

NATIONAL AGENCY FOR THE CONTROL OF AIDS (NACA)

Federal Republic of
NIGERIA

GLOBAL AIDS RESPONSE

Country Progress Report

Nigeria GARPR 2012

2012

ABUJA, NIGERIA

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ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Ante-Natal Clinics
ART	-	Anti-Retroviral Therapy
ARV	-	Anti-Retroviral
BSS	-	Behavioural Sentinel Survey
CSO	-	Civil Society Organization
CSW	-	Commercial Sex Workers
DoC	-	Declaration of Commitment
FCT	-	Federal Capital Territory
FMOH	-	Federal Ministry of Health
HCT	-	HIV/AIDS Counselling and Testing
HEAP	-	HIV/AIDS Emergency Action Plan
HIV	-	Human Immunodeficiency Virus
IBBSS	-	Integrated Biological and Behavioural Surveillance Survey
ICAP	-	International Centre for AIDS Care and Treatment Program
IDU	-	Injecting Drug Users
LACA	-	Local Action Committee on AIDS
LAC	-	Local Government Action and Communication
LGA	-	Local Government Area
MDA	-	Ministries, Department and Agencies
MDG	-	Millennium Development Goals
M & E	-	Monitoring and Evaluation
MARPs	-	Most at Risk Populations
MOT	-	Modes of Transmission
MSM	-	Men who have Sex with Men
NACA	-	National Agency for the Control of AIDS
NASA	-	National AIDS Spending Assessment
NARHS	-	National HIV/AIDS Reproductive Health Survey
NARHS Plus	-	National HIV/AIDS Reproductive Health Survey Plus
NDHS	-	National Demographic and Health Survey
NGOs	-	Non-Governmental Organization
NNRIMS	-	Nigeria National Response Information Management System
NOP	-	NNRIMS Operational Plan
NSF	-	National Strategic Framework

NIGERIA GARPR 2012 STEERING COMMITTEE

1. Prof. John Idoko- NACA
2. Dr. Kwame Ampomah- UNAIDS
3. Dr. Kayode Ogungbemi- NACA
4. Dr. Aderemi Azeez- HIV/AIDS Division (FMOH)
5. Dr. Greg Ashefor- NACA
6. Dr. Job Sagbohan- UNAIDS
7. Dr. Niyi Ogundiran- WHO
8. Mr. Akin Atobatele – USAID
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10. Mr. Richard Ugbena – CDC
11. Miss Chika Anene- UNAIDS
12. Mr. Francis Agbo- NACA
13. Mrs. Oby Okwuonu – FMWASD
14. Mrs. Hajara Obayemi – NEPWHAN
15. Mr. Talle Ghali- FME

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6. Mr. Francis Agbo – NACA
7. Mr. Collins Imarhiagbe– CIHP
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17. Miss Theresa Jilaga – Data manager
18. Mr. Victor Onwukwe – Data manager

FOREWARD

The Federal Government of Nigeria reaffirmed its commitment to leading an effective and coordinated response to the HIV epidemic at the 2011 UN High Level meeting in New York. Nigeria remains committed to reaching universal access targets as well as meeting the MDG goal of halting and reversing the spread of the HIV epidemic by 2015. It is in this regard that the country is pleased to submit the Nigeria 2012 Global AIDS Response Progress report (GARPR) that provides update on the progress the country has made towards meeting universal access and GARPR targets.

The response in Nigeria continued to build on the principle of accountability, partnership and collaboration. We are pleased to report significant progress in all thematic areas of the HIV response in the country. Government has commenced the decentralization of HIV treatment and care to the primary health care level to increase coverage. Government with support from the relevant partners has continued to establish and strengthen structures to deliver on the expected outcomes for the National response.

The Federal Government of Nigeria has continued to invest in the response by in-kind contributions, payments of emoluments and other related employee benefits such as pensions. Donor investment in the HIV response has however, continued to outstrip the government's investment even though spending on HIV by Government increased from 7.6% in 2008 to 25% in 2010.

We want to use this opportunity to acknowledge and express our gratitude to all our national response partners and stakeholders for your continued support to the national response. As in previous reporting rounds this 2012 GARPR report was made possible with the support of all the relevant stakeholders. It is hoped that we will continue in this spirit of partnership and collaboration as we strive to meet the goals and targets of the HIV response in the country.

Professor John Idoko,

Director General, National Agency for the Control of AIDS (NACA)

ACKNOWLEDGEMENT

The National Agency for the Control of AIDS wishes to acknowledge the support of the various stakeholders that contributed to the process of developing this Nigeria 2012 Global AIDS Progress Report. In particular we wish to express our appreciation to the Joint United Nations programme on HIV/AIDS in Nigeria for her financial and technical support to the process.

Several other organizations contributed directly to the process including the HIV/AIDS Division (FMOH), Federal Ministries of Education and Women Affairs & Social Development, USAID, CDC, networks of civil society and persons living with HIV/AIDS and key implementing partners like IHVN and CIHP.

We would also like to especially thank members of the Nigeria 2012 GARP Report Steering Committee for providing oversight and technical guidance for the report writing process.

NACA also appreciates the indirect contributions of implementing partners that provided data for the report as well as helped validate the data before submission of the report. The core team and the consultants who led the report writing process is hereby acknowledged and appreciated. It is our earnest hope that the report will be useful for the information, review, planning and decision-making needs of the relevant stakeholders.

Finally, we would like to express the gratitude of the national response stakeholders to the Federal Republic of Nigeria and all our external donor partners for their unflinching support towards ensuring that our country halts and reverses the spread of the epidemic as well as ensure universal access to comprehensive prevention, treatment and care and support.

Dr Michael Kayode Ogungbemi,
Director, Strategic Knowledge Management Department,
National Agency for the Control of AIDS.

Section One: Status at a Glance

Inclusiveness of Stakeholders in the Report Writing Process

The report writing process commenced with the formation of the Global AIDS Response Program Reporting Steering Committee by the National Agency for the Control of AIDS in February 2012. This steering committee was tasked with supporting the compilation of the country report and ensuring submission to meet the deadline of 31st March 2012. Three sub-committees were instituted to guide data collection and analysis, planning and execution of stakeholder engagement, compile AIDS spending data and examine core indicators. Technical Assistance was provided by the Nigeria UNAIDS Country Team.

Stakeholders from the government and civil society organizations contributed to this report by meeting regularly to review progress, providing data for the report and reviewing the report till its finalization. A team of consultants were engaged for this process and progress toward the completion of the report was monitored by the steering committee.

Data collection commenced on the 5th March 2012 with formal letters dispatched from NACA Director General to line ministries and key development partners in the national HIV/AIDS response. The letters sent out introduced the exercise to recipient organizations and included specific requests for data, appropriate sections of the NCPI questionnaire and requests for submission of organizational best practices. The consultants worked with the guidelines for the construction of core indicators to define specific data requests to be sent to government and development partners. Where necessary additional data was sourced from Ministries, civil society organizations (CSOs) and UN Agencies through letters of request, consultative meetings and/or administered interviews. Key Informant Sessions were conducted with NACA and line Ministries, Departments and Agencies key personnel, NGOs, UN agencies, bilateral partners, development partners, private sector players and other key members of the civil society.

The Ministry of Health was given the responsibility of collating all health sector data. Due to the currently existing weaknesses in the national reporting system, the Federal Ministry of Health relied extensively on the data collection systems of implementing partners to collate data. Data collected were facility level data. At the point of collation at the Strategic Information unit of the HIV/AIDS Division of the Federal Ministry of Health, an M & E Officer analyzed the data and sent queries for the implementing partners to respond to. The whole database was now shared with WHO, CDC and USAID FOR concurrence before presentation.

The NCPI questionnaire was circulated to government department and agencies, development partners and civil society organizations contributing to the national response to HIV. This was done at the early stages of commencement of the exercise to enable stakeholders prepare responses ahead the stakeholders workshop and NCPI response collation. Part A of the NCPI questionnaire was completed by NACA and the HIV/AIDS division of the Federal Ministry of Health. Part B was administered to representatives from national and international CSOs, bilateral partners and UN agencies. Responses to the questionnaires were collated and agreement obtained on unified responses to NCPI questions at the NCPI workshop. Thereafter, responses were validated at a broader stakeholder's data validation meeting organized with participants from UN agencies, bilateral and multilateral development partners and the civil society organizations including persons living with HIV in order to validate the data to be submitted.

The compilation of the report started with a desk review of background documents on the HIV epidemic and response in Nigeria. Documents reviewed included the following:

- a. Strategic documents: National HIV/AIDS Strategic Framework (NSF) 2010-15(1)
- b. Programmatic Reports: National AIDS control programme annual reports.
- c. Population based survey reports: Nigeria Demographic and Health Survey (NDHS) 2003 and 2008, National HIV/AIDS and Reproductive Health Survey (NARHS) 2005 and 2007.(2)(3)
- d. Sub-population survey reports; Antenatal HIV sentinel surveillance 2008, 2010. Integrated Biological and Behavioural Surveillance Survey (IBSS) 2007 & 2010 (4) (5) (6).
- e. Specialized surveys in specific population groups, patient tracking systems, programmatic data, National AIDS Spending Assessment report 2007/2008, and 2009/2010.
- f. Programme Reviews: the National Composite Policy Index (NCPI), Joint Annual Review of the National Response to HIV/AIDS 2011 and Nigeria Country UNGASS Report, 2003, 2005,2007 and 2010 (7)
- g. Epidemic and response synthesis, programme data and other relevant data sources.
- h. Modes of HIV Transmission report 2009
- i. Universal Access report 2010

Three days post validation meetings were held to finalize the report prior to submission.

Status of the Epidemic

Nigeria carries the second heaviest burden of HIV in Africa and has an expanding population of People Living with HIV (PLHIV). Despite challenges in scaling up access, institutional reforms and political commitment to tackle the diseases, the country has seen more citizens placed on life saving medication.

For the twenty six year period dated 1986 till December 2011, that AIDS was first reported in Nigeria, 3,459,363 people now live with HIV and an estimated 1,449,166 require ARV. 388,864 new infections occurred in the year ended 2011 and records show 217,148 AIDS related deaths (4). Between 1991 and 2001, Nigeria witnessed an increase in the prevalence of HIV in the country. The first case of AIDS in Nigeria was reported in 1986 thereby establishing the presence of the epidemic in the country. Consequently, and in line with guidelines from the World Health Organization (WHO), the government adopted ANC sentinel surveillance as the system for assessing the epidemic. The national HIV Seroprevalence level, obtained from sentinel surveys of antenatal care attendees, increased from 1.8 percent in 1991 to 5.8 percent in 2001 and then declined to 5.0 percent in 2003 and further to 4.4 percent in 2005. This was followed by a rise to 4.6 percent in 2008 and then a recent decline to 4.1 percent in 2010.

With an estimated population of 162,265,000, Nigeria is the most populated country in sub-Saharan Africa, a region which carries the globe's heaviest burden of HIV/AIDS. The most recent HIV Seroprevalence figure represents about 3.5 million people infected with HIV, ranking Nigeria third among the countries with the highest HIV/AIDS burden in the world, next only to India and South Africa. Although the national median prevalence of HIV has taken a downward turn in recent years, the absolute number of people living with HIV has

increased by almost half a million people in three years and AIDS related mortality has also slightly increased in the same time period to about 217,148 annual deaths attributed to AIDS.

Although most-at-risk populations contribute to the spread of HIV, heterosexual sex, particularly of the low-risk type, still makes up the bulk of infections (about 80 percent). Mother-to-child transmission and transfusion of infected blood and blood products are generally estimated as ranking next as common routes of infection; arguably, each of these two are believed to account for almost ten percent of infections. Even as HIV prevalence in the general population has decreased from the 1990s, it has risen in sex workers and men having sex with men, hence, who have become very important bridge groups. In the country, women below the age of 49 years have the highest HIV prevalence rates and mother –to-child transmission now accounts for 10% of new infections. The North central zone has the highest prevalence rates per zone while urban areas had more HIV prevalence than rural.

Table 1 - Epidemiology of HIV in Nigeria: Key Facts

	2008	2012
National Median HIV Prevalence	4.6%	4.1%
Estimated Number of PLWHIV	2,980,000	3,459,363
Annual AIDS Death	192,000	217,148
Number requiring Antiretroviral Therapy	857,455	1,449,166
New HIV Infections	336,379	388,864
Total Number of AIDS Orphans	2,175,760	2,193,745

Key drivers of the HIV epidemic in Nigeria include low personal risk perception, multiple concurrent sexual partnerships, intense transactional and inter-generational sex, ineffective and inefficient services for sexually transmitted infections (STIs), and inadequate access to and poor quality of healthcare services. Entrenched gender inequalities and inequities, chronic and debilitating poverty, and stubborn persistence of HIV/AIDS-related stigma and discrimination also significantly contribute to the continuing spread of the infection.

Policy and Programmatic Response

Policy

HIV/AIDS remains a threat to population health in Nigeria; it continues to strain the struggling health system and reverse many developmental gains of the recent past including maternal and under-five mortality rates. Nigeria has enacted a number of laws and policies to guide the multi-sectoral response to HIV/AIDS. The policies have been well articulated in and draw on a number of documents including the following:

- A. The **National Policy on HIV/AIDS** (8) was developed in 2009 by the National Agency for the Control of AIDS. This policy document provide regulations and guiding principles on topics ranging from prevention of new infections and behaviour change, treatment, care and support for infected and affected persons, institutional architecture and resourcing, advocacy, legal issues and human rights, monitoring and evaluation, research and knowledge management and policy implementation by the various stakeholders in the national response. The national policy was developed in agreement with key national and international frameworks relevant to the HIV/AIDS response in Nigeria, including:
 - The 1999 Constitution of the Federal Republic of Nigeria, which affirms the national philosophy of social justice and guarantees the fundamental right of every citizen to life and to freedom from discrimination.
 - Complementary government policy documents which provide the framework for the National HIV policy, including the NACA Act, Medium Term Strategy, National

Economic Empowerment and Development Strategy (NEEDS) I and II, National Gender Policy, and the Seven Point Agenda of the Federal Government of Nigeria.

