local and foreign) and coordinate its equitable application for HIV&AIDS activities;
- Develop its own capacity and facilitate the development of other stakeholders capacity;
- Provide linkages with the global community on HIV&AIDS; and
- Monitor and evaluate all HIV&AIDS activities.
2.3 NACA Organogram
## 2.4 NACA Top management as at December 2012

<table>
<thead>
<tr>
<th>s/no</th>
<th>Name</th>
<th>Department/Unit</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Professor John Idoko</td>
<td>Office of the DG</td>
<td>Director General</td>
</tr>
<tr>
<td>2</td>
<td>Hajiya Maimuna Muhammed</td>
<td>Partnership coordination</td>
<td>Director</td>
</tr>
<tr>
<td>3</td>
<td>Mr. Emmanuel Chenge.</td>
<td>Administration &amp; support service</td>
<td>Ag. Director</td>
</tr>
<tr>
<td>4</td>
<td>Dr. Kayode Ogungbemi</td>
<td>Strategic Knowledge Management</td>
<td>Director</td>
</tr>
<tr>
<td>5</td>
<td>Mr. Alex Ogundipe</td>
<td>Policy &amp; Strategy</td>
<td>Director</td>
</tr>
<tr>
<td>6</td>
<td>Dr. Akudo Ikpeazuza</td>
<td>Program Coordination</td>
<td>Director</td>
</tr>
<tr>
<td>7</td>
<td>Mr. Nsikak Ebong</td>
<td>Finance &amp; Accounts</td>
<td>Director</td>
</tr>
<tr>
<td>8</td>
<td>Dr. Emmanuel Alhassan</td>
<td>Resource Mobilization</td>
<td>Director</td>
</tr>
<tr>
<td>9</td>
<td>Dr. Ibrahim Atta</td>
<td>Partnership Coordination</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>10</td>
<td>Dr. Greg Ashefor</td>
<td>Strategic Knowledge Management</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>11</td>
<td>Mr. James Ofodi</td>
<td>Internal Audit</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>12</td>
<td>Dr. Kenneth Kalu</td>
<td>Finance &amp; Accounts</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>13</td>
<td>Mr. Sam Archibong</td>
<td>Communication</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>14</td>
<td>Mr. Victor Udoidung</td>
<td>Administration &amp; support service</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>15</td>
<td>Dr Olufunke Oki</td>
<td>Policy and Strategy</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>16</td>
<td>Mrs Kalu Josephine U</td>
<td>Resource Mobilization</td>
<td>Deputy Director</td>
</tr>
<tr>
<td>17</td>
<td>Mrs Uwa Nne Samuel</td>
<td>Finance &amp; Account</td>
<td>Deputy Director</td>
</tr>
</tbody>
</table>

## 2.5 NACA Staff Profile as at December

<table>
<thead>
<tr>
<th>s/no</th>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Senior Staff</td>
<td>151</td>
</tr>
<tr>
<td>2</td>
<td>Junior Staff</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td><strong>Total number of staff</strong></td>
<td><strong>175</strong></td>
</tr>
</tbody>
</table>
CHAPTER 3: NACA OPERATIONS

The federal government established the National Committee on AIDS in 2000 to coordinate the multi-sectoral response to HIV/AIDS. This committee became an agency in May 2007 by an enabling act of the Federal republic of Nigeria; the agency has seven departments, with four units under the DGS' office.

3.1 Department of Administration and support services

3.1.1. Mandates:
- Responsible for the general administrative matters of the Agency,
- Providing administrative advice to the leadership of the Agency,
- Coordinating the Human resources administration,
- Relating the Agency to general administrative matter from the Public Services of the Federation,
- Planning and managing the work plan budget of the department,
- Coordinate capacity building activities of human resources for the agency
- Coordinating Performance management system for NACA Staff including staff requirements and maintaining harmonious staff relations,

3.1.2 Achievements
- Provided adequate office accommodation and equipment for efficient staff performance.
- The agency was kept connected with other organizations through an effective courier service.
- The department organized thirty five (35) management and One (1) senior staff committee meetings for the year.
- Conduct routine cleaning and fumigation of NACA environments, to ensure a healthy workplace.
- Ensure adequate security surveillance of the office premises.
- Conducted senior and junior staff promotions exercise
3.2 Department of Programme Coordination

3.2.1. Mandates

- Provide technical guidance and direction to multi sectoral programming for HIV prevention, care and support
- Facilitate the development, standardization and updating of draft programme coordination technical plans, strategy documents and tools (e.g. National Prevention plan (NPP), National SBCC strategy, etc.)
- Coordinate the activities of relevant programme coordination technical platforms e.g. National Prevention Technical Working Group (NPTWG), Social and Behaviour Change Communication (SBCC ) TWG and Care and Support TWG and gender Technical Committee
- Responsible for facilitating the development and updating of databases of stakeholders in key technical programme areas e.g. Prevention, ARV, care and support and Social and Behaviour Change Communication (SBCC)
- Provide technical assistance and managerial oversight for the day to day implementation of Global Fund, World Bank and other projects
- Work with partners to identify key target audiences and develop appropriate national campaign activities and messages based on research and the priorities of the national response to promote behaviour change, prevent new infections and generate demand for services
- Coordinate and advocate for scale up of prevention, treatment care and support interventions to meet set national targets
- Conduct capacity assessment, development and strengthening for MDAs, CSOs and other stakeholders in HIV technical interventions and activities
- Facilitate the mainstreaming of HIV and gender into sectoral plans and programs at all levels of the response
- Lead the promotion of behavioural change and prevention of new infection in Nigeria
- Lead and coordinate the care and support of PLHIV and PABA
3.2.2. Achievements

- Develop operational guidelines for FSW programme
- Development of national SBCC coordination toolkit
- Development of draft National community conversation toolkit
- Chaired the four National Prevention Technical working group meetings for the year
- Supported the institutionalization of SBCC in two Nigerian Universities by the C Change project
- Inauguration of National Technical Working Group for Care and Support

3.3 Department of Strategic Knowledge Management:

3.3.1. Mandates:

- Harmonization of indicator and standardization of the data tools and information and strengthening of second generation surveillance and HIV/AIDS operational research,
- Development and maintenance of the central database for strategic information on the national response
- Defining clear roles and responsibilities in monitoring and evaluation across different levels and sectors of the systems
- Facilitate and oversee efficient data transmission and feedback flow,
- Coordinating the use of HIV data in the national databank and or generated in country,
- Tracking progress in the implementation of the National HIV/AIDS response
- Using information to improve programme policies, service delivery including funding for M & E.
- Facilitate and coordinate the conduct of priority research in the national response
- Development of the requisite infrastructure for the monitoring and evaluation in Nigeria
- Development of the required human resources capacity across the national response

3.3.2. Achievements:

- Analysis of Epidemic appraisal data in 16 states for the impact evaluation of FSW programmes
- Production and distribution of harmonized health sector tools
- Production of the 2012 GARPR and UA reports
- Coordination of Nigeria participation in IAS in Washington
- Presentation of country report to UNAIDS
- Development of PF/IPR for HPDP2 project.
- The selection of nine operation research topics for commissioning.
- Chaired the four National M&E Technical working group meeting for the year.
- Supported two health and non-health sector data validation exercises to come up with one country data to meet national and international reporting obligations.
- Coordinated the production and launch of the National HIV vaccine plan
- Supported the development of state M&E plans.
- Coordinated the conduct of the joint national data quality assessment.

3.4 Department of Resource Mobilization:

3.4.1. Mandate:
- Project the financing gaps for the National HIV Response
- Develop, coordinate and support the implementation of NACA resource mobilization strategy
- Mobilize resources from FGN, bilateral and multilateral donors, philanthropic foundations, business sector & other sources
- Manage donor relationships & lead fund-raising nationally
- Support SACAs, LACAs, etc. in their fund-raising efforts; develop & promote innovative funding / implementation arrangements
- Provide leadership in the preparation of proposals for donor funding across all NACA programmes
- Lead & conduct market research to identify resource mobilization opportunities stakeholders’ opinions/practices
- Maintain updated information on current & potential sources of funding
- Track resource allocated throughout the implementation / reporting period.

3.4.2. Achievements:
- Conducted the Zonal and National consultations on Ownership & Sustainability of the National Response
• Commissioning of the National Call Centre on HIV/AIDS and Related Diseases (a PPP with Airtel, Etisalat, Skye Bank, Access Bank & Development Partners).
• Facilitation of partnership with O’Neill Institute, Georgetown University, NY and Bill & Melinda Gates Foundation on PrEP formative research. Facilitation of partnership with Children Investment Fund Foundation, UK for PMTC scales up.
• Commissioning of MTN supported Youth Friendly Centre in Olabisi Onobanjo University, Ago-Iwoye, Ogun State. The project is valued at N24 Million.
• Provision and activation of E1 line by Etisalat on the National Call Centre platform.
• Development and validation of the Resource Mobilisation Strategic Plan with support from ENR/SFH
• Development of call centre Business Plan with support from MSH.
• Successful implementation of GF supported workplace programme in 79 SME.
• Successful completion of SPDC funded NiDAR Plus project valued at $3 million.
• Facilitation of partnership meetings with MTV Foundation for Implementation of Shuga 3 (Shuga Nigeria) TV Reality Show
• Served as Secretariat for Abuja+10 Africa Summit Planning Committee
• Phase II of Chevron/NACA SME wellness programme in North Central and South West Nigeria commenced.
  Successfully coordinated 2012 World AIDS Day programme.

3.5. Department of finance and Accounts:

3.5.1. Mandates:
• Financial management of the agency (WB, GF, FGN) staff.
• Preparation of payment vouchers for salaries.
• Preparation of payment vouchers for other payments.
• Disbursement of funds to beneficiaries.
• Carrying out payment for the activities done by every department within and outside the city.
• Preparation and payment of VAT and WHT to the relevant authorities.
• Preparation of bank reconciliation.
• Preparation of financial report (quarterly, biannual or annual).
- Financial monitoring to state, line ministries, MDG’s etc.
- Preparation of payment schedule.
- Liaison with other government agencies and parastatal and financial institutions on financial matters.