- Commitments to and ratification of numerous international conventions including Universal Declaration of Human Rights (1948), the Convention on Economic, Social and Cultural Rights (1976), the Convention on the Elimination of All Forms of Discrimination Against Women (1979), Convention on the Rights of the Child (1989), and the African Charter on Human and People's Rights (2003)
 - Nigeria's ratification of agreed international community goals including the Programme of Action of the International Conference on Population and Development ICPD (1994), The Political Declaration and further action and initiatives to implement the Beijing Declaration and Platform for Action (2000), Political Declaration at the World Summit for Social Development (1995), The United Nations Millenium Declaration (2000) which target 2015 for the reversal of the epidemic trajectory, Greater Involvement of People with AIDS (GIPA) and Meaningful Involvement of People with AIDS (MIPA) principles, The Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and other related diseases in Africa (2001) and the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (2001).
 - Nigeria's Commitment to Universal Access and to comprehensive HIV prevention, treatment, care and support as enunciated in the following: the 2005 Gleneagles G8 Universal Access Targets, the 2006 United Nations Political Declaration on HIV/AIDS, the African Union's Abuja Call for Accelerated Action towards Universal Access for HIV/AIDS (2006), and the Brazzaville Commitment on scaling up towards Universal Access to HIV and AIDS prevention, treatment, care and support services in Africa by 2010.
- B. The Nigerian government has been pro-active in its efforts to confront the HIV scourge with its overarching strategy elaborated in the bottom-up poly-stakeholder and multi-sectoral National Strategic Plan (NSP). The NSP is derived from the architecture of the **National Strategic Framework 2010-15** (NSF II) and has targets to halt and begin to reverse the spread of HIV infection, as well as mitigate the impact of HIV/AIDS, by 2015. With the condition that where appropriate, the targets of the NSP should be population-based, the Federal Government of Nigeria implicitly recognizes HIV care and treatment as a national public health good. To this effect, The NSF II was developed to provide direction and ensure consistency in the development of the strategic plans by all stakeholders including all the 36 states of the Federation and the Federal Capital Territory (FCT); Government Ministries, Departments and Agencies (MDAs); and the constituent coordinating entities of Civil Society Organization (CSOs) Networks. The NSF II, unlike the NSF 2005-2009 (NSF I), is linked to Universal and MDG targets and Vision 20:2020 and has an overriding emphasis on HIV prevention.

The Response Analysis of the preceding NSF 2005-2009, together with input from over 250 stakeholders from public, private and civil society sectors and development partners provided the evidence for findings and recommendations that guided the NSF II. Although approximately 1, 555, 780 PLHIV require ARV drugs, about one third of this group are currently on treatment. The gender dynamics in the profile of infections and the growing burden of the 2.2 million HIV orphans in the country has made it necessary for the revised policy to critically address the following:

- The rising HIV prevalence among women
- The expansion in number of orphans and vulnerable children
- The stigmatization of PLHIV and violation of their rights as well as their roles and responsibilities.
- The differences in communication messages on abstinence, condom use etc in post – primary educational institutions.
- The issues associated with increased access to treatment and care.

The NSF II builds on the National HIV Policy and provides and provides a broad structural framework for the implementation of this policy. Considerations that informed the development of this framework include the burden of HIV/AIDS in the

country, the public health challenge of HIV/AIDS, comprehensive HIV/AIDS services, feminization of the epidemic and strategy for gender streaming, young people, MARPs, modes of HIV transmission, drivers of the epidemic, stigma and discrimination, cultures, traditions and religion, human rights and multisectoral partnership.

- C. Other policy documents that the national response to HIV draws from are The National Action Plan on Orphans and Vulnerable Children and The National HIV/AIDS Prevention Plan.

In spite of the numerous policies, minimal progress has been made in addressing the human rights and legal issues surrounding HIV/AIDS. This is mainly due to the fact that, in Nigeria, official policy documents do not constitute law and cannot be enforced in the courts of law. They constitute merely administrative tools and guidelines that provide direction for governmental action. However, these policy documents can and may elaborate and specify the goals, values, and standards to which existing laws aspire and may be useful in interpreting the latter as well as guiding programmatic interventions by the government. The problem is that, at the moment, there are no HIV/AIDS specific laws on the statutes. Due to the delay in the progress of legal reforms and the absence of the backing of the law, government policy documents can only serve to inspire an effective national HIV/AIDS response that respects the rights of PLHIV and PABA.

Currently, the 1999 Nigerian constitution and international treaties ratified by the country have provided the major sources of human rights for PLHIV and PABA in the country. However, as none of these treaties or the constitution specifically addresses the situation of PLHIV and PABA, the case of their applicability often has to be made through advocacy and lobbying. One outcome of this advocacy agenda has been the efforts made by civil society networks in spearheading the pressure for the passage of the anti-discriminatory bill. Anti-stigma and discrimination bill has passed through Senate and House of Representatives. The bill is waiting to be sign into law by the presidents. 3 states have passed the bill into law. Efforts by civil society networks like CiSHAN, NYNETHA and NEPWHAN have recently included advocacy for increased government investment in the HIV response, facilitation of the use of available policies and guidelines and promotion of the establishment of the legal framework for protection of prospective employees and intending couples.

For most-at-risk and other vulnerable population groups like sex workers, men who have sex with men (MSMs) and injecting drug users (IDUs), there remains a clear absence of non-discrimination laws or regulations specifying protection for these groups. Rather, the country has enacted laws that threaten past successes in mitigating the spread of HIV and present obstacles to effective prevention, treatment, care and support for MSMs. The Nigerian Senate, have passed a bill to prohibit same sex marriage. Tagged Same-Sex Prohibition Bill, the law proposed up to 14 years imprisonment each for gay couples who decided to solemnize their union while witnesses to the marriage or anyone who assisted the couples to marry could be sentenced to 10 years behind bars. The Bill also makes operation or registration of gay clubs or organizations a criminal offence. Also proscribed by the new Bill is “public show of same-sex amorous relationships directly or indirectly” with 10 years’ imprisonment stipulated as punishment. But the new bill must be passed by the lower chamber, the House of Representatives and signed by the President before it can become law. This bill, originally designed to outlaw gay marriage in Nigeria, will turn out to effectively criminalize gay groups and organizations and promote the discrimination and persecution of persons on the basis of their sexual orientation and gender identity if passed.

Same-sex sexual activity in Nigeria is a felony according to Chapter 21, Articles 214 and 217 of the Nigerian Criminal Code and is punishable by imprisonment of up to 14 years throughout the country.

In the 12 northern states that have adopted Shari'a law, anal intercourse is punished with 100 lashes (for unmarried Muslim men) and one year's imprisonment and death by stoning for married or divorced Muslim men. As of March 2006, press reports say that more than a dozen people have been sentenced to death by stoning since 2000, but the sentences had not been carried out.

Programmatic Response

Based on commitments to secure significantly increased resources (human, material, financial and technical) for the national HIV/AIDS response from both domestic and international sources, Nigeria set ambitious country specific targets to monitor progress towards Universal Access to HIV/AIDS Interventions. A number of large scale interventions were identified as critical to the success of progress towards the universal access goal. These interventions included gender mainstreaming, advocacy at all levels, capacity building including training and skills development, increased access to material goods, technical assistance and sustainable funding addressed in all six defined thematic areas for the national response, outlined below:

1. Promotion of Behaviour Change and Prevention of New Infections
2. Treatment of HIV/AIDS and related Health Complications
3. Care and Support of PLHIV, PABA and OVC
4. Policy, Advocacy, Human Rights and Legal Issues
5. Institutional Architecture, Systems, Coordination and Resourcing
6. Monitoring and Evaluation Systems comprising M & E, Research, and Knowledge Management

Indicator Overview Table

Table 2 - Global AIDS Response Program Indicators

TARGET / INDICATOR	UNGASS 2007	UNGASS 2010	GARPR 2012
Target 1: Reduce Sexual Transmission of HIV by 50%			
<i>General Population</i>			
Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	22.5% NARHS 2005	24.2% NARHS 2007	24.2% NARHS 2007
Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	9.8% NARHS 2005	11.9% NARHS 2007	11.9% NARHS 2007
Percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	10.4% NARHS 2005	11.4% NARHS 2007	11.4% NARHS 2007
Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months and who report the use of a condom during their last intercourse	56.1% NARHS 2005	52.5% NARHS 2007	52.5% NARHS 2007
Percentage of women and men aged 15-49 who received an HIV test in the past	8.60% (NARHS 2005)	11.7% (NARHS 2007)	11.7% (NARHS 2007)

12 months and know their results			
Percentage of young people aged 15-24 who are living with HIV	4.3% (ANC 2005)	4.2% (ANC 2008)	4.2% (ANC 2010)
Sex workers			
Percentage of sex workers reached with HIV prevention programmes	34.30% (IBBSS 2007)	34.30% (IBBSS 2007)	18.2% (IBBSS 2010)
Percentage of sex workers reporting the use of a condom with their most recent client	91.97% (IBBSS 2007)	98% (FSW only)	88.6% (MSW & FSW) 54.7% (MSW) 92.9% (FSW) (IBBSS 2010)
Percentage of sex workers who have received an HIV test in the past 12 months and know their results	38.2% (Female Sex Workers Only) (IBBSS 2007)	38.2% (Female Sex Workers Only) (IBBSS 2007)	41.8% (Male & Female Sex Workers) 17.5% (Male Sex Workers) 44.8% (Female Sex Workers)
Percentage of sex workers who are living with HIV	32.7% (Female Sex workers only) (IBBSS 2007)	32.7% (Female Sex workers only) (IBBSS 2007)	24.5% (Male & Female Sex Workers) 18.6% (Male sex workers) 25.2% (Female Sex Workers) (IBBSS 2007)
Men who have sex with men			
Percentage of men who have sex with men reached with HIV prevention programmes	54.38% (IBBSS 2007)	54.38% (IBBSS 2007)	17.99% (IBBSS 2010)
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	52.79% (IBBSS 2007)	52.79% (IBBSS 2007)	50.97% (IBBSS 2010)
Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	30.15% (IBBSS 2007)	30.15% (IBBSS 2007)	24.92% (IBBSS 2010)
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015			
Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	Not Available	Not Available	Not Available
Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	66.1% (IBBSS 2007)	66.2% (IBBSS 2007)	52.5% (IBBSS 2010)
Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	89.2% (IBBSS 2007)	89.2% (IBBSS 2007)	70.89% (IBBSS 2010)
Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	23.19% (IBBSS 2007)	23.19% (IBBSS 2007)	19.42% (IBBSS 2010)
Percentage of people who inject drugs who are living with HIV	5.6% (IBBSS 2007)	5.6% (IBBSS 2007)	4.2% (IBBSS 2010)
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths			

Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	5.25% (NNRIMS Data Base)	21.6% (FMOH 2009)	15.9% (FMOH 2011)
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Not Available	Not Available	4.0% (FMOH 2011)
Mother-to-child transmission of HIV (modelled)	--	29.1% (2010 Spectrum Modelling)	19.8% (2011 Spectrum Modelling)
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015			
Percentage of eligible adults and children currently receiving antiretroviral therapy	16.67% (NNRIMS Data Base)	34.4% (FMOH 2009)	29.8% (FMOH 2011)
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	94.56% (ICAP Programme Record)	70% (FMOH 2009)	73.4% (FMOH 2011)
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015			
Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	55.95% (NTBLCP-Programme Data)	69.1% (FMOH 2009)	-----
Target 6: Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries			
Domestic and international AIDS spending by categories and financing Sources	US\$42,275,977.57 (NASA)	US\$ 394,963,881 (NASA 2008)	US\$497,817,471 (NASA 2010)
Target 7: Critical Enablers and Synergies with Development Sectors			
National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Refer to CRIS	Refer to Online UNGASS Reporting Template	Refer to Online GARP Reporting Template
Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	-----	-----	17.5% (NDHS 2008)
Current school attendance among orphans and non-orphans aged 10–14*	Orphans:75%, Non-Orphans:87% (CRS 2006 OVC Situational Analysis)	OVC: 83.9% Non-OVC:71.7% (NDHS 2008)	OVC: 83.9% Non-OVC:71.7% (NDHS 2008)
Proportion of the poorest households who received external economic support in the last 3 months	Not available	Not available	Not available

Section Two: Overview of the Epidemic

Nigeria lies within latitudes 4° 1' and 13° 9' North and longitudes 2° 2' and 14° 30' East, and is bordered in the North by Niger Republic; in the East by the Republic of Chad and Cameroun; in the West by the Republic of Benin and in the South by the Atlantic ocean. It has a total surface area of approximately 923,768 square kilometres and 800km of coast line.

Nigeria's climate varies with an equatorial south, a tropical centre, savannah and arid north. Natural resources include: natural gas, petroleum, tin, iron ore, coal, limestone, niobium, lead, zinc and arable land. Nigeria has southern lowlands which merge into central hills and plateaus; while mountains abound in the southeast, mostly plains dominate the north.