3.5.2. **Achievements:**
- Training on Flexible Accounting software and SAP software for 10 new Account staff to be able to report using the soft wares.
- Financial monitoring visit to SR to access their financial records in line with GF guidelines.
- Asset verification exercise to sight physically GF assets in the facilities all over the country.
- Preparation of budget proposals

3.6. **Department of policy and strategy:**

3.6.1. **Mandate:**
- Promoting advocacy on issues related to HIV/AIDS and the associated national response
- Advocacy for the mainstreaming of HIV/AIDS interventions into all the sectors of the economy
- Provide leadership in the formulation of policies, and sector/gender specific guidelines on HIV/AIDS
- Facilitate the development of NACA strategic plan
- Encourage proactive planning of the national response and interventions on HIV/AIDS, Work planning, National Annual Priority Planning and National Strategic Framework Development
- Develop and periodically update the strategic plan for the national response program
- Coordination of donors providing support to the national HIV/AIDS response
- Liaison between NACA and the National Planning Commission
- Responsible for representing and coordinating development partners platform e.g. ETG, UNTG, DPG, JFA etc.
- Coordination of the NACA Global Fund Portfolio for effectiveness and efficiency and particularly deliverables through the inter-departmental coordinating mechanism.
• Leadership/Coordination of HIV/AIDS proposal development processes particularly in response to Global Fund call for proposal on behalf of the CCM.

3.6.2 Achievement:
• Trained 51 persons in the planning clinic from 13 MDAs, comprising of 3 officers each; (PM, M&E, and Prevention Officer) for the HPDPII programme.
• A number of 16 work plans were developed for transmission to World Bank for NO Objection.

3.7 Department: Partnership Coordination & Support

3.7.1 Mandate:
• Provide Leadership in partnership support and coordination of the national response,
• Promoting advocacy on HIV/AIDS issues in Government, Civil Society (CSOs) and Private Sector,
• Support civil society, private sector organizations and umbrella organizations through various funding mechanism
• Develop Partnerships support documents,
• Continuous engagement with Government organs, civil society and the private sector to ensure that HIV/AIDS is mainstreamed into their various programmes/activities
• Provide technical assistance to states on programme planning and implementation
• Facilitate mobilization of resources for CSOs
• Facilitate and coordinate the PPP forum on HIV/AIDS
• Identify and classify sectoral stakeholders and determine sector based interaction opportunities, options and priorities,
• Facilitate support to manage the process of engagement, develop TORs, work plan, budgets and allocate resources available through the organization.

3.7.2 Achievements:
• Conducted quarterly zonal meeting with SACAs & some selected LACAs involving all departments in NACA in the South-South, South West & South East geopolitical zones to train them on the use of NHOCAT for capacity assessment of organizational structure,
introduction to board governance and follow up on the supervisory visit conducted in Q1 on improved understanding of NHOCAT, Board governance and improved adherence to agreed standards for project implementation.

- Development of Operational guidelines for SACA/LACA engagement to improved coordination of the state response.
- Trained thirty-six participants comprising of Programme Managers, Community mobilization officers in the South- South and North East zones on the HAF Process implementation with focus on HAF Flow chart.
- Finalized the HAF capacity building manual for the states.
- Conducted Capacity needs assessment of SACAs & LACAs and other stakeholders at the state level to improved evidence based programming.
- Finalized the HAF manual to provide guidance to HAF process implementation, M & E and reporting.

3.8. Office of the Director- General:

3.8.1. Mandates:
- To ensure that the organization manages day to day operation to the highest possible standards and efficiency in line with the FGN Laws, Regulations and Directives,
- To act as the Principal Accounting officer and Authority to sign cheques and enter contracts and legal agreements on behalf of the organization in accordance with the Agency Act and Federal Laws and Regulations
- To inspire and motivate the personnel of the Agency to work as a Team in order to achieve the agreed objectives and performance targets.
- To ensure adequate and effective organizational policies and procedures are in place and regularly reviewed to cover staff welfare, human resources management, support functions and office procedures,
- ensure compliance with development /donor policies and procedures and sign off project agreements, documents, aides memoir for World Bank, GFATM and other Donor projects,
To act as the Secretary to the Board and keep the board informed on all critical issues in line with the Agency Act,

To ensure all Agency accounts and Funds are both internally and externally audited in line with Federal Government guidelines,

To ensure the Agency has an effective communication strategy, plan and programmes.


Ownership and Sustainability forum to Solicit Increased Government Commitment to HIV programmes by advocacy to states and Local government councils.

The DG attended the 19th Edition of the Conference on Retroviruses and Opportunistic Infections Scheduled for 5 – 8 March 2012 In Seattle, Washington USA this is for Information Sharing on Best Practices.

3.8.3 .Corporate Communication Unit:
3.8.3.1. Mandate:

- Corporate communications in NACA provides visible and proactive leadership to all stakeholders' activities in the war of AIDS.
- Work in tandem with other national response partners, including IPs, mass media, the private sector, support groups, civil society, and all others.
- The unit leads the coordination of all activities of communication including the internet, operators of urban mass media, community media, while networking with other information providers, education and advocacy groups.
- Establish, develop, coordinate, and maintain relationship with relevant government agency for purposes of keeping them abreast with HIV/AIDS national response, with the aim of achieving NACA'S strategic objection in line with the NSF.
- Works with a network of collaborators, the unit gives direction to HIV/AIDS information and publications in the public space, of needful documentation that may be exigent.
- Maintain the NACA brand in fighting AIDS to finish.
3.8.3.2. Achievements:
- Jingle Placement on 21 selected states to create service demand for PMTCT services across the selected states.
- Media Coverage for Signing of MOU with SFH, NACA and Hope World Wide
- Media coverage for HIV Vaccine plan launch.
- Media Coverage for International AIDS Conference (IAS) (July 22\textsuperscript{nd} - July 27\textsuperscript{th})
- Post IAS Media Conference (August 15\textsuperscript{th}-August 15\textsuperscript{th}) To brief media and disseminate to the public the activities of NACA/Nigeria at the IAS and share important resolution of the conference.

3.8.4 Legal Unit:
3.8.4.1 Mandate:
- Provision appropriate legal advice, support and opinion to the Agency and its departments
- Regulatory affairs: keep the agency in compliance with rules and regulations
- Represent the Agency in negotiation, mediation and arbitration
- Drafting, reviewing and execution of contracts and other binding agreements.
- Prosecution of court cases and litigation management
- Supervision of legal research and analysis, identifying issues and appraising operational department of emerging trends
- Serving on various standing Boards, Committees, ad-hoc working groups and tasks forces as required to take care of legal issues and framing policy
- Coordinating legal inputs in Human Rights issues
- Any other duty/task that may be assigned by the Director-General

3.8.4.2. Achievements:
- Meeting of the technical working group (TWG) on human rights/anti stigma bill.
- Hosting of the ECOWAS committee on human rights which brought about convergence of ideas on the anti-stigma bill

3.8.5 Audit Unit.
3.8.5.1. Mandate.
• Auditing of advanced payment vouchers
• Auditing capital projects payments vouchers
• Management audit and special investigation
• Writing periodic audit report
• Auditing salary variations

3.8.5.2. Achievements:
• Improved over-sight of the Sub-recipients of GF
• Improve in the key business processes of the Sub-recipients through recommendation of process improvement strategies
• Highlight of system weaknesses and recommendation of possible improvements

3.8.5. Information Technology Unit:
3.8.5.1. Mandate:

• To equip and empower NACA with adequate cutting edge information and strategies that will directly contribute to the Agency’s mission accomplishment in an effective and fast manner.
• To provide the information Technology leadership, guidance and services that enables NACA to coordinate Nigerians HIV/AIDS response effectively and make its programs and operations efficient, effective and secure through the use of information technology solutions and services
• To provide the following IT applications in NACA. They are: SAP (ERP), EXCEED (HR), DHIS (DATABASE), RESOURSE CENTER (DATABASE), and CALL CENTRE (CRM).

3.8.5.2. Achievements:
• Up to 90% uptime of ICT infrastructures (servers, client computers and other network devices) available in NACA.
• Edo house which house the strategic knowledge management department is equipped with functional LAN infrastructure and internet access.
• The availability of these services will make staff become effective and productive.
3.9 KEY ACTIVITIES 2012:

3.9.1. International AIDS Conference Washington DC, United States of America.
The XIX International AIDS Conference 2012 held from the 22 -27 July in Washington DC, United States of America. The conference theme, “Turning the Tide Together”, reflects a unique moment in time, emphasizing that the HIV epidemic has reached a defining moment. By acting decisively on recent scientific advances in HIV treatment and biomedical prevention, the momentum for a cure, and the continuing evidence of the ability to scale-up key interventions in the most-needed settings, we now have the potential to end the HIV epidemic. Capturing the current sense of hope and the renewed optimism that a change of course in the epidemic is possible, “Turning the Tide Together” also serves as an urgent call to action.

Following the participation of the Director General, several key partnerships were established with international organisations and international research institutions. Nigeria now hopes to benefit from a PrEP formative research, financial contributions to the National Call Centre and Vaccine plan, and more resources for the scale-up of PMTCT services nationwide.

In line with the amount of new information made available during the IAS conference 2012, the Director General thought it a good thing to invite stakeholders for a meeting to discuss and share information. The post International AIDS Conference meeting was held at Rock View Hotel Abuja on the 15\textsuperscript{th} of September, 2012. At this meeting, relevant information obtained from the IAS conference which could enhance the national HIV response was shared with stakeholders. Through consensus, several new ideas which could immediately be ploughed back into the national HIV response were adopted. Some other issues which would require policy directives are also being considered.