The country is organized into 36 states and the Federal Capital Territory (FCT). The states are further divided into 774 Local Government Areas (LGAs). The states are grouped into six geopolitical zones based on geopolitical considerations; North-East (NE), North-West (NW), North-Central (NC), South-West (SW), South-East (SE) and South-South (SS). Each zone is distinct in character with their own unique size, composition of population, ecology, language, norms, settlement patterns, economic opportunities and historical background.

Nigeria is the most populous African country with an estimated population of 162,265,000 as at mid-2011 and Total Fertility Rate (TFR) of 5.7. Nigeria's annual growth rate is estimated to be 2.6% in 2012. Nigeria is composed of more than 250 ethnic groups; languages include English (Official), Hausa, Yoruba, Igbo and over 500 indigenous languages. Approximately 50% of the population lives in urban areas with the rate of urbanization estimated at 3.5% annual rate of change.

HIV Prevalence

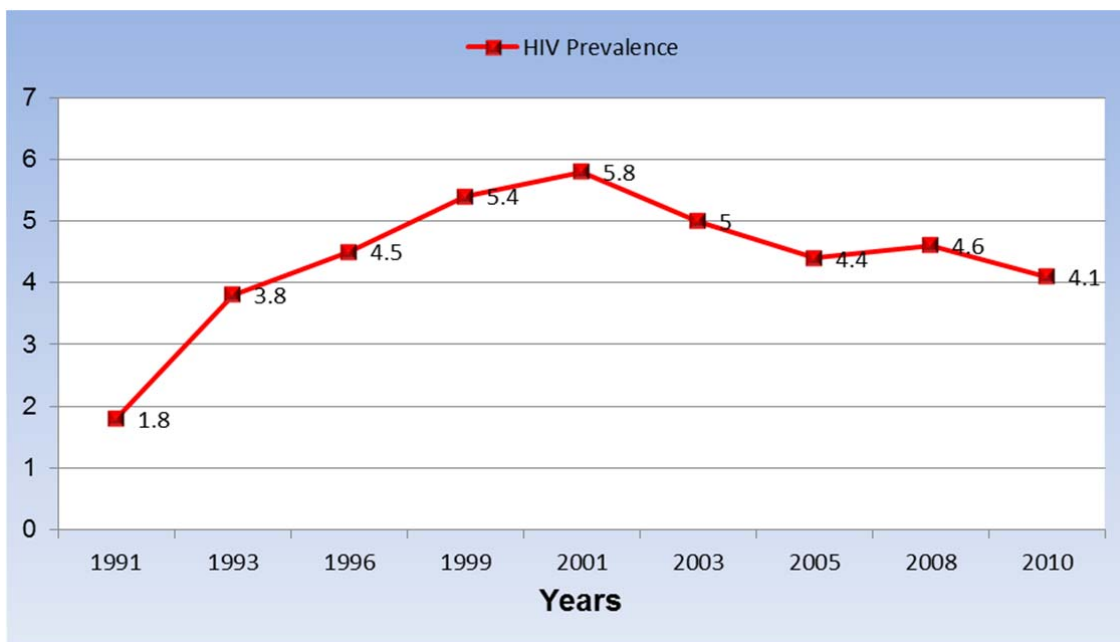
National HIV Prevalence

The first case of AIDS in Nigeria was reported in 1986 thereby establishing the presence of the epidemic in the country. Consequently, and in line with WHO guidelines, the government adopted ANC sentinel surveillance as the system for assessing the epidemic. The first HIV Sentinel Survey in 1991 showed a prevalence of 1.8%. Subsequent sentinel surveys produced prevalence of 3.8% (1993), 4.5% (1996), 5.4% (1999), 5.8% (2001), 5.0% (2003), 4.4% (2005), 4.6% (2008) and 4.1% (2010), a trend signalling a general reversal of the epidemic in the country.

Nigeria's epidemic is generalized (above 1% prevalence among ANC attendees), with wide variation of prevalence within the country. An analysis of the 2010 prevalence rates (4) in the country's six geopolitical zones shows that the highest concentration is in the North Central Zone (7.5%) and the lowest prevalence rate is in the North Western Zone, at 2.1%. There are also differences between and within urban and rural areas with prevalence figures in urban areas varying between 2.7% and 18.0%, while that of the rural area range from 0.7% to 21.3%. Socio-demographic differences in the HIV prevalence are also observable with women, youths, and people with low level of formal education being worst affected by the epidemic.

With an estimated population of 162,265,000, Nigeria is the most populated country in sub-Saharan Africa, a region which carries the globe's heaviest burden of HIV/AIDS. In estimated numbers this represents about 3.5 million² people, still keeping Nigeria as the country with the second highest burden of HIV in the world, only after South Africa. Recent studies show a reduction (4.1%) in the 15-24 years age group down from 4.2% in 2008 and 5.8% in 2001. The number of persons requiring ART stands at 1,449,166 in 2011, a decrease from the number requiring same in 2010, attributed mainly to the massive scale up in initiation of PLHIV on ART.

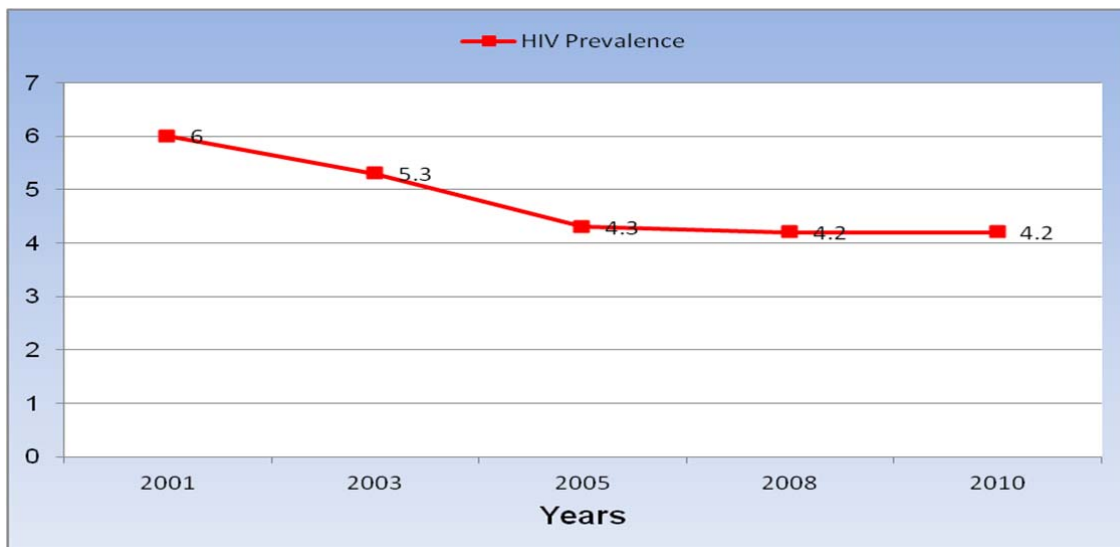
Figure 1 - National HIV Prevalence Trend (1991 - 2010)



HIV Prevalence by Age

HIV prevalence among young people aged 15 – 24 is measured using the HIV prevalence among women attending ANC. Trend analysis of HIV prevalence in this age group has shown a consistent decline from 6% in 2001, plateauing at 4.3% in 2005 and 4.2% in 2010. Within this group, HIV prevalence among young women aged 20 – 24 was found to be higher at 4.6% than that of women aged 15 – 19 at 3%.

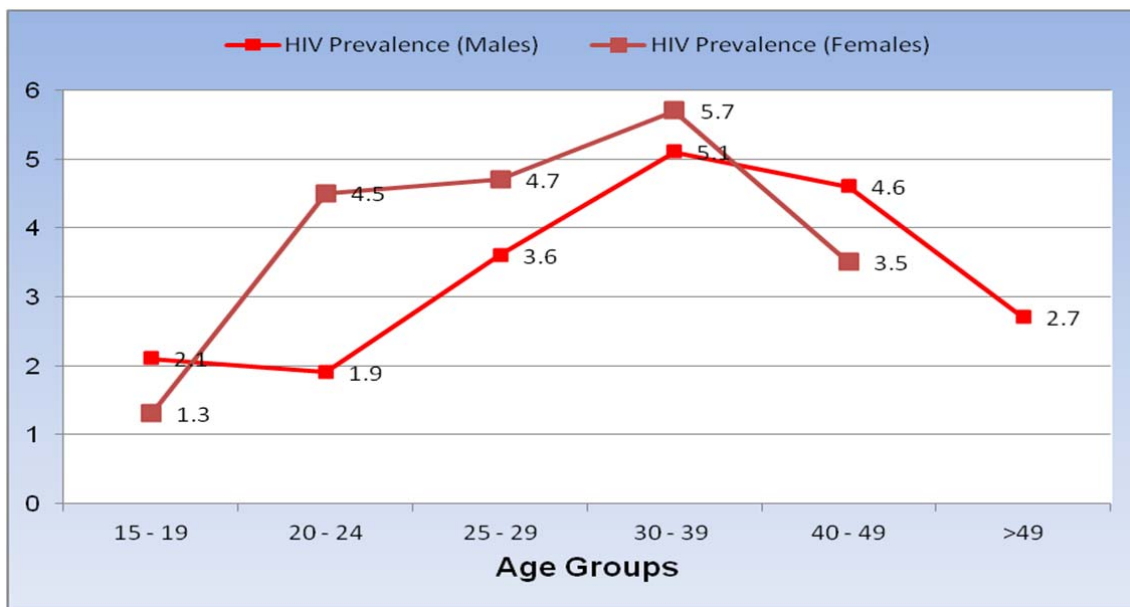
Figure 2 - HIV Prevalence in young women aged 15 - 24



Patterns observed in a previous population based survey (NARHS 2007) (3) shows that gender inequality is an important driver for the epidemic. Prevalence rates were generally higher among females (4.0%) than males (3.2%). Findings also showed higher early vulnerability and infections for girls and women relative to boys and men.

Even among key target populations, women showed a higher HIV prevalence than men. The prevalence of HIV among female injecting drug users was almost seven times that of male IDUs – 21.0% vs. 3%. Among the police, prevalence was higher amongst female police at 4.5% than their male colleagues at 2.0%.

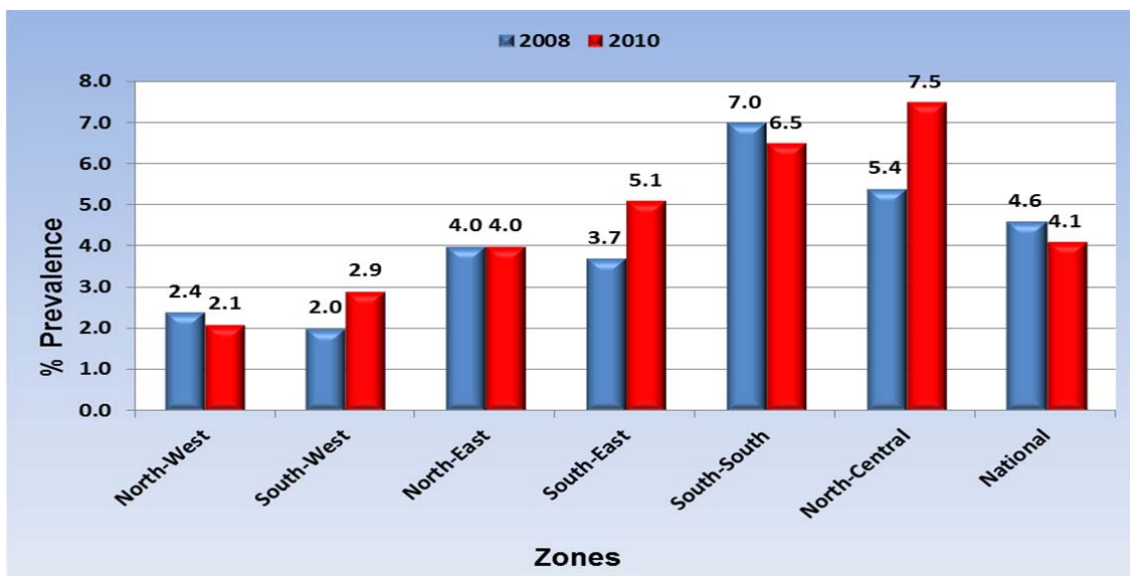
Figure 3 - HIV Prevalence disaggregated by age and sex - Source - NARHS 2007



HIV Prevalence by Geopolitical Zones and States

HIV prevalence increased in the North-Central, South-East and South-West Zones between 2008 and 2010. It dropped in North-West (NW) and South-South (SS) but remained stable in the NE.

Figure 4 - HIV among pregnant women by geopolitical zone



Five states had prevalence of 8.0% and above while five other states had a low prevalence ranging 1.0 to 2.0%. A total of 16 states and FCT had prevalence higher or above 5%. The three states with the highest rates were Benue, Akwa-Ibom and Bayelsa. Benue, Akwa-Ibom, Bayelsa and Anambra respectively showed increases in prevalence from 2008 while FCT, Nassarawa and Cross River experienced a decrease.

The highest site prevalence of 21.3% was reported from Wannune in Benue state while the lowest prevalence of 0% was reported in four sites namely Kwami (Gombe State), Rano (Kano), Owhelogbo (Delta State) and Ganawuri (Plateau State).

Figure 5 - Geographic Distribution of HIV Prevalence by States

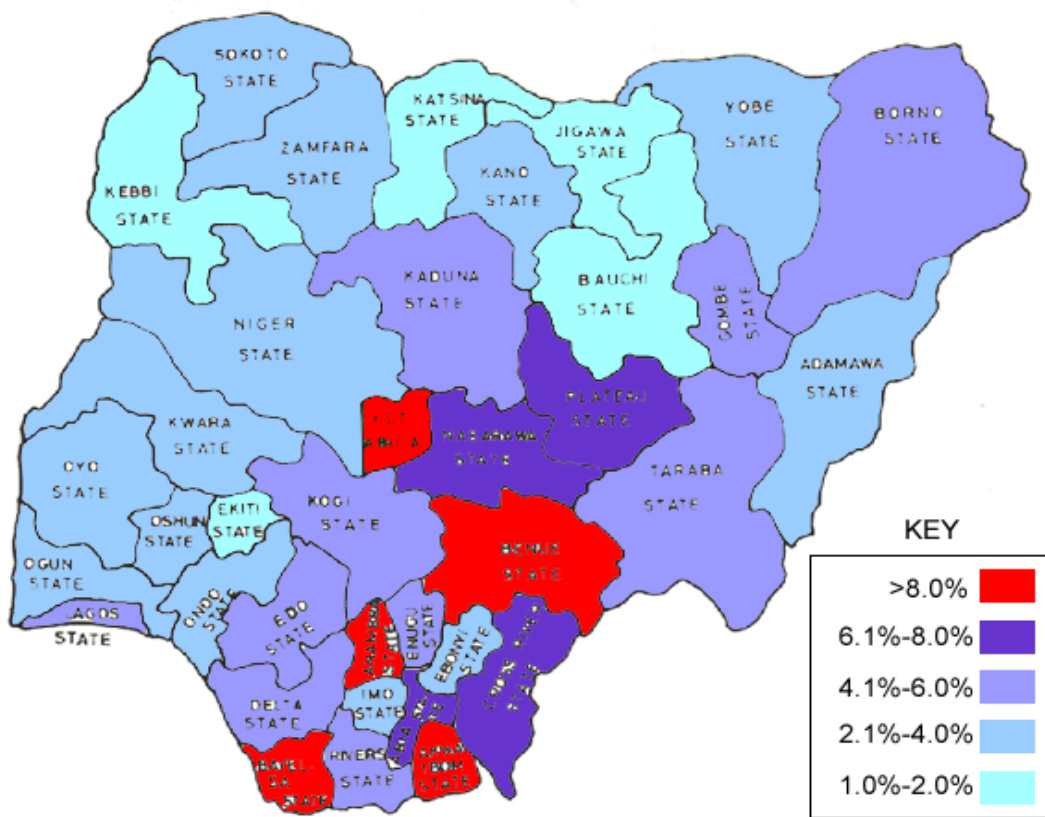


Figure 6 - HIV Prevalence in states with the highest prevalence

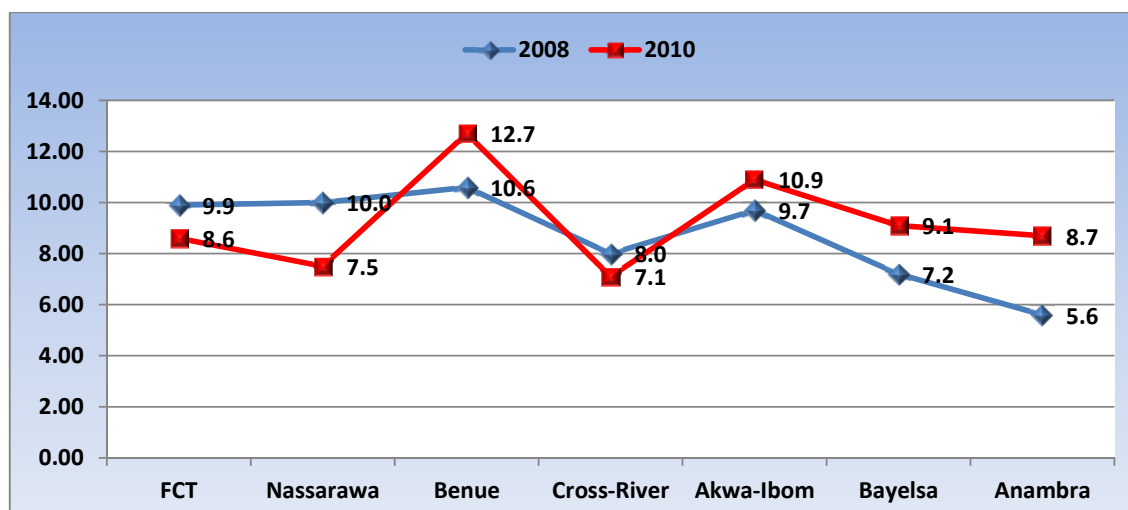
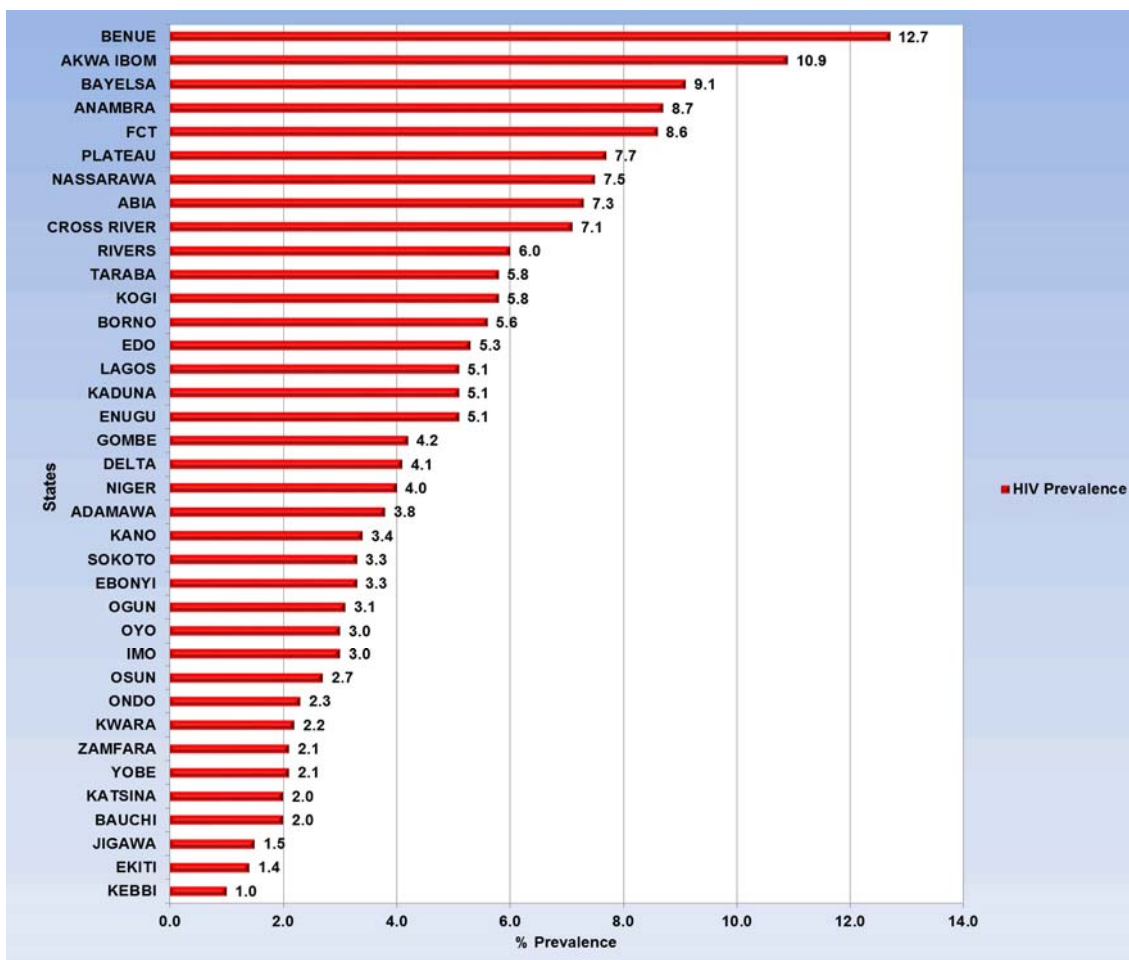
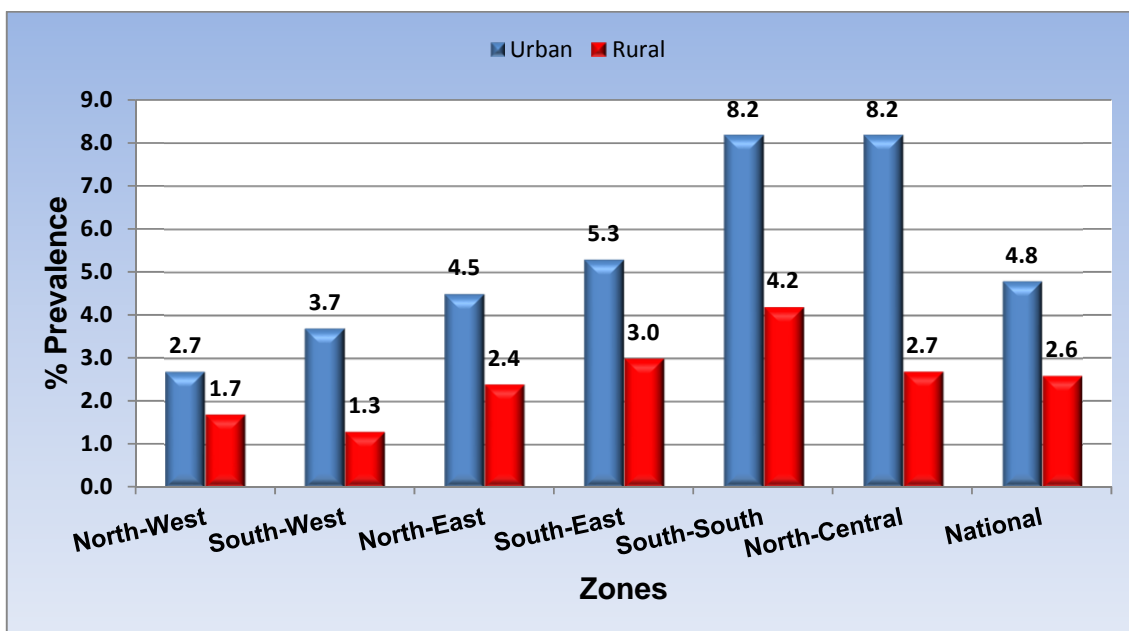


Figure 7 - HIV Prevalence by States



Across the country, urban prevalence is higher than rural in all six geopolitical zones. Similarly, urban prevalence was found to be higher in twenty eight states and FCT with the remaining eight states having higher rural prevalence.

Figure 8 - HIV Prevalence by urban and rural areas



HIV Prevalence among Most-at-Risk-Populations

Some sub-population groups had significantly high prevalence rates with prevalence figures that were well above the national HIV Prevalence. At the top of this group were brothel-based female sex workers (BBFSW), with a current estimated prevalence level of 27.4%. Non-brothel based female sex workers (NBBFSW) came in next with an estimated prevalence of 21.7%, followed by men who have sex with men with an estimated prevalence of 17.2%. HIV Prevalence among BBFSW was found to be higher among those of the reproductive age group. While the HIV prevalence among FSW and transport workers is dropping, the prevalence is increasing among MSM: from 13.5% (2007) to 17.4% (2010) (6).

Figure 9 - HIV Prevalence in MARPS 2010

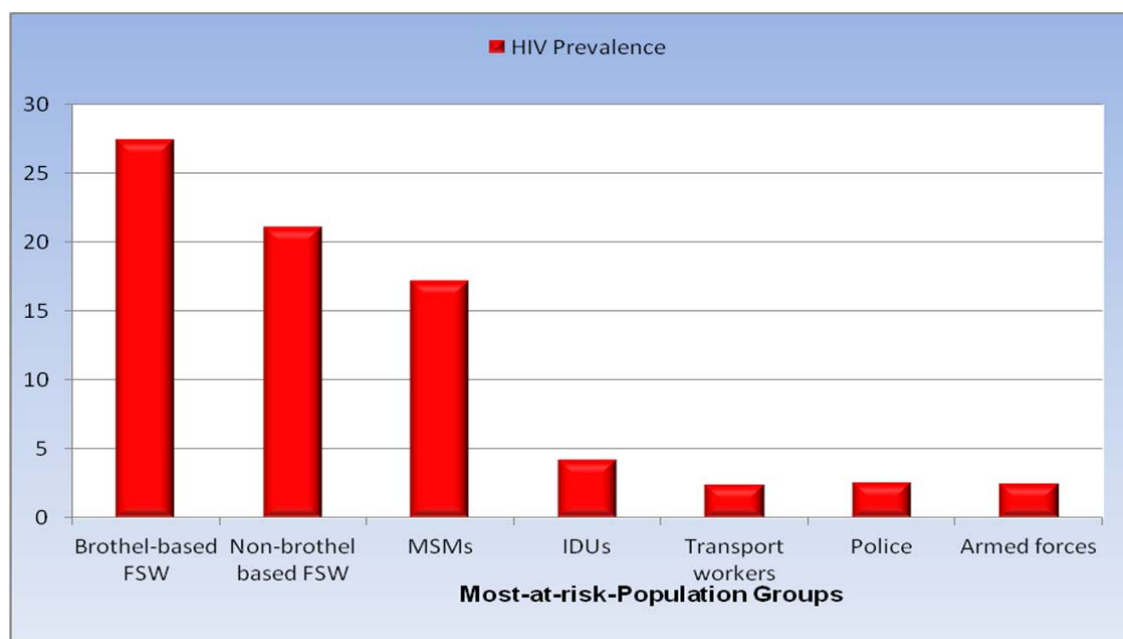


Table 3 - HIV Prevalence trends in MARPS from 2007 to 2010

Most-at-risk-population sub-group	2007	2010
	HIV Prevalence (%)	
NBBFSW	37.4	27.4
BBFSW	30.2	21.7
MSM	13.5	17.2
IDU	5.6	4.2

HIV Incidence

New Infections

Recent estimates indicate that the annual number of new infections in the country has been on a steady decline, decreasing by 6.1% from 340,015 in 2008 to 319,322 in 2010 and then slightly again by 2.7% to 310,620 in 2011. The decline in Adults mainly fuelled this decline in the total number of new infections, dropping during this period by about 10.2% from 271,151 in 2008 to 243,430 in 2011 while the number of infections in children increased by 4.0% from 2008 to 2010 before declining in 2011 by about 6.2% most likely because of recent scale up activities to improve PMTCT uptake. New infections in females continue to surpass that in males, contributing to about 54.9% of sero-conversions that occurred in 2011.