3.9.2. HIV Vaccine Plan Launch
To attain a reversed HIV epidemic in line with the global aspiration of ‘getting to zero’, Nigeria must take bold steps towards the advancement of HIV prevention. The ultimate success is in
the development of a preventative vaccine. That is really when we can claim the desired but elusive ‘cure’.

Due to Nigeria’s huge population and status as the second most burdened country with the HIV epidemic, it behooves on the nation to become a strategic partner in the global innovation to develop an HIV Vaccine. It is in that spirit that a review of the vaccine plan has come at an opportune time. Unlike the first attempt at implementing an HIV Vaccine plan which the Director General was a part of in 2001 and 2002, the Director General ensured a more realistic HIV Vaccine plan was developed and launched by the SGF.

3.9.3 National Call Centre on HIV/AIDS & Related Diseases

The National Call Centre on HIV/AIDS and Related Diseases is established to provide information, counseling and referral services on HIV/AIDS. It has the capacity to take 30 toll-free voice calls simultaneously and is designed to reach every community that has access to mobile telephony in Nigeria.

The GSM technology has proven to be a veritable tool for communication, it is imperative to note that with a viable National Call Centre information on HIV/AIDS is now accessible, affordable and equitable especially to Airtel Network subscribers.

The National HIV/AIDS Call Centre is a Public Private Partnership which involves the National Agency for the Control of AIDS, Skye Bank, Access Bank and Development partners. Both banks have provided the needed furniture and hardware respectively while installation of E1 line was provided by Airtel. This initiative is to engender ownership and sustainability on the National Response on HIV/AIDS.

The NSF places much emphasis on the fact that communication interventions, including Information, Education and Communication (IEC) and Behavior Change Communication (BCC), hold a vital and indispensable place in HIV prevention interventions.

We hope to achieve the following through the National Call Centre:

- At least 50 % of all Nigerians having comprehensive knowledge on HIV and AIDS by the year 2014
To provide accurate, confidential and personalized information, counseling and referral services on HIV/AIDS/STIs and related sexual health issues

- Facilitate sustained change in risk behaviour of clients as well as enhance their emotional support.
- Complement and strengthen government communication strategy in line with the NSF
- In view of ensuring that we have really met our target of 50% of all Nigerians having comprehensive knowledge on HIV and AIDS by year 2014, we hope to conduct an external assessment / evaluation of the contribution of the National Call Centre to the National Response.

While Funding for the National Call Centre has been a great challenge, the centre recorded the following achievement:

- The National Call Centre was officially commissioned on the 26th day of April, 2012 by the First Lady Her Excellency, Dr. Dame Patience Jonathan
- The National Call Centre since commissioning has received 23,695 calls from across the geo-political zones in the country.
- Information on HIV/AIDS and Related Diseases is accessed from the grassroots.

Prevention is the cornerstone of HIV/AIDS response since there are no vaccines and no medical cure. Hence, information/communication is key in prevention intervention. It is in view of this that we solicit for funding to sustain the National Call Centre on HIV/AIDS

3.9.4 Strengthening District Health Information systems (DHIS)

The HIV/AIDS response is faced with challenges of timely, accurate and complete data and this has a direct bearing on decision making and planning. In 2011 the country completed the latest review of the national M&E System known as the Nigeria National Response Information Management System (NNRIMS). The review helped to standardize and harmonize indicators and reporting tools for the national response.

Nigeria has adopted a free and open source District Health Information Software (DHIS) as the national standard system for the capture, storage, analysis, and reporting of routine health data including HIV/AIDS. In 2012 NACA with major partners in the HIV/AIDS response adopted DHIS
as the electronic data collection and reporting platform for the HIV/AIDS response. HIV/AIDS stakeholders also agreed that efforts should also be stepped up to strengthen the National health management information system.

The goal of the NNRIMS-DHIS is to develop an electronic database system with the ability to efficiently and effectively track Routine Indicators of the Nigerian National Response Information Management System (NNRIMS) strengthening the National Health Management Information System (NHMIS). Following extensive deliberations with the relevant partners including department of planning, research and statistics (DPRS) of FMOH it was agreed that the rollout of the NNRIMS DHIS to the states be divided into two components or phases

Phase 1: DHIS web client targeting secondary and tertiary facilities. Under this component 34 states were trained on DHIS. State teams consisting of SACA, SMOH and state HMIS were constituted to oversee implementation of NNRIMS DHIS at the state level including stepping down the training to the secondary and tertiary facilities. So far 4 states using World Bank funds have conducted step down training for LACAs and selected secondary and tertiary facilities.

Phase 2: DHIS mobile phone client targeting PHCs and using mobile phone solutions considering the dearth of infrastructure such as internet and computers at that level. The mobile phone client solution will ensure that the harmonized and integrated NHMIS reporting form is programmed into mobile phones and used for reporting by the PHCs. NACA and DPRS is set to commence implementation of the mobile phone component and will target reaching 600 PHCs providing HIV/AIDS services by the end of March 2013.

3.9.5 Pre-exposure Prophylaxis (PrE-P)

Access to treatment for people living with HIV has significantly improved in the past five years. However, during this same period, millions of people have become newly infected and prevention efforts have failed to stem the epidemic. Unless the influx of new infections is slowed, governments will be less able to provide care to those in need, and AIDS will continue to have a devastating effect on individuals, families, communities and nations.

Due in part to these concerns, as well as to the growing realization that AIDS is a long-term event rather than a short-term emergency, the last few years have witnessed a renewed commitment to prevention. This commitment has increasingly focused on developing new biomedical, behavioral and structural approaches to prevent HIV transmission and
implementing proven approaches in combination, tailored to specific epidemiological and social contexts.

Over the past 2 years, four large-scale studies of interventions to prevent HIV have worked, and for the first time, the goal of ending AIDS epidemics in some locales—and, in time, the world—seems like a possibility, provided, of course, that there's political will and money. This slew of successes in clinical trials has elated the HIV prevention field, and models now suggest that combining them might virtually stop HIV's spread even before we have a vaccine. There is however, the recognition that the impact of proven interventions might vary from place to place because the epidemics have different features.

Several large clinical trials under way or in the works should reveal which new prevention strategies best bring down incidence in a population versus simply protecting an individual. In addition to on-going large scale trials, it is important that, in parallel, countries begin to apply new combinations of proven strategies today with through an iterative process of using the information at hand and being willing to adjust and modify within a trial setup.

Within the context of combination prevention, PrEP holds promise for protecting many of the most vulnerable and at-risk populations, including MSM, commercial sex workers, the HIV-negative partner in sero discordant partnerships and women and girls.

Within the Nigerian context, these vulnerable populations bear a high burden of HIV. The IBBSS 2007 and 2010 results show clearly that the prevalence of HIV amongst MSMs and FSW is 4 times and 7 times higher than the national prevalence respectively. Also, there is a high incidence of HIV sero discordancy amongst couples increasing the risk of prospective new incidence in the country where concerted efforts are not taken. Finally, women and girls may be particularly notable for a number of reasons as the prevention tools that currently exist are not well suited to protect women from sexually-transmitted HIV. Although women may be faithful to male partners, they cannot guarantee that monogamy is reciprocated, particularly when the husband is working away from home for long periods. Gender norms that condone multiple sexual partnerships for men underlie this challenge, while also increasing women’s vulnerability. Furthermore, male and female condoms, the most commonly promoted risk reduction strategy, require that male partners elect or agree to use them, a condition that also makes condoms potentially useless as an HIV-prevention strategy during rape and sexual
violence. Because PrEP can be used by women – and used covertly if desired – it is an important addition to the HIV-prevention toolkit.

In view of the above, it becomes critical to explore the feasibility of using PreP within the context of combination prevention to address the HIV epidemic in Nigeria.

3.9.6. PMTCT Scale-Up
The transmission of HIV from an HIV-positive mother to her child during pregnancy, labour, delivery or breastfeeding is called mother-to-child transmission which may be due to poor quality health services, and low uptake of PMTCT services amongst women living with HIV. In the absence of any interventions transmission rates range from 15-45%. This rate can be reduced to levels below 5% with effective interventions. Programs that enable women to prevent mother-child HIV transmission are an essential part of comprehensive primary prevention. Most children less than 15 years living with HIV acquire infection through MTCT each year. The global community has committed itself to accelerate progress for the prevention of mother-to-child HIV transmission (PMTCT) through an initiative with the goal to eliminate new paediatric HIV infections by 2015 and improve maternal, newborn and child survival and health in the context of HIV. In 2009 United Nations declare her commitment toward the Elimination of Mother to Child Transmission of HIV (EMTCT). World leaders including Nigeria’s President Goodluck Jonathan in 2011 launched the Global Plan towards the elimination of new HIV infections among children and keeping their mothers alive. World AIDS Day 2011, Theme: Getting to zero; depict Nigeria’s focus on Elimination of Mother to Child transmission of HIV.

Achieving Nigeria’s EMTCT goals will require strong leadership, commitment and ownership of PMTCT programs at sub-national levels. PMTCT Scale-up Technical Committee constituted in Dec 2011 was aimed to engage the states and provide support towards acceleration of PMTCT at state level. The programme emphasized on state ownership and leadership and Phased engagement starting with 12+1 priority states of Abia, Akwa-Ibom, Anambra, Bayelsa, Benue, Cross-Rivers, Kaduna, Kano, FCT, Lagos, Nassarawa, Plateau and Rivers which bear 70% of the burden of the epidemic and selected based on prevalence, no of births by HIV+ women and population size.
In continuation of its work the PMTCT Technical committee provided the states with templates to carry out data analysis in March 2012 and pre-consultative meeting in Abuja, April, 2012 which was chaired by the Minister of State for Health, Dr. Muhammad Ali Pate. The Opening remark was delivered by DG NACA and ED NPHCDA. The State teams present at the meeting were Commissioner for Health, Director Primary Health/Public Health, SAPC, SMOH PMTCT Focal person, SMOH M&E officer, SACA PM, SACA M&E, State PMTCT Lead IP. The technical sessions include the PMTCT/EMTCT, PMTCT service delivery package, PMTCT & Primary Health Care, Guidance on development of PMTCT action plan. The Interactive session with the co-chairs of the Global steering Group Michel Sidibé (UNAIDS Executive Director) and Ambassador Eric Goosby (United States Global AIDS Coordinator). The Key output of the meeting was Costed one year PMTCT action plan developed by the state teams took into consideration their capacity and peculiarities, include all 4 PMTCT prongs with emphasis on prong 3, plans to activate at least 10 new PMTCT sites (PHCs with ANC services) for a start, ensure referral linkages to secondary facilities, prioritize MSS facilities, Provide for periodic state PMTCT working group meetings. The three prong components include, Community mobilization, Site Assessment for new PMTCT sites, Training of healthcare workers: HCT, PMTCT service provision, Infant feeding, PMTCT Management Information System / National Health Management Information System, Early Infant Diagnosis (EID), Logistics Management, Provision of HCT, Provision of ARV prophylaxis for HIV positive pregnant women and HIV-exposed babies, provision of EID services, supply chain management for commodities (RTKs, ARVs, EID commodities, consumables), printing of reporting tools (PMTCT, NHMIS), supportive supervision and mentoring visits to PMTCT sites.
CHAPTER 4: ACTIVITIES AND ACHIEVEMENTS OF WORLD BANK HPDPII PROJECT:

4.1 World Bank Project: 

Background

The signing of a US$ 225 million credit agreement by the Nigerian government in 2010, with the World Bank for the implementation of the HIV/AIDS Program Development Project (HPDP-2) was the second time, considering the gains of the first project. The National Agency for the Control of AIDS (NACA) signed the credit at the federal level, while 36 states and FCT signed independent credit agreements at the state level. The second project is divided into three components base on the experiences of the first project as follows:

Component 1: Expanding Public Sector Response

- Agencies identified as having a more central role in the fight against HIV/AIDS including Health, Education, Women Affairs and Defense will receive more funds to scale up their activities.
- Funds will be allocated to the implementation of strategic HIV/AIDS work plans, tailored to the specific client base and issue areas within the national and state-level response most appropriately addressed by each line ministry.
- Specific individual training in core functions like strategic planning for scaling up high impact, client-oriented interventions, resource mobilization, M & E, fund management, governance and leadership.

Component 2: Expanding Civil and Private Sector Engagement and Response through the HIV/AIDS Fund (HAF).

- This component will support the design and implementation of revised HIV/AIDS guidelines to expand and scale up the non-public sector response to HIV/AIDS.
- Capacity building of the staff of NACA, SACA and CSOs
- Funding to civil society networks
- Provide support for private sector HIV/AIDS service provision

Component 3: Strengthening mechanisms for project coordination and management
The third component will support capacity building in respect of NACA, SACAs, LACAs, and MDAs in the three tiers of government, the civil society and private sector in order to deliver strengthened evidence-based planning, increase coordination, harmonization and alignment by all stakeholders.

**Objective**

The main goal of the second HIV/AIDS Program Development Project is to reduce the risk of HIV infections by scaling up prevention interventions and to increase access to and utilization of HIV counseling, testing, care and support services.

4.2. Summary of key Achievements States SACAs

The 34 credit effective states planned a total number of 2,724 activities in 2012, of these 47% (1284) of these activities were completed, 17% (475) were still ongoing and 35% (965) were not yet started. Two out of the 34 states had a 100% completion rate of their planned; these are Edo and Zamfara. The states with low levels of implementation include Enugu and Ogun state, with 25% and 28% percent respectively. These activities yielded results in the various thematic area as spelt out in the NSP as shown below

4.2.1 Promotion of Behavior Change and Prevention of New Infection

- For the year 2012, ten SACAs procured and distributed 39,114 HIV test kits, of this Ondo distributed 20,100 test kits to SMOH, Sokoto distributed 450 to 23 DOT centers and 225 test kits to mobile testing targeting MARPS; Bornu distributed 100 to SMOH, Jigawa distributed 240,000, Ogun state distributed 21150 test kits to 20 PHCs, 4 private hospitals and 22 secondary health care facilities.

- 4,198,696 condoms were distributed by 15 states of this Yobe SACA procured 100,000 male condoms and 5,000 female condoms and distributed them to 19 facilities, Kwara state distributed 90,000 condoms to CSO and MDAs.

- 1,898 persons were trained on HCT by 11 SACAs, in Delta state nurses in general and central hospitals from the three senatorial districts of Delta & 30 other focal persons benefited;100 older youths and 100 health workers in Abia;54 health care givers in Imo state;20 PHC counselors, 30 HCT counselors in Ondo ;160 health givers 30 DOTs officers in Taraba;30 Health care workers in Ogun;30 HCT counselors in Ondo ;54 HCT
Counselors in Imo; 30 DOTS staff in Bauchi; 128 health workers in Katsina; 60 HIV counselors per LGA in Kebbi State.

- On sensitization and awareness on HIV/AIDS states reached a total of 1,986 cutting across extension workers, Line ministries, youths leaders, in School youths, athletes, long distant drivers and hotel managers.
- The states trained a total of 2646 on the minimum prevention package (MPPI).

### 4.2.2. Treatment of HIV/AIDS and Related Health conditions

- The states reactivated a total of 37 PMTCT sites in 2012, 32 in Katsina state and 5 in Sokoto state for the purpose of scaling up of PMTCT services
- A total of 600 PLHIV benefited from nutritional support for the year (Enugu state provided for 300 in Enugu north senatorial zone, Ondo provided for 300 PLHIV across the 18 LGAs)
- Lagos SACA developed Traditional Birth Attendant (TBA) BCC material towards reduction of MTCT in the state. Also, 250 TBAs (50 per batch) were trained on PMTCT and universal precaution

### 4.2.3 Policy, Advocacy, Human rights and Legal Issues

- Holding of quarterly gender, advocacy and policy TWG meeting.
- Advocacy visits Ministry of Women Affairs, Youth and Strategy, Education, NAPEP and NDE on rights of PLHIV in the workplace, Ministry of Local Government and Chieftaincy Affairs and Head of Service Office for information and institutionalization of LACA and to nine LGA council chairmen and their council members and traditional rulers in three senatorial zones on uptake of ART service.
- Benue SACA held the quarterly gender, advocacy and policy TWG meeting.

### 4.2.4 Institutional Architecture, Systems, coordination and Resourcing

- The HPDP project has been launch in 34 states of the federation.
- A total of 13 states have engaged 174 LACAs and build their Capacity to develop their 2012 work plan, proposal development for 15 CSOs, and resource mobilization for 25 CSOs.
CHAPTER 5: ACTIVITIES AND ACHIEVEMENTS OF GLOBAL FUND PROGRAMME:

Background

The Global Fund is an international financing institution dedicated to attracting and disbursing resources to prevent and treat HIV and AIDS, TB and malaria.

The Global Fund promotes partnerships among governments, civil society, the private sector and affected communities, the most effective way to help reach those in need. This innovative approach relies on country ownership and performance-based funding, meaning that people in countries implement their own programs based on their priorities and the Global Fund provides financing where verifiable results are achieved.

Since its establishment in 2002, the Global Fund has supported more than 1,000 programs in 151 countries, providing AIDS treatment for 4.2 million people, anti-tuberculosis treatment for 9.7 million people and 310 million insecticide-treated nets for the prevention of malaria. The Global Fund works in close collaboration with other bilateral and multilateral organizations to supplement existing efforts in dealing with the three diseases.

Objectives.

To achieve this, the Global Fund will “invest for impact”, based on five strategic objectives:

- To Invest more strategically in areas with high potential for impact and strong value for money, and fund based on countries’ national strategies;
- To evolve the funding model to provide funding in a more proactive, flexible, predictable and effective way;
- Through more active grant management and better engagement with partners; Actively support grant implementation success
To Promote and protect human rights in the context of the three diseases; and Sustains the gains, mobilize resources—by increasing the sustainability of supported programs and attracting additional funding from current and new sources.

**Achievements**

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<th>Indicator</th>
<th>2011</th>
<th>2012</th>
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<tr>
<td>The number of service delivery points providing antiretroviral combination therapy</td>
<td>143</td>
<td>195</td>
</tr>
<tr>
<td>Number of Adults and Children enrolled in HIV care and eligible for cotrimoxazole prophylaxis (according to the national guidelines) and currently receiving cotrimoxazole prophylaxis.</td>
<td>225125</td>
<td>272,513</td>
</tr>
<tr>
<td>Number of health facilities providing comprehensive high-quality PMTCT service package as per updated guidelines</td>
<td>143</td>
<td>653</td>
</tr>
<tr>
<td>Number of HIV-infected pregnant women who received antiretroviral drugs to reduce the risk for mother to child transmission</td>
<td>6526</td>
<td>10,454</td>
</tr>
</tbody>
</table>

![Bar chart showing number of service delivery points providing antiretroviral combination therapy (Global Fund supported) 2009-2012.](image)

The number of service delivery points providing antiretroviral combination therapy (Global Fund supported) 2009-2012.
Number of Adults and Children enrolled in HIV Care and eligible for co-trimoxazole prophylaxis (according to the national guidelines) and currently receiving co-trimoxazole prophylaxis (GF supported) 2009 – 2012.

Number of HIV-infected pregnant women who received antiretroviral drugs to reduce the risk for mother-to-child transmission  (GF supported) 2009 – 2012.