Table 4 - Trends in HIV Incidence 2008 to 2011 from Spectrum modelling

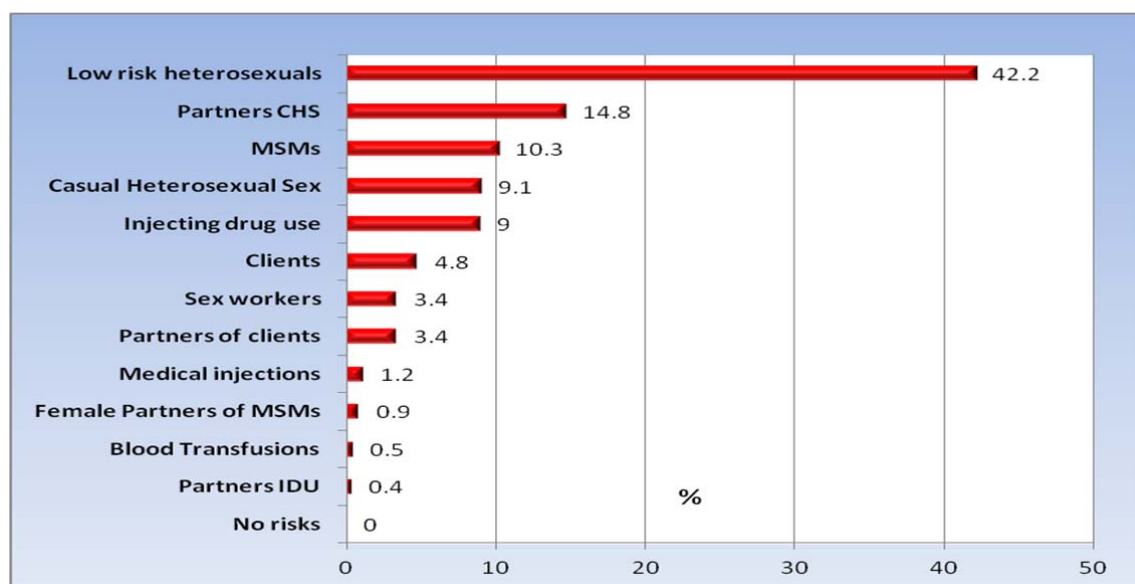
Population	2008	2010	2011
Total population	340,015	319,322	310,322
Adults > 15 years	271,151	247,718	243,430
Children < 15 years	68,864	71,604	67,190
Male	N/A	144,258	140,169
Female	N/A	175,064	170,431

Transmission of HIV Infection

According to the mode of transmission studies conducted in 2008, majority of the infections occurring in Nigeria are due to HIV transmission within the general population. The bulk of the new infections occur in persons who are not engaging in high risk sex, a sub-population that includes cohabiting or married sexual partners. Two-fifths (42%) of the infections occur amongst persons practicing 'low-risk' sex. Because condom use in this group tends to be particularly low, infection acquired as a result of the previous / present high risk behaviours or relationships by one of the sex partners is easily transmitted to the unsuspecting partner.

However, the high risk groups still contribute a significant proportion of the new infections. Directly, Female Sex Workers, IDUs and MSMs alone, who constitute about 1% of the adult population, contribute as much as almost 23% of new HIV infections. These most-at-risk-population groups and their partners contribute as much as 40% of new infections, a population that makes up only about 3.4% of the adult population. Half of the infections contributed by MARPs and their partners are attributed to female sex workers, their clients and clients' partners alone, highlighting a profound need for programmatic response focus on this sub-population group. MSMs and IDUs and their partners contribute about 10% and 9% respectively of the annual new infections. Targeting these groups will be significantly beneficial to reversing the spread of the epidemic in Nigeria. Notwithstanding the clarity of this need, there still remain enormous hurdles to mounting an effective response targeted at slowing down the transmission of HIV through these groups. These include the presence of policy and regulatory barriers that prevent engagement and recognition of these groups, increasing stigma and discrimination and threatening all efforts made at providing effective prevention, treatment, care and support for them.

Figure 10 - Distribution of New Infections by mode of exposure



Impact of HIV/AIDS on Children

Children are affected by HIV/AIDS through mother to child transmission infection or through the loss of one or both parents from AIDS. The 2008 National Situation Assessment and Analysis (SAA) on OVC showed that not only has HIV and AIDS been a major cause of death of parents, especially in households where both parents have died, but also before the loss of a parent, social and economic vulnerability is exacerbated by serious illness of a parent or other adult member of the household. When parents fall chronically ill from AIDS, children migrate between households. Many of the households taking on these children find it difficult to afford their support. Of 17.5 million vulnerable children, an estimated 7.3 million have lost one or both parents due to various causes. Of these, 2.23 million were orphaned by HIV/AIDS, while about 260,000 children are living with HIV/AIDS. About 20.3% OVC are not regular school attendants, and 18% have been victims of sexual abuse.

Section Three: National Response to the Epidemic

A. Policy and Framework

After the first case of AIDS was reported in 1986, Nigeria's first national response was initiated with the creation of the National Expert Advisory Committee on AIDS (NEACA) in 1987. This was soon followed with the establishment of the National AIDS and STI Control Program (NASCP) in the Federal Ministry of Health in 1988. Though it was an improvement, NASCP was essentially a health sector response.

Following the advent of democratic rule in 1999, a Presidential Committee on AIDS (PCA) and the National Action Committee on AIDS (NACA) were established in 2001 to coordinate the multi-sectoral response at the federal level. This represented the crucial point that domestic political acknowledgement of the diseases began in earnest. Six years later, NACA was transformed into an agency - the National Agency for the Control of AIDS (NACA) to further strengthen its coordinating role and national response to the epidemic. NACA oversees the activities of the State Action Committee on AIDS (SACA) and Local Government Action Committee on AIDS (LACA) that coordinate response at the sub-national level.

As a mechanism to enhance harmonization and effectiveness of the national HIV/AIDS response, the “*three ones*” principle was adopted in 2005. NACA being the coordinating body for HIV National response utilizes one National Strategic Framework (NSF), and one Monitoring and Evaluation system - Nigeria National Response Information Management System (NNRIMS). All these are operational in line with the three ones principle.

A notable outcome of the significant investment in the NNRIMS is that the functionality of the national HIV Monitoring and Evaluation (M&E) system in Nigeria has consistently improved.

The first National Strategic Framework (NSF) for action tagged NSF 2005-2009 was implemented following the review and expiration of the HIV/AIDS Emergency Action Plan 2001-3 in 2004/2005. The expiration of NSF 2005-2009 provided yet another opportunity to review the national response with a view to deploying new strategies to ensure the attainment of the national development goals and objectives. This is designed to reposition

the prevention of new HIV infections as the major focus of the national HIV/AIDS response, for the National HIV/AIDS Strategic Plan (NSP) 2010-2015.

B. Strategy

The main thrust of the NSP 2010-2015 is on behaviour change and the prevention of new infections while sustaining the momentum in HIV treatment, care and support for adults and children infected and affected by the epidemic. In addition, the plan aims to address gender inequality, knowledge, management and research in a bid to ensure that interventions are evidence driven. The strategic plan has formal program goals, clear targets, detailed costs for each programmatic area and a monitoring and evaluation framework. It has been endorsed by most development partners who have all aligned and harmonized their HIV related programs to the national plan.

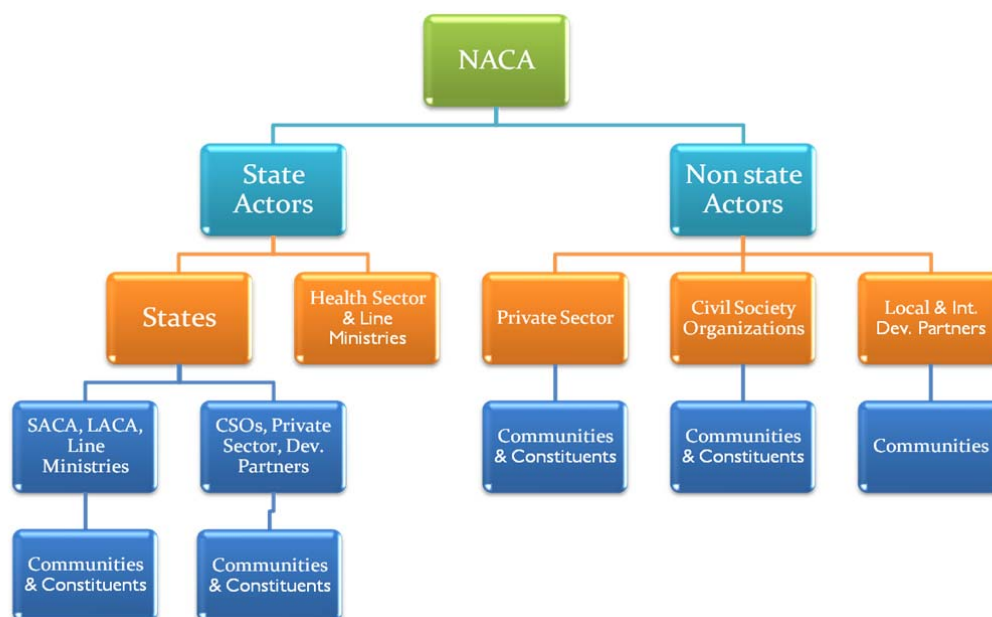
The NSP 2010-2015 is a multi-sectoral strategy covering sectors such as health, education, military, police, labour, transport, women and youth; with specific earmarked HIV budgets for their activities. The strategy also covers key and vulnerable populations, and settings such as prisons, schools and the workplace.

Though the strategy planning efforts have yielded key achievements such as collaboration with a broad range of stakeholders, review of policies, integration of services, GAP analysis and conduct of sustainability studies; challenges still remain. These include insufficient use of evidence, the annual operational plan not being based on the strategic plan, implementation of plans that are not human right sensitive, inadequate results based management and gender based approaches.

C. Coordinating Structures

The arrangement and relationships of coordinating and implementing institutions of HIV/AIDS response have evolved in response to the character and progression of the epidemic. The NSF approach is to provide an institutional framework that positions public sector institutions to provide effective leadership while ensuring efficient coordination of a broad range of stakeholders at all levels.

Figure 11 - Coordinating Structures of the National HIV/AIDS Response



NACA is at the apex of linked institutions in the HIV/AIDS response structure. From this vantage point, the agency provides overall political, coordination, program and oversight functions while interfacing with state and non-state players. Similarly, states and LGA responses are coordinated by SACAs and LACAs respectively. Together these state entities relate with line ministries, private sector, and Civil Society Organizations (CSOs) including faith and community based organizations and local and international development partners as shown in the chart above.

National Level Coordination and Interface

NACA is mandated to provide overall coordination of the national response while SACAs and LACAs ensure the same in states and LGAs respectively. This responsibility entails establishing and sustaining relationships with diverse state and non-state actors at multiple levels. The definition, maintenance and sustenance of relationships between NACA and stakeholders remain a critical challenge. Currently NACA interfaces in five domains: SACA, CSO, private sector, public sector and development partners.

SACA Interface

NACA has established interactive platforms with SACAs such as the biennial NACA-SACA forum, the NACA-SACA Resolution Workshops on state issues, NACA Technical Assistance (2009-2010) funded by DFID to support capacity building in SACAs; and lessons learned dissemination workshops of Enhanced National Response (ENR) Project. NACA also conducted advocacy visits to various arms of government to build support for the transformation of SACAs to agencies as well as provided technical, financial and managerial oversight for World Bank HIV/AIDS Funds (HAF) projects in several states. Technical Working Groups (TWGs) were established to coordinate joint planning and technical support for critical issues such as M&E and Gender.

Civil Society Organizations Interface

NACA facilitated the formation, funding, and capacity building of CSOs into constituent coordinating entities. These CSOs have had active involvement in the development of the multi-sectoral strategy; their involvement include the review of the national HIV/AIDS Policy, participation in the NSP development, work with the House Committee on HIV/AIDS Civil, and advocacy and subsequent participation in the review of the NSF II. They have actively participated in the planning and budgeting process for the NSP on HIV both at the state and national level. Society Network for HIV and AIDS in Nigeria (CiSHAN) and Network of People Living HIV/AIDS in Nigeria (NEPWHAN), and youth networks. Furthermore, NACA created a platform for CSO interaction and partnerships with donors. CSO networks and constituent coordinating entities that NACA has facilitated their development have become viable platforms for program activities. These networks have become recognized as critical players in the national response. For example, CiSHAN has a membership of over 3000 affiliate CSOs with six large constituencies.