The number of service delivery points providing antiretroviral combination therapy supported by Global Fund (GF) increases from 143 in 2010 to 195 in 2012, a 96% achievement from the target of 203. This is in line with the GF drive to place HIV positive clients eligible for drugs on treatment. The number of Adults and Children enrolled in HIV care and eligible for cotrimoxazole prophylaxis (according to the national guidelines) and currently receiving...
cotrimoxazole prophylaxis rose to 272,513 in 2012 from the 2011 figure of 225125. By 2012
10,454 pregnant women living with HIV had received ARV drugs through global fund supported
program to reduce the risk for mother to child transmission and 6526 pregnant women
received the same treatment in 2011, this is a reflection of the contributions of the GF
programme elimination of Mother to child transmission of HIV.
CHAPTER 6: PHOTO SPEAK

The quarter witnessed a lot of activities a few of which are depicted pictorially below:

The Nigerian delegation to the international AIDS conference (IAS)

Seating R-L: Mr Mark Eldon-Edington (Head of the Global Fund Grant Management Division), Professor Onyebuchi Chukwu (Minister for Health), Senator Ayim Pius Ayim (Secretary to the Government of the Federation), Professor John Idoko (Director General, National Agency for the Control of AIDS) and Dr Fatai Bello (Executive Secretary of the Country Coordinating Mechanism (CCM) for Nigeria) during the Global Fund Supported HIV/AIDS and Tuberculosis Grant signing Ceremony in Abuja
L-R: 1st Lady, Dame (Dr) Patience Jonathan, DG NACA and the Minister of Health during the commissioning of NACA National Call Centre in Abuja.

1st Lady Dame (Dr) Patience Jonathan (Centre) making a call to the NACA National Call Centre, wife of the Vice President of Federal Republic of Nigeria, Hajia Amina Sambo and other dignitaries during commissioning of NACA National Call Centre in Abuja.
L-R: Prof. John Idoko (DG NACA), Mr Kunle Adeniyi (Head, Legal Unit, NACA) decorating the leader of ECOWAS team as NACA ambassador, during a courtesy call on DG NACA.

L-R: Dr James Anenih (Assistant Director SKM, NACA), Dr Kayode Ogungbemi (Director SKM, NACA) and Dr Greg Ashefor (Deputy Director SKM, NACA) at a strategic Monitoring and Evaluation meeting.
L-R Head Community Health Service, National Primary Health Care Development Agency (NPHCDA) Dr David Malgwi, Mr Alex Ogundipe, Director Policy and Strategy (NACA) and Professor John Idoko, Director General, National Agency for the Control of AIDS (NACA), during the handing over of Global Fund utility vehicles to Sub-Recipients.

DG NACA Prof John Idoko, Dr Emmanuel Alhassan Director Resource Mobilization NACA, Deputy Director Resource Mobilization Mrs Josphine Kalu and Toyin Aderibigbe Assistant Chief Communication Officer at the Church Service for the Commemoration of World AIDS Day, 2012.
Staff at work in the National HIV Call Centre

The DG commissioning a youth friendly centre
NACA staff at the World AIDS day 2012

The DG NACA on his advocacy visit to Benue state
The DG NACA, Secretary to the Government of the Federation Chief Anyim Pius Anyim, the Minister of health, Prof. Onyebuchi C hukwu at the World AIDS day celebration, 2012.

The DG briefing the press at the World AIDS day celebration 2012.
6.1 NACA Top Management As At December, 2012
(Photograph of all Directors and the DG)
6.2 Summary Of The Achievements Of The DG’s Office

- Commissioning Of Hilux Vans Purchased For Global Fund to improve supervision of Global Fund Supported projects
- Advocacy trip to Ogun State Executive Governor to Advocate for the Creation of Ogun State Agency for the Control of AIDS and Advocate to State Governors for increases commitment to OGUNSACA activities.
- Courtesy visit by NAFDAC DG and Pharmacovigilance Committee to strengthen linkages with MDAs.
- Ownership and Sustainability forum to Solicit Increased Government Commitment to HIV programmes by advocacy to states and Local government councils.
- The DG attended the 19th Edition of the Conference on Retroviruses and Opportunistic Infections Scheduled for 5 – 8 March 2012 In Seattle, Washington USA this is for Information Sharing on Best Practices.
- The DG attended the Multi-Stakeholder Consultation on Sustainable Efficiency and Effectiveness in National Programme on Aids in Nairobi, Kenya from 17 – 21 April 2012, which is towards information sharing on best practices.
- Launch of Prep Research programs for Strengthening Institutional Support for research in HIV prevention in Nigeria
- Workshop on HIV prevention and control programs from 4 – 8 June 2012 (Bangalore and New Delhi India) for information sharing on best practices.
- World Health Organization (WHO) Meeting On “The Ethics Of Pre-Exposure Prophylaxis (Prep) And Antiretroviral (ARV) for HIV Prevention” In Geneva, Switzerland, From 10 To 11 October 2012 for information sharing in support of Prep/ARV ethical considerations for research in Nigeria.
• Signing of MOU with SFH/Hope World-Wide Foundation 28th September to Support the realizations of the goals of the national call centre for HIV/AIDS and Other Related Diseases.
• World AIDS Day, 2012 commemoration to take stock of achievements and canvass for more resources for HIV.

6.3 Statements Of Priority For 2013
• Review of National HVI/AIDS Prevention Plan (NPP) and development of user guide
• Development and production of an Advocacy toolkit
• Support the implementation of the PMTCT programme including the production of PMTCT campaign materials and Launch of national PMTCT
• Demand creation campaign (including the branding of PMTCT) Development and production of media materials and messages for HIV prevention and behaviour change for general population and MARPS
• Production of National Community Conversation toolkit
• Development and production of National SBCC training of trainers manual
• Conduct SBCC training for CSOs and State teams and promote the consistent implementation of the minimum package of prevention intervention (MPPI)
• Dissemination of national community conversation toolkit and training of stakeholders on the use of the national community conversation toolkit
• Harmonization of Peer education (NYSC PET) and FLHE programmes
• Harmonize Peer education for In-school youth (NYSC PET) and FLHE manuals
• Development, production and dissemination of the care and support guidelines
• Development of guidelines for mainstreaming gender and HIV into all sectors
• Capacity building for SRs on Quality improvement based on the RSQA findings for HIV care and service delivery
• Assess and build capacity of stakeholders to manage IGA programmes
• DHIS step down training in the states for facility and LACA M&E focal persons.
• Support capacity building for state teams on the use of new harmonized data collection and reporting tools in order to step down the training at the state level to LACAs, HIV & AIDS service providers and facilities.
• Support Setting up of IE core team in the state in preparation for the implementation of the FSW programme and conduct of impact evaluation of the programmes.
• Commencement of HAF Implementation in the states.
• Commissioning of the nine operation research topics
• Roll out of mobile phone client of DHIS 2.0 to 600 PHCs in the country.
• Harmonization of non-health sector data collection and reporting tools.
• The Midterm review and Joint Annual Review of the NSP for 2013.
• The conduct of NASA and SASA 2011 and 2012
• The production of the National annual HIV and AIDS response report 2012.
CHAPTER 7: MANPOWER DEVELOPMENT AND RECRUITMENT:

7.1 Staff recruitments:
The agency in 2012 recruited 46 new staff, of these number five were junior staff while fifty one were senior staff. The recruited senior staff were six administrative, seven finance and accounts, twenty nine programmes one each of cooperative and legal and two Audit officers to fill vacant positions, this is in its resolve to achieve her vision, mission and reach set targets.

7.2 Staff Promotions:
In recognition of the impetus staff promotion brings to bear on the output of organizations manpower, the agency in 2012, promoted forty one of its staff. The promotion exercise had 6 chief programme officers promoted to the rank of assistant director and four assistant chief programme officers to the rank of chief programme officers, while one principal officer each from account and finance, store and asset, information technology, confidential secretary and executive officer were elevated to assistant chiefs in their cadre. A total of 6 senior programme officers promoted to the rank of principal officer and 1 each from information technology (IT) and procurement. 2 programme officer I promoted to senior programme officer and 1 each from finance and account and administration. The promotion exercise also included two programme officers II to programme Officer I, one programme officer I to senior technical officer. One higher executive officer to senior executive officer, one higher store officer elevated to higher executive officers. The junior cadre had 3 clerical officers promoted to senior clerical officer, 1 senior motor driver mechanic to chief motor driver mechanic and 2 clerical officers II promoted to clerical officer I.

7.3 Staff Trainings:
The Agency is a research base organization so the need for continued capacity building of its staff is paramount, so as to keep in touch with emerging trends in the HIV/AIDS response in the country. The agency base on the training need assessments and its training plan sent fifty five staff for various training programmes in 2012.
CHAPTER 8: FINANCE.

Summary of 2012 appropriation and expenditure

<table>
<thead>
<tr>
<th></th>
<th>Disbursed</th>
<th>Expenditure</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSONNEL</td>
<td>400,667,133.84</td>
<td>400,631,224.63</td>
<td>35,909.21</td>
</tr>
<tr>
<td>OVERHEAD</td>
<td>203,219,903.41</td>
<td>203,207,120.39</td>
<td>12,783.02</td>
</tr>
<tr>
<td>CAPITAL</td>
<td>342,750,024.00</td>
<td>342,733,773.22</td>
<td>16,250.78</td>
</tr>
<tr>
<td>TOTAL</td>
<td>946,637,061.25</td>
<td>946,572,118.24</td>
<td>64,943.01</td>
</tr>
</tbody>
</table>

Expenditure from Government of Nigeria:
Summary of disbursement and expenditure for 2012.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disbursements</td>
<td>96,518,968.15</td>
<td>186,174,068.68</td>
<td>490,734,191.21</td>
<td>173,146,833.21</td>
<td>946,637,061.25</td>
</tr>
<tr>
<td>Expenditure</td>
<td>66,103,777.21</td>
<td>164,337,139.79</td>
<td>332,043,324.29</td>
<td>384,087,876.95</td>
<td>946,572,118.24</td>
</tr>
<tr>
<td>Variance</td>
<td>31,453,190.94</td>
<td>21,836,928.89</td>
<td>158,690,866.92</td>
<td>210,941,043.74</td>
<td>64,943.01</td>
</tr>
</tbody>
</table>