Throughout this network, CSOs have participated robustly in advocacy, program planning and implementation with national, state and development partners at all levels. Their activities in the areas of HIV prevention, treatment, support and care are included in the national HIV strategy, budget and reports; however they still lack the capacity to source for domestic/international funds. Faith based interventions leveraged the wide network of faith based advocacy and care providing institutions in communities to provide prevention, care, treatment and impact mitigation interventions. In this regard, a National Faith-Based Advisory Committee comprising Christians and Muslims was established by NACA to facilitate coordination of Faith Based Response component of NSF.

Coordination of Private Sector Response

Private response in the national response is relatively recent and remains largely untapped. The Public-Private Partnership Forum was established to organize and leverage the vast pool of resources and competencies in this highly organized sector to strengthen the national response. Workplace programs including prevention and treatment have been initiated in about 39 multi-national companies through the Nigeria Business Coalition against HIV and AIDS (NIBUCCA). In addition, companies supported outreach programs to the public embedded in Corporate Social Portfolios either directly or through partnerships with local organizations. Small and Medium Scale Enterprises Development Agency (SMEDAN), Trade Union Congress (TUC) and National Association of Traders also have some HIV/AIDS program particularly at the national level and have been engaging with NACA.

Coordination of Non-Health Public Sector Response

Thirty-one Federal Ministries, agencies and parastatals are engaged in HIV/AIDS activities which are convergent with their mandates. Most states also have line ministries and agencies' response. NACA's focal unit for line ministries provides oversight for public sector activities including allocation and disbursement of funds such as the disbursement of funds to selected line ministries between 2002 and 2007 from the World Bank Multi-country AIDS Program (MAP).

Achievements in the non-health sector response include the development of National Orphans and Vulnerable Children (OVC) policy, the OVC Action Plan and the Standard Operation Procedures by the Ministry of Women's Affairs and Social Development; the development and distribution of Behaviour Change Communications (BCC) materials by the Ministry of Information and IEC materials targeting long-distance and transport fleet workers by the Ministry for Transport. Significantly, the HIV/AIDS response in the security forces is ahead of other public sector responses. The Armed Forces Program on AIDS Control (AFPAC) and the Prison Services developed expanded HIV/AIDS responses for their respective services; AFPAC covers the entire armed forces Army, Navy, and Air Force. These activities are supported by the United States Department of Defence.

Coordination of Development Assistance

Despite improved federal government financial contributions, development partners' contributions drive the national response. As the numbers, diversity and magnitude of contributions of development partners continue to outstretch current coordination mechanisms, NACA has evolved tentative steps toward re-evaluation of coordination, collaboration and harmonization. NACA has forged partnerships with development partners to leverage multi-donor resource envelopes for many critical planning and program management activities including the development of the NSF, NNRIMS, HIV/STI Integrated Biological and Behavioural Surveillance Survey (IBBSS), and the National HIV/AIDS and Reproductive Health Survey (NARHS). The NACA-Donor Interaction Platform –“Donor Coordination Group” meets monthly, and donor supported activities from service delivery points are generally captured in NACA reporting systems.

D. National Targets and Program Responses

Promotion of Behaviour Change and Prevention of New Infections

The HIV Prevention response is coordinated at the national level by the National Prevention Technical Working Group (NPTWG), hosted by NACA and at the state level, by the state prevention technical working group hosted by SACA. Other TWGs reporting to the NPTWG

are the BCC TWG, the HCT TWG. These groups met regularly in 2010 and 2011, developed the 2010-2012 National Prevention plan, had a 2010 and 2011 annual workplan and developed a data capturing tool (PITT) for the national HIV prevention programme.

Table 5 - National Strategic Plan Objectives for HIV Prevention

NSP Objectives on Behaviour Change Communication and Prevention of New Infections
<ul style="list-style-type: none"> • 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 sexually active Nigerians have access to quality gender responsive STI services by 2015 • At least 80% of young people 15-24 years adopting appropriate HIV and AIDS related behaviour • At least 80% of sexually active males and females use condoms consistently and correctly with non-regular partner by 2015. • At least 80% of MARPs use condoms consistently and correctly by 2015 • At least 80% of Most-At-Risk Populations (MARPs) reached with group-specific interventions and adopting appropriate HIV and AIDS related behaviour. • At least 80% of all private and public health institutions practicing universal safety precautions and procedures by 2015 • All (100%) donors of blood, blood products and organs for transplant including sperm for assisted reproductive technology are screened for HIV and other transfusion transmissible infections (TTIs) according to relevant national protocol, standards and guidelines by the year 2015. • At least 80% of drug dependant persons (IDUs and non-IDUs) have access to quality prevention programs/services in accordance with national guidelines by 2015. • At least 80% of health facilities provide post-exposure prophylaxis (PEP) to relevant health workers and survivors of rape in line with national protocols by 2015

HIV Counselling and Testing

HCT is an important entry point for most forms of HIV and AIDS prevention and control interventions including PMTCT, treatment and care. It also constitutes a good platform for linkage between sexual and reproductive health services and HIV/AIDS related programs.

The percentage of persons that received an HIV test in the past 12 months is usually used as an indicator of the proportion of people who currently know their HIV status. Overall, the uptake of HCT is still low among the Nigerian population even though the proportion of people who had tested and received their results had doubled between 2003 and 2007. According to the NARHS 2007, only 11.7% of all women and men aged 15 to 49 years received an HIV test and know their results. This shows that a lot more needs to be done to increase uptake of counselling and testing in order to achieve the universal access target for this objective.

As at December 2011, the number of women and men aged 15 and older who received HIV testing and counselling in the past 12 months and know their results was 2,056,578. In the data available for 2010, women constituted 71% of those who tested, showing a greater uptake of testing in women compared to men. This is a clear departure from previous trends in 2003 and 2007 that showed a higher uptake of HCT services in men.

The number of HCT sites decreased by 2.6% in 2010: from 1074 sites in 2009 to 1046 sites in 2010 due to a closure of HCT programmes funded by the United States government. However, this number was scaled up in 2011 by 21.6% to 1357 due mainly to new sites activated with funding from the Global Fund Round 9 grant. With this scale up, there has been an expansion of HCT services into the private sector – faith based organizations and private hospitals, through partnership with Hygeia. Most services are still facility based, located mainly at tertiary and secondary facility level and in urban centers. These all provide

access challenges communities and hard-to-reach populations with increased risk for HIV infection.

Support for DOTS/HCT integration by development partners has already begun with HCT integration into stand alone DOTS centres across the country.

Institutional efforts have been targeted at promoting the uptake of Couple Counselling and Testing (CCT). An assessment of two sample programmes showed that most couples accessed this service as a pre-condition for marriage rites and some because it is actively promoted as a component of their PMTCT services.

The national HCT guidelines advocates for the promotion and use of Provider Initiated Counselling to increase HCT uptake. The FMoH issued a formal letter on PITC and the need for routine testing of patients based on an “opt-out” approach to facilities in 2009. While some health facilities implement PITC as a common practice and it remains directed by individual health care provider interest in others, there is still no known facility in the country that has instituted a policy on PITC.

Sexually Transmitted Infections

The 2007 – 12 Ward Minimum Health Care Package strategy, developed by the National Primary Health Care Development Agency (NPHCDA) includes Control of Communicable Diseases (Malaria, STI/HIV/AIDS, and TB) as a component with 5.7% of all PHCs in the country providing all its components. The expectation is that a larger number of PHCs provide STI services even if they do not provide other components. It is also assumed that all tertiary care centres and some of the secondary care centres in the country will have the capacity to ‘appropriately’ diagnose and treat patients with STI.

Behaviour Change Communication among young people

The country’s HIV prevention approach for adolescent and youths involves the use of Family Life and HIV Education (FLHE) training curriculum and peer education as a co-curricular strategy. With support from Global Round 9, the Federal Ministry of Education, in collaboration with State Ministries of Education and State Universal Basic Education Board (SUBEB) HIV&AIDS desk officers, 80 master trainers from 36 states were trained in 2011. These trainers in turn trained 5,432 teachers from 791 schools. 250,973 students have since been reached. FLHE has since then been mainstreamed into the teachers training curriculum.

NYNETHA, through support from the Global Fund round 9, developed programmes to target out-of-school youths in 36 states through the engagement of 111 CBOs. It is expected that about 1.8% of the total target would be reached with the MPPI approach. As at September, 2011, 270,509 youths had been reached with this programme.

The NYSC peer education programme reaches out to in and out-of-school youths. In 2010, 762,840 (458,704 male and 304,136 female) in-school youths were reached through 16,571 (10,671 male and 5,900 female) trained peer educators and as at June 2011, 179,856 (107,801 male and 72,055 female) students had been reached by 8,556 (4,869 male and 3,687 female) peer educators within the same year. No records were kept on the number of out-of-school youths reached.

NACA, in collaboration with its partners, made efforts to design HIV education programmes that could impact on the behaviour of community of persons who engage in high risk behaviours. This includes the development and production of prototype BCC messages and materials for prevention by the National Prevention TWG and airing of HIV prevention messages. NACA and its partners also prescribed the use of the Peer Education Plus model

for peer educator training for key target populations with high risk for contracting HIV infection. The adoption of the Peer Education Plus model was through a consultative meeting held with partners on the 4th and 5th of November 2009. The intervention is considered appropriate for behaviour change as it allows for intensive exposure of the trained peer educators and peers to HIV control education. The model also provides a platform for the implementation of the MPPI. The model has been tested and the curriculum developed.

Behaviour Change Communication among MARPs

Female IDUs are much more likely than Male IDUs to be infected with HIV. The main route of transmission of HIV for female IDUs is sex with sex work serving as a major source of income to sustain the habit. Although there is no national programme for IDUs, there are efforts by organizations like Population Council in Nigeria to identify such populations and link them to appropriate MARPs friendly HIV/STI and harm reduction services.

Prevention of Mother to Child Transmission of HIV

Nigeria contributes 32% to the world gap in achieving a global target of eradicating MTCT making the highest in the world. Because of this, increased attention has been paid to PMTCT in the national response, thereby bringing it to the fore front as a priority agenda for the country.

The Health Sector Plan and the 2010 PMTCT guidelines articulate clear strategies to accelerate the expansion and strengthening of PMTCT services through decentralization and integrated service delivery at the PHCs.

Overall, PMTCT coverage still remains low with only 1,120,178 (16.9%) pregnant women counselled and tested for HIV and receiving their results in 2011. Nevertheless, this represents an improvement from 2010 when only 907,387 pregnant women were counseled and tested.

The number of HIV-infected pregnant women in 2011 was estimated to be 221,129 with about 17.1% of them (37,868) receiving antiretrovirals in 2011 to reduce MTCT, reflecting a 45% increase from 2010 in the proportion of pregnant women receiving antiretroviral prophylaxis for MTCT. It is estimated that 26.5% (58,495) of the HIV infected pregnancies led to child infections in the same year. There has been a marked decrease in the proportion of HIV positive pregnant women on ARV prophylaxis taking single dose Nevirapine for PMTCT (24.5% in 2010 to 8.4%) and an increase in percentage taking Maternal Triple ARV (Option B) from 25.2% in 2010 to 33.2% as ARV prophylaxis for PMTCT.

Condom Programming

In 2010, 2,181,544,402 male condoms and 886,979 female condoms were distributed by both Society for Family Health, an indigenous NGO and the Federal Ministry of Health. Key to the success of the distribution of female condoms was the effectiveness of its entry method and social marketing in raising awareness and an initial rush for the product.

For sex workers, condom use has remained high among female sex workers (92.9% at last sex with client) and percentage of MSMs selling sex that used a condom the last time they had anal sex with a paying partner was 54.7%. Consistent condom use with clients remained high as well for female sex workers in 2010 and remained very low (20.7% for BBFSW; 26.1% for NBBFSW) with boyfriends.

Biomedical Transmission of HIV

National statistics show that blood transfusions and unsafe injection practices contributed to 0.54% and 1.16% of new HIV infections in 2010 respectively. While the data from national

blood transfusion services reported that 100% of blood collected in 2009 were screened for Transfusion transmissible infections (TTIs), state blood transfusion services do not use antigen tests to screen blood, so they do not guarantee 100% safety unlike their national counterparts.

Many health facilities operated inadequate environmentally acceptable healthcare waste management programmes, uptake of HBV vaccination among waste handlers was poor (39%), and hand washing with soap and running water was low (23%) prior to sustained intervention. Universal precautions are also poorly adhered too. There are current legislative frameworks and guidelines for safe blood practices. However, there are no guidelines on the clinical use of blood and blood products. There is also no system for collection of blood safety data from all the public and private facilities in Nigeria where organ transplant, and blood and blood product use occur. There are thus, existing challenges to ensuring biomedical transmission of HIV is completely eradicated.

The widespread availability of sterile needles/syringes at pharmacies makes needle sharing not a major route of HIV transmission in the IDU community in Nigeria (9). About 83% of IDUs use clean sterile needle. Unfortunately, there is no active national HIV programme targeting IDUs.

There are no concrete public engagement programmes that promote post exposure prophylaxis (PEP) access by the general public. PEP provision is still limited to about 20% of health facilities. It can however be assumed that all 491 ART sites are able to provide PEP to those in need though very few have PEP programmes in place. There are no concrete programmes and guidelines on PEP, male circumcision and future microbicide and HIV vaccine access beyond its mention in the NPP 2010-2012. NACA is, however, committed to addressing this gap from 2012. On the other hand, there have been significant efforts in the field by CSOs to promote community understanding and involvement with NPT trial. These efforts have however, been concentrated in Southern Nigeria.