Expenditure from Global Fund Project:
Summary of disbursement and expenditure for 2012.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disbursements</td>
<td>(Bal. b/f)</td>
<td></td>
<td>1,995,482,076.00</td>
<td>86,602,618.85</td>
<td>7,141,574,804.79</td>
</tr>
<tr>
<td></td>
<td>5,059,490,109.94</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditure</td>
<td>713,924,517.90</td>
<td>1,265,675,050.19</td>
<td>2,655,472,248.37</td>
<td>2,086,524,597.03</td>
<td>6,721,596,423.49</td>
</tr>
<tr>
<td>Variance</td>
<td>4,345,565,592.04</td>
<td>1,265,675,050.19</td>
<td>-659,990,172.37</td>
<td>-1,999,921,978.18</td>
<td>419,978,391.30</td>
</tr>
</tbody>
</table>

Expenditure from World Bank Project:
Summary of disbursement and expenditure for 2012.
### Basic Fact sheet on Nigeria HIV and AIDS Expenditure for the period 2009-2010

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disbursements</td>
<td>28,045,370.62</td>
<td>75,754,991.98</td>
<td>67,630,502.57</td>
<td>97,768,883.80</td>
<td>269,199,748.97</td>
</tr>
<tr>
<td>Expenditure</td>
<td>28,076,846.85</td>
<td>75,480,396.60</td>
<td>70,185,708.90</td>
<td>91,953,979.13</td>
<td>265,696,931.48</td>
</tr>
<tr>
<td>Variance</td>
<td>-31,476.23</td>
<td>274,595.38</td>
<td>-2,555,206.33</td>
<td>5,814,904.67</td>
<td>3,502,817.49</td>
</tr>
</tbody>
</table>

### HIV and AIDS Expenditure by Funding Sources

<table>
<thead>
<tr>
<th>Source</th>
<th>2009 Amount(USD)</th>
<th>%</th>
<th>2010 Amount(USD)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Spending</td>
<td>415,287,430.00</td>
<td></td>
<td>496,917,471.00</td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>97,790,519.00</td>
<td>23.55</td>
<td>125,139,587.00</td>
<td>25.18</td>
</tr>
<tr>
<td>Private Funds*</td>
<td>278,303.00</td>
<td>0.07</td>
<td>850,547.00</td>
<td>0.17</td>
</tr>
<tr>
<td>International</td>
<td>317,218,608.00</td>
<td>76.39</td>
<td>370,927,337.00</td>
<td>74.65</td>
</tr>
</tbody>
</table>

### HIV and AIDS Expenditure by Financing Agent

<table>
<thead>
<tr>
<th>Source</th>
<th>2009 Amount(USD)</th>
<th>%</th>
<th>2010 Amount(USD)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>98,073,517.00</td>
<td>23.62</td>
<td>125,294,375.00</td>
<td>25.21</td>
</tr>
<tr>
<td>Private</td>
<td>4,256,866.00</td>
<td>1.03</td>
<td>26,774,251.00</td>
<td>5.39</td>
</tr>
<tr>
<td>International</td>
<td>312,957,047.00</td>
<td>75.36</td>
<td>344,848,845.00</td>
<td>69.40</td>
</tr>
</tbody>
</table>

### HIV and AIDS Expenditure by Service Provider

<table>
<thead>
<tr>
<th>Category</th>
<th>2009 Amount(USD)</th>
<th>%</th>
<th>2010 Amount(USD)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Providers</td>
<td>140,782,985.00</td>
<td>33.90</td>
<td>177,719,983.00</td>
<td>35.76</td>
</tr>
<tr>
<td>Private Non-Profit</td>
<td>269,069,366.00</td>
<td>64.79</td>
<td>302,395,926.00</td>
<td>60.85</td>
</tr>
<tr>
<td>Bilateral and Multilaterals</td>
<td>5,435,079.00</td>
<td>1.31</td>
<td>16,801,562.00</td>
<td>3.38</td>
</tr>
<tr>
<td>Rest of the world providers</td>
<td>0.00</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

### HIV and AIDS Expenditure by Programmatic Area

<table>
<thead>
<tr>
<th>Programmatic Area</th>
<th>2009 Amount(USD)</th>
<th>%</th>
<th>2010 Amount(USD)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>36,184,378.00</td>
<td>8.71</td>
<td>61,877,789.00</td>
<td>12.45</td>
</tr>
</tbody>
</table>

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NACA ANNUAL REPORT

Page 54
<table>
<thead>
<tr>
<th>Category</th>
<th>2023支出 (百万)</th>
<th>占比</th>
<th>2024支出 (百万)</th>
<th>占比</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and treatment</td>
<td>204,304,508.00</td>
<td>49.20</td>
<td>186,032,729.00</td>
<td>37.44</td>
</tr>
<tr>
<td>OVC activities</td>
<td>9,099,704.00</td>
<td>2.19</td>
<td>7,118,795.00</td>
<td>1.43</td>
</tr>
<tr>
<td>Program management activities</td>
<td>77,212,683.00</td>
<td>18.59</td>
<td>121,831,097.00</td>
<td>24.52</td>
</tr>
<tr>
<td>Human resources</td>
<td>84,989,602.00</td>
<td>20.47</td>
<td>95,919,210.00</td>
<td>19.30</td>
</tr>
<tr>
<td>Social protection and social services</td>
<td>83,718.00</td>
<td>0.02</td>
<td>183,189.00</td>
<td>0.04</td>
</tr>
<tr>
<td>Enabling environment</td>
<td>2,679,626.00</td>
<td>0.65</td>
<td>21,870,065.00</td>
<td>4.40</td>
</tr>
<tr>
<td>Research activities</td>
<td>733,211.00</td>
<td>0.18</td>
<td>2,084,597.00</td>
<td>0.42</td>
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</tbody>
</table>

### HIV and Expenditure by Beneficiary

<table>
<thead>
<tr>
<th>Category</th>
<th>2023支出 (百万)</th>
<th>占比</th>
<th>2024支出 (百万)</th>
<th>占比</th>
</tr>
</thead>
<tbody>
<tr>
<td>People Living with HIV</td>
<td>207,110,810.00</td>
<td>49.87</td>
<td>187,424,838.00</td>
<td>37.72</td>
</tr>
<tr>
<td>Most at risk populations</td>
<td>378,255.00</td>
<td>0.09</td>
<td>557,700.00</td>
<td>0.11</td>
</tr>
<tr>
<td>Other key populations</td>
<td>20,332,659.00</td>
<td>4.90</td>
<td>22,744,908.00</td>
<td>4.58</td>
</tr>
<tr>
<td>Specific “accessible” populations</td>
<td>1,130,254.00</td>
<td>0.27</td>
<td>3,118,459.00</td>
<td>0.63</td>
</tr>
<tr>
<td>General Population</td>
<td>23,452,982.00</td>
<td>5.65</td>
<td>62,125,892.00</td>
<td>12.50</td>
</tr>
<tr>
<td>Non-targeted interventions</td>
<td>162,882,470.00</td>
<td>38.41</td>
<td>220,787,650.00</td>
<td>44.43</td>
</tr>
<tr>
<td>Specific targeted populations not elsewhere classified</td>
<td>0</td>
<td>0.0</td>
<td>158,024.00</td>
<td>0.03</td>
</tr>
</tbody>
</table>

### Out of Pocket Expenditure

<table>
<thead>
<tr>
<th>Category</th>
<th>2023支出 (百万)</th>
<th>2024支出 (百万)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>170,634,393</td>
<td>202,290,739</td>
</tr>
</tbody>
</table>
CHAPTER 9: NATIONAL RESPONSE STATISTICS

9.1 Data on Universal Access Indicators

9.2. National Achievement on the Millennium Development Goal 6 Indicators

<table>
<thead>
<tr>
<th>TARGET</th>
<th>INDICATOR</th>
<th>Before 2011</th>
<th>At the end of 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Sexual transmission of HIV by 50% by 2015 – General Population</td>
<td>Percentage of people aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>22.5%</td>
<td>24.2%</td>
</tr>
<tr>
<td></td>
<td>Percentage of young women and men who have had sexual intercourse before the age of 15</td>
<td>9.8%</td>
<td>11.9%</td>
</tr>
<tr>
<td></td>
<td>Percentage of women and men aged 15–49 who have had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse</td>
<td>56.1%</td>
<td>52.5%</td>
</tr>
<tr>
<td></td>
<td>Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results</td>
<td>8.6%</td>
<td>11.7%</td>
</tr>
<tr>
<td></td>
<td>Percentage of young people aged 15-24 who are living with HIV</td>
<td>4.3%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Reduce Sexual transmission of HIV by 50% by 2015 in Most at risk population</td>
<td>Percentage of sex workers reporting the use of a condom with their most recent client</td>
<td>91.97%</td>
<td>88.6%</td>
</tr>
<tr>
<td></td>
<td>Percentage of sex workers who have received an HIV test in the past 12 months and know their results (Female Sex Workers)</td>
<td>38.2%</td>
<td>44.8%</td>
</tr>
<tr>
<td></td>
<td>Percentage of sex workers who are living with HIV (Female Sex workers only)</td>
<td>32.7%</td>
<td>24.5%(Male &amp; Female Sex Workers)</td>
</tr>
<tr>
<td></td>
<td>Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results</td>
<td>30.15%</td>
<td>24.92%</td>
</tr>
<tr>
<td></td>
<td>Current school attendance among orphans and non-orphans aged 10–14*</td>
<td>OVC:75%, Non OVC:</td>
<td>OVC: 83.9%</td>
</tr>
</tbody>
</table>
ART Treatment coverage | Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards).
---|---
| | 87% | Non-OVC: 71.7%
| | 432,285 | 491,021
| | 28.8% | 32.7%
| Percentage of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy | 73.37% | 77.55%

The year 2011 and 2012 recorded remarkable progress in the national response to the epidemic and currently the national median prevalence stands at 4.1% from a sharp decline of 4.6% about four years ago. The figure indicates that the country has started to halt and reverse spread of the epidemic in line with the MDG goal 6 and targets for HIV.

There are evidences to show that the continued investment of human and capital resources in the HIV prevention response is showing slow but steady positive impact. Awareness about HIV/AIDS is at a commendable level of 87.7% in 2007 to 93.8% currently. Young people aged 15–24 years show gradually improving knowledge about HIV and the same modest progress can also be said about behaviour with adolescents and youths reducing risky sexual behaviour. There is also a rise in the median age at first sex - from 17.3yrs to 18.1yrs. These indicators may well be responsible for the observed reduction in HIV prevalence among youths from 4.3% to 4.1%.

For Nigeria, the key target populations for HIV are female sex workers, MSMs, IDUs and transport workers. There is evidence to show improved knowledge for female sex workers and transport workers. The Most at Risk Populations (MARPs) received high priority in the year under review, mapping of MARPs hotspots and size estimation for MARPs (FSW, IDU, MSM) was completed in 16 states. The mapping and size estimation will help to better target these populations with HIV/AIDS interventions.

The ART programme in Nigeria commenced in 2002 with the number of sites providing ART substantially increasing from 393 in 2009 to 516 in 2012. There has also been increased uptake of ARVs from 302,973 in 2009 to 491,000 in 2012. This increased uptake of ARVs impacted
significantly on PLHIV with an observed decline of 22.1% in number of deaths among PLHIV between 2008 and 2012.

9.2.3  KEY HIGH IMPACT PROGRAMMES AND POLICIES OF NACA.

In line with the guidance from the National Planning commission, this report will focus on five of the NACA high impact programmes and policies among those identified in the HIV/AIDS NSP 2010 – 2015.

- Prevention intervention in General Population and most at risk population
- HIV Counselling and Testing
- Antiretroviral therapy for people living with HIV
- Prevention of Mother to Child Transmission
- Coordination of the National Response.

9.2.3.1  PREVENTION OF HIV IN GENERAL POPULATION AND MOST AT RISK POPULATION

Prevention remains the most important strategy and the most feasible approach for reversing the HIV epidemic since there are no vaccines or medical cure yet. The majority of Nigerians are HIV-negative and keeping them uninfected is critical for altering the trajectory of the epidemic. This underscores the importance of prevention as a cornerstone of the national HIV and AIDS response. The HIV/AIDS National Strategic Plan 2010-2015 and the National HIV/AIDS Prevention Plan 2010-2013 are strategic plans/documents that underscore the importance of preventing new infections, and call for continuous and concerted focus on effective preventive interventions.

It has been proven that effective HIV/AIDS prevention interventions are those that focus on the prevention needs of the various population subgroups; specifically address the related cognitive, attitudinal and behavioral issues of each population subgroup, particularly the vulnerable and most-at-risk populations (MARPs), through tailored and effective approaches; and, meet the prevention needs of PLHIV through the promotion of Positive Health, Dignity and Prevention (PHDP) activities. These prevention interventions prioritize population subgroups
and individuals who are most affected and those most vulnerable to HIV, and are implemented in a participatory manner involving wide group of stakeholders, including PLHIV.

It is in the light of this evidence that Nigeria adopted the Minimum Prevention Package Interventions (MPPI) approach for HIV prevention targeting the HIV/AIDS prevention needs of both the general population and most-at-risk population groups (MARPS). The MPPI approach takes into consideration the drivers of the epidemic as it relates to various target populations and subgroups, with emphasis on dosage, intensity and recognition of structural and environmental influencers of behavior and process of behavior change.

9.2.3.2 HIV/AIDS Prevention among the general population
Among the general population specific HIV/AIDS prevention using the MPPI approach have been developed and are currently being implemented. The specific objectives of HIV prevention in the general population as articulated in the HIV/AIDS National strategic plan 2010-2015 and its related National Prevention Plan (NPP) are as follows:

- At least 80 % of all Nigerians have comprehensive knowledge on HIV and AIDS by the year 2015
- At least 80% of young people 15-24 years adopting appropriate HIV and AIDS related behavior
- At least 80% of men and women of reproductive age (MWRA) have knowledge about dual protection benefit of condoms
- At least 80% of sexually active males and females use condoms consistently and correctly with non-regular partner by 2015.

9.2.3.3 Key achievements for HIV/AIDS Prevention in General Population (2010 – 2012)

Population surveys have shown that the level of awareness of HIV/AIDS is very high in Nigeria. The proportion of people with awareness of HIV/AIDS has increased from 87.7% in 2007 to 94% currently. Similarly survey findings have shown that there has been a decrease in the proportion of adolescents (15-19 years) who ever engaged in sexual intercourse. Youths are
recognized as a group that must be targeted with HIV interventions and this has resulted in the inclusion of a Family Life HIV/AIDS Education (FLHE) curriculum in the formal educational program of secondary schools. This has contributed to increasing awareness of HIV/AIDS, and reduces the spread of new infections among youths.

Among the workforce and recognizing the impact HIV/AIDS can have on the human capital of a nation, as at 2012 a total of 60 Federal Ministries, Departments and Agencies (MDAs) are implementing HIV/AIDS work place programmes targeted at staff of these MDAs towards raising awareness, improve correct knowledge of HIV/AIDS and discourage behavior and attitudes that promote infection with HIV.

**HIV/AIDS prevention in the general population- Routine indicators**

<table>
<thead>
<tr>
<th>S/No</th>
<th>Indicator</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Number of condoms distributed</td>
<td>204,334,784</td>
<td>213,110,527</td>
</tr>
<tr>
<td>2</td>
<td>Number of schools implementing FLHE curriculum</td>
<td>1,723</td>
<td>9,836</td>
</tr>
<tr>
<td>3</td>
<td>Number of students/ pupils reached with FLHE</td>
<td>893,437</td>
<td>1,308,581</td>
</tr>
<tr>
<td>4</td>
<td>Number of MDAs that have HIV/AIDS workplace programs</td>
<td>25</td>
<td>60</td>
</tr>
</tbody>
</table>

**9.2.3.4 HIV/AIDS Prevention among Most-at-risk-populations (MARPS)**

HIV/AIDS mode of transmission studies which predict where new infections are coming from have shown that Injecting drug users (IDU), female sex workers (FSW) and men who have sex with men (MSM) who constitute about 1% of the adult population, contribute almost 25% of new HIV infections. Similarly these IDU, FSW, MSM and their partners, contribute as much as 36% of new infections even though together they constitute only 3.4% of the adult population. In the light of this evidence the HIV/AIDS response have also targeted these MARPS with
HIV/AIDS prevention interventions using the MPPI approach. Specific Objectives of HIV/AIDS prevention for Most-At-Risk-Populations is:

- At least 80% of Most-At-Risk Populations (MARP) reached with group-specific interventions and adopting appropriate HIV and AIDS related behavior.
- At least 80% of MARPs use condoms consistently and correctly by 2015
- At least 80% of drug dependent persons (IDUs and non-IDUs) have access to quality prevention programs/services in accordance with national guidelines by 2015.

9.2.3.5 Key Achievements for HIV/AIDS Prevention in Most-At-Risk Populations for 2011 and 2012

To improve targeting of MARPS, mapping of locations where these MARPs are found and size estimations have been conducted. HIV/AIDS epidemic appraisal in states to understand the “drivers” of the epidemics among these MARPS and therefore formulate appropriate prevention interventions have so far been completed in 16 states.

Most recent behavioral sentinel surveys in 2010 among MARPS shows that though HIV/AIDS prevalence is higher among MARPS than in the general population there has been a decrease in prevalence among IDUs and FSWs- (Table 1). The IBBSS also showed that correct knowledge of HIV/AIDS prevention methods among the various MARPS was also high (Figure 1).

**HIV prevalence among MARPS- IBBSS 2007 & 2010**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Brothel Based FSW</td>
<td>37.4</td>
<td>27.4</td>
</tr>
<tr>
<td>Non brothel based FSW</td>
<td>30.2</td>
<td>21.1</td>
</tr>
<tr>
<td>MSM</td>
<td>13.5</td>
<td>17.4</td>
</tr>
<tr>
<td>IDU</td>
<td>5.6</td>
<td>4.2</td>
</tr>
</tbody>
</table>
Knowledge of HIV/AIDS prevention methods by MARPS- IBBSS 2010

IBBSS findings also showed that the rate of condom use by Female sex workers with client is high while condom use with regular partner/spouse or boyfriend is comparatively lower.

Condom use at last sex with regular spouse and clients by BBFSW- IBBSS 2010
### HIV/AIDS prevention among MARPS - Routine indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MARPs (female sex workers) reached with individual and/or small group level MPP intervention</td>
<td>17,717</td>
<td>41,747</td>
</tr>
<tr>
<td>Number of MARPs (transport workers) reached with individual and/or small group level MPP intervention</td>
<td>48,138</td>
<td>58,917</td>
</tr>
<tr>
<td>Number of MARPs (MSMs) reached with individual and/or small group level MPP intervention</td>
<td>15,042</td>
<td>24,910</td>
</tr>
</tbody>
</table>

Routine data on coverage of Minimum Package of Prevention intervention (MPPI) among MARPs has also been improving steadily.

### 9.2.3.6 HIV COUNSELLING AND TESTING (HCT)

HCT is the entry point for most HIV and AIDS prevention and control programs. The HCT program has helped millions learn about their HIV status and for those testing positive learn about options for long term care and treatment. The number of sites providing HCT has increased from 1,064 in 2010 to 2,391 as at December 2012. The proportion of people who received HCT doubled between 2003 and 2007. However, the uptake of HCT is still low among Nigerians and the most-at-risk populations. In 2012, the total number of persons who were counseled tested and received results was 2,792,611. Even though the HIV prevalence in the general population is showing a decline it is not the case with the MARPs (Sex Workers and Men having sex with Men). Specific Objectives of HIV/AIDS prevention for HIV Counseling and Testing:

- At least 80% of sexually active adults (including discordant couples and people in concurrent multiple partnerships) accessing HCT services in an equitable and sustainable way by 2015
- At least 80% of most at-risk-populations accessing HIV counseling and testing by 2015
### 9.2.3.7 Key achievements on HCT

There has been an increase in the number of HCT sites in the country, from 1,046 in 2010 to 2,391 in 2012. This is as a result of the strong commitment by government and increase donor support to get Nigerians know their HIV status and make informed decisions.