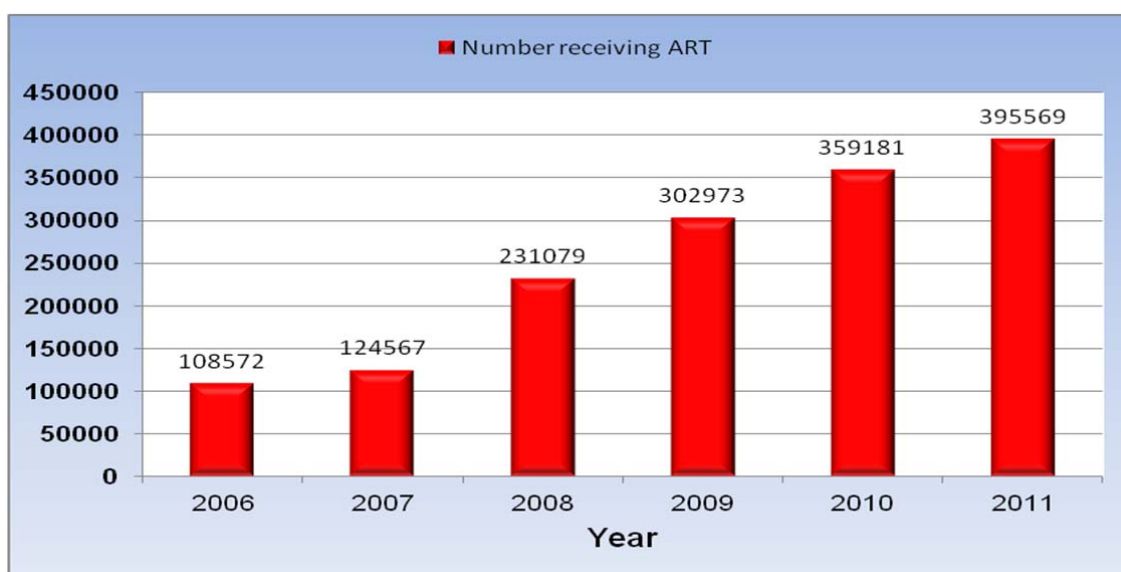
Treatment of HIV and related Health complications

NSP Objectives on treatment of HIV/AIDS and Health Related complications

- At least 80% of adults (men and women) and all children (boys and girls) have access to comprehensive quality HIV and AIDS treatment by 2015
- At least 80% of adults (men and women) and all children (boys and girls) on ART have access to quality management of Opportunistic Infections by 2015
- To establish and strengthen TB and HIV/AIDS collaboration in all states and LGA's by 2015

The ART programme in Nigeria commenced in 2002 with the number of sites substantially increasing by 13.5% between 2009 and 2010 (from 393 in 2009 to 446 in 2010) and then by another 10.1% to 491 sites in 2011. These sites are located in tertiary, secondary and primary health care facilities and are spread across the 36 states of Nigeria and the FCT. These sites also make up about 14.7% of the 3351 health facilities that can offer ART services. Uptake of ARVs also increased along with the scale up ART sites, increasing by 56,208 from 2009 (302,973) to 2010 (359,181) and by another 10.1% to 395,569 in 2011 with 63% of the uptake attributable to females. The Federal Ministry of Health continues to make effort to scale up the number of sites providing ART services in 2012.

Figure 12 - Number of males and females on ART



Provision of ART services to children also continues to increase. The number of children aged 0 – 14years receiving ART increased from 20,401 to 36,716 in 2011, falling significantly short of annual targets. Factors responsible for non-achievement of national targets include increase in estimated number requiring ART due to the increase in the CD4 count threshold for initiating ART in the 2010 national guidelines, poor linkages from HCT sites and stock out of RTK's.

Co-Management of TB and HIV is fundamental in reducing the transmission of multi drug resistant TB forms and improving survival rates for PABA. Compliance with the 2010 national guidelines that requires that all HIV-infected individuals with active TB, irrespective of the CD4 count be initiated on ARV remains poor. As at the end of 2011 only 16.9% (8410) of estimated HIV positive incident TB cases received treatment for both HIV and TB. There are a number of stand-alone DOTS sites that mean that intra-facility and inter-facility linkages are required for effective referrals. Poor linkages of DOT sites with ART sites affect uptake of ART by TB clients.

Only 969 (0.5%) of the newly enrolled PLHIV (183,866) started Isoniazid Preventive Therapy (IPT) in 2011, down from the very low 1% that started IPT in 2010. Currently, most ART sites do not offer IPT. Many physicians are also reluctant to prescribe IPT due to difficulties with diagnosis of active TB and fear of INH resistance. In 2011, only one Implementing Partner (IP) was scaling up IPT delivery and three other IP's conducted pilot studies.

Care and Support of people infected and affected by HIV/AIDS including OVC

NSP Objectives on Care and Support of people infected and affected by HIV/AIDS including OVC

- To improve access to quality care and support services (as defined by national guidelines) to at least 50% of PLHIV by 2015
- Link at least 50% PLHIV and PABA, especially females (women and girls) and marginalised and people with special needs, to IGA and poverty alleviation programmes by 2015.
- Improve effective referral and linkages within and between relevant health care facilities and community based services to 80% in 2015
- Create an enabling environment for the legal protection of OVC by 2015

- Provide integrated comprehensive social support (as defined by national guidelines) to at least 30% of most vulnerable OVC by 2015
- Strengthen the capacity of 30% of older OVC (especially girls' headed households) to mitigate the impact of HIV/AIDS by 2015.
- Establish and/or strengthen OVC coordination structures at all levels

In 2011, the Federal Ministry of Health developed guidelines on nutritional care and support for PLHIV. These guidelines provide detailed and comprehensive guidance on nutritional support that can be provided for PLHIV (children and adults), thereby addressing a long recognised gap.

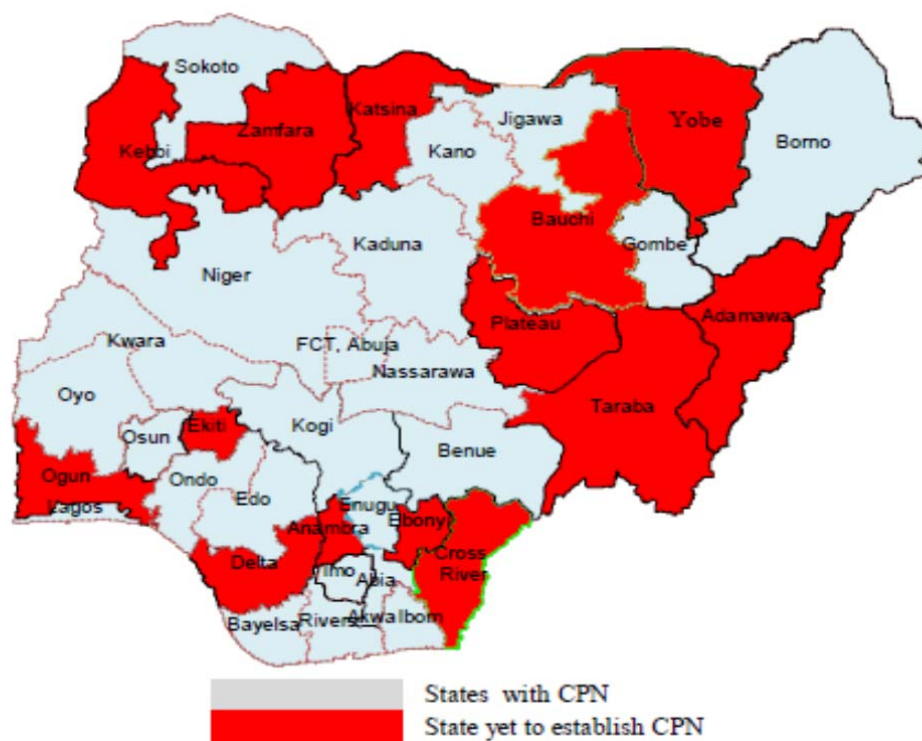
Income Generating Activities (IGA) for Support Groups of PLHIV were initiated by NEPWHAN and funded by the Global Fund. The IGA include cattle rearing, equipment hire, business centre and sales of stationeries, storage and sales of vegetable oil and setting up of provision stores. In 2010, 40 Support Groups were provided funds for new projects and 41,269 PLHIV accessed community care and support services provided by CBOs.

The Hub and Spoke Network Model (cluster system) enables a continuum of care to be provided for PLHIV and PABA in the communities. The model consists of one treatment centre, 2 HCT centres and 2 support groups of PLHIV providing treatment adherence, stigma reduction and generating uptake for HCT services, five CBO providing HBC services, and one CBO providing OVC services. Outside the cluster model, CSOs, trained HBC officers, PHC officers, youth groups and PLWHA support groups help to mobilise PLHIV to receive care.

Programming for Orphans and Vulnerable Children

The 2003 Child Rights Act (CRA), in combination with the National Plan of Action for OVCs and the National Child Policy provides a legal framework for the implementation of services for orphans and vulnerable children in Nigeria.

Figure 13 - Map of Nigeria showing CPN, UNICEF CPN Update MTR, 2011



Child Protection Networks (CPN), funded by UNICEF, have been established in 23 States and the FCT between 2010 and 2011 (Figure 13). They serve to engage a diverse range of interested organizations in monitoring, reporting and responding to child protection abuses, as well as providing legal aid for children in conflict and in contact with the law. The Federal Ministry of Women and Social Development (FMWASD) hosts the coordination platforms for the National OVC response. These platforms include the National OVC Steering Committee and the National Technical Coordinating Group (NTCG). Implementation of OVC programmes have also been significantly supported by external support from PEPFAR and the Global Fund Rounds 5 and 9, with PEPFAR supported IPs providing legal assistance and protective care services to OVCs in 2010 /2011.

There have also been various state level efforts at supporting OVCs, for example, the provision of food and nutrition services to OVCs and PLHIV in Kaduna state, the provision of food and nutrition services and skills acquisition to OVCs in Taraba state.

Section Four: Best Practices

Nigeria has been steadfast in its commitments to strengthen its response to the HIV and AIDS epidemic through the implementation of multi-sectoral comprehensive intervention programs. The same commitment has been replicated in several NGOs and CSOs which have over time initiated programs that propagate grassroots and advocacy efforts aimed at curbing the spread of the epidemic; and may possibly evolve into best practices. The programs below have been identified as best practices by the organizations which implement them at various levels. Though varied they all present a consolidated and innovative effort in HIV prevention, treatment, care and support.

A. MSH Leadership Development Training: Catalyst for Improving Government Leadership and Stewardship for Effective Health Governance and Financing.

The MSH Pro-ACT Leadership Development Program hosted a workshop for health program leaders with the aim of adopting a people-centered approach to improving health outcomes. Participants were drawn from two Pro-ACT project focus states of Kogi and Niger in January 2010. The workshop also aimed at generating long-term commitment to strategic transformation of health systems. During this exercise participants were provided with skills necessary to improve management and operational systems in their workplaces.

At the workshop, each team developed a plan of action to address one specific challenge in their State using the MSH “challenge model”. Using lessons learned from this exercise, state teams were able to articulate and present justifications for their projects to higher level policy makers in their states.

Consequently this contributed to the Niger State house of Assembly passing a budget of ₦100 million for the Niger state SACA in 2010 compared to the ₦4 million approved in 2009. In addition, the MDG office in Niger supported the State’s HIV response through the procurement of Rapid Test Kits (RTKs) and ARVs worth ₦130 million. Similarly, in Kogi state, the State Executive council approved ₦30 million to set up three new HIV comprehensive care and treatment sites in underserved areas.

B. ICAP Nigeria: Establishment of the Network of Traditional Birth Attendants (TBAs) and Health facilities providing PMTCT services in Six States

It is estimated that nearly half of all pregnant women age 15-49 in Nigeria do not access antenatal care nor deliver in health facilities. Majority of women in this group patronize TBAs and are not offered HCT in this setting. To bridge this gap, workshops were organized in six States for a total 237 TBAs with a goal to provide orientation on the importance and need for pregnant women accessing their services to also access HIV counseling and testing in Health facilities providing PMTCT services

A referral network system was established to promote linkages between TBAs and health care workers in facilities. This network system allows pregnant women referred from the TBAs to access HCT and PMTCT services in the health facilities. As a result of this network, a total of 1428 pregnant women have been referred to health facilities with proximity to their locality for HCT. A total of 126 positives pregnant women were identified from the tested population and accessed PMTCT intervention at the Health facilities. Based on the success achieved, there are plans to collaborate with state government to replicate ICAP referral network system model to cover more states.

C. Federal Ministry of Education: Annual Ministerial Youths-Speak out

Federal Ministry of Education HIV/AIDS Unit coordinates the Education sector response to fight HIV epidemic, using the Family Life HIV Education (FLHE) approach in primary and secondary schools. Four participants made up of 2 boys and 2 girls are selected from 120 FLHE implementing schools across the 36 states of Nigeria and FCT.

Selected participants, who are pupils from the upper primary and students from the lower secondary school debate on reproductive health issues of adolescents and HIV prevention education.

Debate is conducted at state, zonal and national levels and 5 final winners are presented with prizes and scholarships. Provision of scholarships on youth speak out has increased interests on HIV and education generally amongst students. The program has provided opportunity for students who have been reached with information to become peer educators and mentors to their peers.