**Table 5: Achievements on HCT**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of HCT sites</td>
<td>1357</td>
<td>2391</td>
</tr>
<tr>
<td>Number of individuals who received HIV testing and counselling and know their results during the reporting period (HCT Setting)</td>
<td>2,056,578</td>
<td>2,792,611</td>
</tr>
</tbody>
</table>

**Fig 3:** Number of men and women aged +15 who have received an HIV test in the last 12 months from 2008 to 2012
The number counseled, tested and received results has continued to increase, it is still inadequate compare to the estimated population of 162 million people in the country. Survey results have shown that the desire by Nigerians to go for HIV testing increase from 43% in 2005 to 72% in 2007 (NARHS, 2007), yet the uptake of HCT is low among the general population. Though the uptake of HCT among MARPs show some increase from 2007 and 2010, the increase is still inadequate considering the fact that the HIV prevalence among these group is higher than that of the general population, hence potential source of new infections.

9.2.3.8 Antiretroviral therapy for patients living with HIV
The ART programme commence in the country in 2002, with the target of placing 10 thousand patients on drugs. Many players came into the field following the free ART policy of the government in 2006, this led to increase access and uptake of treatment by eligible people living with HIV. The number of facilities rendering ART services has increased to 516 as at December 2012. The number of persons receiving ART as at 2012 stood at 491,021. The Specific Objectives of the antiretroviral program are as follows:
- At least 80% of eligible adults (women and men) and 80% of children (boys and girls) are receiving ART based on national guidelines by 2015
- At least 80% of PLHIV are receiving quality management for OIs (diagnosis, prophylaxis, and treatment) by 2015
- All states and local government areas (LGAs) are implementing strong TB/HIV collaborative interventions by 2015
- All TB suspects and patients have access to quality and comprehensive HIV and AIDS services by 2015
- All PLWHIV have access to quality TB screening and those suspected to have TB, to receive Comprehensive TB services.

9.2.3.8 KEY ACHIEVEMENTS ON ART.
The progress of the antiretroviral therapy has been measured over time using the following output, outcome and impact indicators.

Table 6: Output, Outcome and Impact indicators for ART Program

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of health facilities that offer antiretroviral drugs</td>
<td>491</td>
<td>516</td>
</tr>
<tr>
<td>Number of adult and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (WHO standards)</td>
<td>432,285</td>
<td>491,021</td>
</tr>
<tr>
<td>Percentage of adult patients and children with HIV still alive and known to be on antiretroviral therapy 12 months after initiating treatment among</td>
<td>73%</td>
<td>77%</td>
</tr>
</tbody>
</table>
Number of persons receiving ART 2008 to 2012

The figures showed an upward increase of 74% in the number of sites offering ART services from 2008 to 2012; the increase political will of the government and the number of foreign donors in the ART programme accounts for this. The free ARV provision policy in 2006 by the federal government has led to increased access and uptake of treatment for eligible people living with HIV accounting for the increase in the number of patients on ART. The percentage increase in the number of patients on treatment 12 months after initiation shows the increase in quality of life and increase life expectancy of patients on treatment sequel to the improved supply chain management of antiretroviral drugs and RTKs.

9.2.3.9 Prevention of Mother To Child Transmission of HIV (PMTCT)

Prevention of Mother to Child Transmission (PMTCT) aims at eliminating the transmission of HIV from mother to child during pregnancy, labour and breast feeding which accounts for 10% of new infections. The PMTCT programme commenced in 2001 in 6 tertiary health institutions in the country. The number of health facilities offering PMTCT services has increased from 6 2001 to 959 and 1410 in 2011 and 2012 respectively. Specific Objectives of the PMTCT program are as follows:
- At least 80% of all pregnant women have access to quality HIV testing and counseling by 2015.
- At least 80% of all HIV positive pregnant women have access to more efficacious ARV prophylaxis by 2015.
- At least 80% of all HIV exposed infants have access to ARV prophylaxis by 2015.
- At least 80% of HIV positive pregnant women have access to quality infant feeding counseling
- At least 80% of all HIV exposed infants have access to early infant diagnosis services

**9.2.3.10 Key Achievements On PMTCT.**
Increase attention is been paid to PMTCT in the national response making the intervention an area of priority, knowing that it contribute 10% of new HIV infections.

*Key achievements in the PMTCT program*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number PMTCT sites in the country</td>
<td>959</td>
<td>1,410</td>
</tr>
<tr>
<td>Number of pregnant women who were tested for HIV in the last 12 month and received their results</td>
<td>1,054,816</td>
<td>1,197,754</td>
</tr>
<tr>
<td>Number of HIV positive pregnant women receiving ARV prophylaxis to reduce MTCT.</td>
<td>37,864</td>
<td>40,465</td>
</tr>
<tr>
<td>Number of infants born to HIV infected women who received antiretroviral prophylaxis to reduce early mother-to-child transmission(early postpartum in the first 6 weeks)</td>
<td>5,472</td>
<td>12,455</td>
</tr>
</tbody>
</table>
Number of HIV positive pregnant women receiving ARV prophylaxis to reduce MTCT from 2008 to 2012.

![Bar chart showing the number of HIV positive pregnant women receiving ARV prophylaxis from 2008 to 2012](chart1.png)

Number of pregnant women counseled and tested for PMTCT from 2008 to 2012

![Bar chart showing the number of pregnant women counselled and tested for PMTCT from 2008 to 2012](chart2.png)
Increase attention is been paid to PMTCT in the national response making the intervention an area of priority, knowing that it contribute 10% of new HIV infections. Though coverage of PMTCT is low, the number of pregnant women tested for HIV show increase from 907,387 in 2010 to 1,197,754 in 2012. The number of HIV positive pregnant women receiving ARVs prophylaxis to reduce MTCT has increase from 26,133 in 2010 to 40,465 in 2012. These improvements are due to increase funding of the programme by government and donors.

9.2.3.11 Coordination Of The National Response To HIV/AIDS
The national response in Nigeria is coordinated through a system involving state and non-state actors. NACA leads the coordination at national level, with the FMOH responsible for the health sector component of the response and other line ministries for other inter related aspects at National level. Non-state actors are equally responsible for key aspects of the response including resource mobilization, advocacy, demand creation and equity. For purposes of consistency, NACA interfaces with representation from key stakeholders to broaden the coordination reach and effectiveness. These include NACA-SACA, NACA-Civil Society organizations (CSOs), NACA-private sector, NACA-public sector and NACA-development partner and NACA-TWG interactions.

Strategic Objectives of the National Response Coordination include:

- To strengthen NACA, SACA and LACA capacity to effectively coordinate sustainable and gender sensitive and aged-responsive multisectoral HIV/AIDS response at National, state and LGA respectively.

- Increase in the financial contributions of government at all levels to at least 30% of financial resources required for HIV/AIDS interventions by 2015.

- To mobilize additional financial resources from non-governmental sources in support of the implementation of the national HIV/AIDS response.

Table 8: Key achievements in the National response coordination for 2011 and 2012
The numbers of states that have transformed into agencies (backed by legislation) from ad hoc committees have steadily increased from 10 in 2010 to 29 in 2011 and 35 in 2012. The effective coordination of NACA through advocacy and government commitment to fighting HIV/AIDS is responsible for this increase thus there is increase ownership at state levels. Also inherent is its increased funding, from 23% in 2011 to 25% in 2012 of total expenditure in the national response increasing government resolve to ownership and sustainability.
CHAPTER 10: SUMMARY OF KEY ACHIEVEMENTS, CHALLENGES, FORECAST OF KEY ACTIVITIES IN 2013 AND CONCLUSIONS.

10.1 Achievements:
- National mapping and size estimations for MARPs.
- National HIV Vaccine Development Plan production.
- Official launch and take off of the National HIV/AIDS & Related diseases call centre.
- Road Map for Moving Forward prep Access in Nigeria.
- Start up and lunch of National HIV Resource Centre.
- OAFLA meetings.

10.2 Challenges:
- The inability of some SACAs to transform into agencies has affected coordination of the response at the state level.
- The continuous dependence of the national response on donor support to finance most of its programmes is a great challenge to sustainability and ownership.
- The pockets of insecurity in some parts of the country affected the coordination of the national response in the country in 2012.

10.3 Conclusion.
The intensity of various interventions in the fight against the scourge of the HIV epidemic have begun to impact on halting and reversing the spread of the virus. The prevalence rate has remained stable at 4.4% in 2005, 4.5% in 2008 and 4.1% in 2010. Though with this drop in prevalence Nigeria still rank second to south Africa in the number of people living with the virus, which stand at an estimated 3.5 million, current efforts have to be improved and sustained to keep the infected alive, while the uninfected Nigerian remains negative.

Appreciable efforts have been made in the prevention intervention among the general population and MARPs as over 200 million condoms were distributed in 2012. The effect of
these effort is observed in the drop of the HIV prevalence among MARPs in 2010 to 2012 as well as the increase in the number of adult Nigerians taking HIV counseling and testing (HCT).

HIV and AIDS treatment has improved the quality and life expectancy of patients as 77% in 2012 from 73% in 2011 are known to be alive and are still in treatment. Mother-to-child transmission of HIV which contributes 10% of new infections is being stem-down by the PMTCT intervention, where more HIV positive pregnant women are receiving ARVs for prophylaxis in 2012.

The increase in the number of states that are now agencies and government contribution to the total HIV/AIDS expenditure, though still inadequate gives hope for future ownership and sustainability of the HIV response.