Section Five: Major Challenges and Remedial Actions

Progress on Key Challenges from the 2010 UNGASS report

Several challenges were identified in the 2010 report that the country must work towards in improving the quality and access of HIV/AIDS interventions and services. Progress points on key challenges outlined in the UNGASS 2010 report are addressed as follows:

- 1. Funding Gaps:** Funding gaps continued to be a challenge in 2010, with available funding not commensurate with the scale and complexity of the HIV/AIDS epidemic in Nigeria. Total funding for HIV/AIDS in Nigeria increased by more than 26% from \$394,663,885 in 2008 to \$497,817,471 in 2010. In 2010, there was increased funding for HIV Prevention activities, care and support, human resource trainings, creating an enabling environment and research. While the absolute amount of funding allocated by the national response for HIV Care and treatment reduced by 28.5% in 2010 (\$132,870,029) from \$185,911,643 in 2008, the country still succeeded in

increasing the number of sites providing ART by 13.5% and placing 56,208 more PLHIV on ART.

2. **Overdependence on Donor Support:** In 2008, only 7.6% of total funding for HIV/AIDS came from the public sector. The country has strengthened its commitments to funding the national response to the epidemic and in 2010 the proportion of funding for HIV/AIDS rose dramatically to 45.5% of total funding from all sources (\$286,658,813), representing a 7-fold increase in funding.
3. **PMTCT Coverage:** In 2011, the country improved on PMTCT coverage by more than 16% from 2010. While the 1,120,178 pregnant women counseled and tested for HIV in 2011 remains overall a distant achievement for targets set for 2012 and the goal of eliminating MTCT in 2015, there has been a substantial improvement (a 45% increase from 2010) in the proportion of pregnant women receiving antiretroviral prophylaxis for MTCT of HIV. This can be attributed to the focus of all stakeholders in the national response focusing and making efforts to increase PMTCT uptake, progress in integrating PMTCT and reproductive health services at facility level and increase in the number of PMTCT sites.

Challenges in the Current Reporting Period

Although the country has made substantial efforts and progress in improving the national response to HIV, some challenges still remain. A Joint Annual Review of the National Response to HIV commissioned by NACA in July 2011 identified many of these challenges. Some of the challenges summarized below are sourced from this report:

1. National Commitment and Policy

- The anti-discrimination bill has been passed by the Senate and House of Representatives but remains yet to be signed into law by the president.
- Although some states have passed the anti-discrimination bill into law in their states, some state law enforcement agencies (Judiciary and Police) are still not aware of the existence of the law.
- The same sex marriage bill passed in the Senate potentially presents a barrier to future progress on the national response to HIV. According to the modes of transmission study conducted in 2008, MSMs contribute up to 10% of new infections in the country. If the bill is passed by the lower chamber and signed into law by the President, it will criminalize any recognition and engagement of corresponding organizations and make efforts to provide services to these groups very difficult.
- Some of the guidelines in use have not been updated in line with the current scientific and global trends. For instance, the guidelines on syndromic management of STI were last reviewed in 2007.

2. Institutional Architecture, Systems, Coordination and Resourcing

- Linkages of the national response to overall government structures and efforts in other sectors are not well defined in the NSP II e.g. National Economic Empowerment and Development Strategy (NEEDS) and the Millennium Development Goals (MDGs). Linkages to the private sector are also very poor, resulting in little or no information about private sector activity being monitored by the national response. The effort by the Global Fund round 9 to engage the private sector through Hygeia remains inadequate. The 2012 – 2013 biannual planning of the national response is an opportunity to make progress in this area.
- There is still a gap in the coordination of the national response owing to the differing perspectives and practice demonstrating ownership and clarity of process in implementing the national response. Although there are accountability arrangements

between NACA and various implementing partners, there is still a major problem of parallel reporting by the IPs directly to their donors without lateral reference to NACA and this practice is formally established in their performance frameworks.

- Very few state governments have taken up an independent response to the epidemic. As at 2010, state governments contributed less than 0.3% of the total government funding of the national response, with the Federal government contributing the rest of the 99.7% of the funding.

3. Behaviour Change Communication and Prevention Interventions

- HCT coverage is inadequate especially in the hard to reach rural areas. The current effort by the Federal Ministry of Health to decentralise its services to PHC and the community through integration of HCT into routine medical care, inclusive of prevention with positive interventions, are efforts aimed at promoting wider HCT service coverage.
- The reduction of PEPFAR funding for test kits has created a gap that the Government of Nigeria is still currently struggling to address.
- There are still weaknesses in the assurance that referred clients actually access services at facilities that they are referred to. This is one of the challenges that contribute to the continual loss of clients between services points.
- Tracking STI management nationally is still a challenge. Data from secondary and primary facilities are incomplete and unreliable and in tertiary hospitals where efforts are made to diagnose STIs, health workers hardly fill the data collection tools.
- Recommended treatment in the national guidelines is obsolete and will need to be updated e.g. continued use of the recommended prescription for urethritis and Pelvic Inflammatory Disease in the national guideline may predispose patients to antibiotic resistance and inadequately managed infections.
- Transfusion of unscreened blood is still an ongoing practice especially in the rural communities. There are still new cases of blood transfusion related HIV infection managed in many facilities. The main culprits are children who are susceptible to anaemia resulting from malaria and worm infestation. Universal precaution and appropriate standards for waste management are not strictly adhered to in all orthodox health facilities. This is often due to a lack of safe deposit boxes and other materials and supplies, forgetfulness and consideration by health workers that the procedures are time wasting. Unfortunately, the NSP indicator only limits its focus on universal precaution practice by traditional practitioners.

4. PMTCT Coverage

- PMTCT coverage is still well below desired targets (50% target for 2012). Only 15.9% of HIV positive pregnant women received ARV prophylaxis to reduce MTCT in 2011.
- There are still very few facilities providing Early Infant Diagnosis (274). The Federal Ministry of Health will need to allocate funding to the establishment of more EID facilities in Nigeria if national targets of 80% of HIV exposed infants having access to EID services in 2015 are to be met.

5. Treatment of HIV/AIDS and Related Health Conditions

- There are still difficulties in the management of OIs in ART facilities as OI medicines were not adequately provided for at the facilities, forcing patients to purchase them. Also the sheer number of OIs and medicines used to treat them has made data collection and reporting up to the national level difficult.

- Weak linkages between stand alone DOTS and ART at implementing sites results in increased unit service delivery costs and reduced ART uptake. This continues to affect TB/HIV collaboration adversely.

6. Care and Support for PLHIV, PABA and OVC

- There are no comprehensive national guidelines on care and support for PLHIV/PABA. Quality of care provided in the communities remains unregulated with care providers using their own self developed manuals for community interventions.
- There are also no national guidelines on IGA/Poverty alleviation programmes thus training for CSO and Support Group leaders are not standardized.
- There is minimal state activity with regards to providing social safety nets for OVCs.
- Reporting mechanisms for reporting OVC activities by different partners to the Ministry of Women Affairs and Social Development (MWASD) at the state and national levels are still weak and needs strengthening.
- The linkage between the FMWASD/SMWASD and basic service sectors (i.e. Health and Education) who are critical stakeholders for OVC response remain weak and a threat to effective response at both national and sub-national levels.

7. Monitoring and Evaluation

- Limited resources and inadequate capacity are key factors militating against the states, LGAs and facilities implementing their M&E mandates. For instance, many of the State coordinating agencies and sectoral M&E units are staff with a single individual with inadequate capacity to perform required M&E mandates required for such institutions.
- Despite the data collection tools harmonization exercises conducted at the national level, the HIV M&E system is still currently characterized by a proliferation of M&E data collection and reporting tools thereby threatening the quality of the data, mostly at IP supported sites. NACA and line ministries will need to prioritize the implementation of adoption of harmonized tools and their use in public health facilities.
- The data flow structure defined in the NOP-I is not totally complied with by significant number of implementing partners and non-government organizations (NGOs) who report directly to their organization or funding agencies supporting their program. In many cases, the national system depends on donors or bilateral agencies for data retrieval and feedback sometimes leading to double counting.
- Current data on HIV and AIDS activities are not available to many stakeholders who may require such data or information for policy or programmatic decisions. NACA is currently in the process of establishing a HIV Resource centre where available data and guidelines can be posted and accessed by interested stakeholders and individuals.
- There is still inadequate systematic use of routine data for policy and programmatic decisions. The national response will benefit from the establishment of data review meetings at national, state and LGA levels where all stakeholders converge to review data, including data quality and make recommendations for relevant executive bodies at the different levels.

Section Six: M & E

The Monitoring and Evaluation Environment

In the mid-1980s and 1990s when the HIV/AIDS epidemic was at its infancy there was very limited understanding of HIV/AIDS and in Nigeria as in many other sub-Saharan countries affected by the disease, interventions to contain epidemic and care of persons infected with the virus was virtually nonexistent and so there was really nothing to monitor and evaluate.

However, as time passed and understanding about the HIV infection and disease increased, countries across Africa began to establish functional national and sub national programmes on HIV/AIDS to oversee the implementation of strategies for the control of HIV/AIDS.

Across the continent persons were counseled and tested for HIV and eligible persons were enrolled for ART and many organizations were signing up to implement one form of intervention or the other and at this point it became necessary to devise systems for monitoring and evaluating these interventions to determine the impact of the interventions on the epidemic and ensure order and accountability.

In early years of the epidemic Nigerian systems for Monitoring and Evaluation were limited to HIV Sentinel Surveys. The M&E system adopted by the country in the mid-1990s had several shortcomings, some of which include:

- 1) The use of several behavioral studies that were conducted using different sampling methods and indicators.
- 2) Failure to share and pass on results to a central coordinating system for analysis such that results were not fully utilized for formulating policy.

However, in 2002 buoyed by increasing national knowledge and expertise in HIV/AIDS the Government of Nigeria, in collaboration with development partners like WHO/UNAIDS proceeded to adopt a more robust and standardized framework for Monitoring and Evaluating HIV/AIDS interventions in the country. Improvements in the Monitoring and Evaluation System has continued since 2002 adapting guidelines, innovations, best practices and recommendations of multilateral agencies like WHO and UNAIDS.

In 2004 the country adopted the principle of *Three Ones*- one coordinating body, one national strategic framework and one M&E system. And from then on government has worked to ensure that there is a single M&E system applicable to all partners working on HIV/AIDS in the country. Accordingly in April 2004 the Nigeria National Response Information Management System (NNRIMS) was established as a vehicle for the National reporting system.

A lot of confidence was placed on NNRIMS as the panacea for our M&E challenges and it was expected that it will give government full control of M&E for HIV/AIDS. The State AIDS Programmes commence reporting on HIV/AIDS based on NNRIMS protocol but this has been limited due largely to inadequate state-level resources and capacity for M&E, duplication of efforts, non-adherence to national tools and reporting protocols by partners operating in some states; and a poor M&E subsystems that are mostly donor driven and not responsive to NNRIMS. For instance NNRIMS was designed to collect information on all related HIV/AIDS services including community level activities; however each program area such as OVC, ART, and PMTCT has its own parallel routine information system to respond to the needs of program funders.

Another noticeable weakness of the M&E system is its failure to capture the contributions of private health sector to the control of HIV/AIDS.

To address these weaknesses, government has consistently taken steps to improve the national response including its M&E systems. The National Policy on HIV/AIDS, and the NSF and NSP 2010-2015 were developed to provide one unified strategy for the control of HIV/AIDS with a uniform implementation plan for all stakeholders and the findings of the response analysis and the policy thrusts of the National Policy on HIV/AIDS informed the development of the strategic objectives and interventions of the M&E systems thematic focus (which comprises the thematic areas of “Monitoring and Evaluation” and “Research and Knowledge”) of the National HIV/AIDS Strategic Framework and the National HIV/AIDS Strategic Plan 2010-2015.

The goal of the M&E thematic focus is to strengthen and embed a sustainable system based approach to delivering a cost effective, multidimensional and gender sensitive M&E system which supports the continuous improvement of the national response. The proposed objectives are:

- 1) To enhance the leadership and managerial skills of Federal/State/LGA authorities for the delivery of an effective one national M&E system by 2015.
- 2) To improve coordination, partnership, gender sensitivity and cost-effectiveness of data collection, analysis and use of program data and information (routine, surveys and surveillance) to inform program-planning and decision-making by all HIV/AIDS implementing agencies and stakeholders at all levels of HIV/AIDS response by 2015.
- 3) To continuously improve data quality and supportive supervision at all levels by 2015
- 4) To improve the efficiency and effectiveness of the delivery of the costed national multi-sectoral HIV M&E plan through a systems management approach.
- 5) To Strengthen and regularly update an integrated, optimally aligned, cost-effective, appropriate to local context, National HIV/AIDS database(s) to capture, verify, analyze and present program monitoring data from all levels and sectors by 2015.

It is expected that full implementation of this new approach to M&E will bring about the establishment of a national M&E system that is independent, self-sustaining and responsive to the needs of the country.

Meeting Internal Obligations for M & E Reporting

Nigeria is signatory to several HIV/AIDS resolutions including the Declaration of Commitments on HIV/AIDS adopted by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) which mandates member states to take strong and decisive action against the HIV/AIDS epidemic. In order to monitor global response across countries, the declaration emphasizes the need to compile accurate information using standard indicators in the reporting tool. Furthermore, 2011, Nigeria participated in the high level meeting of HIV/AIDS where new targets for monitoring of millennium development goals was reemphasized.

In its 2003 report, Nigeria was able to report on only nine of the thirteen indicators; however efforts have since been made to meet international obligations and establish a national M&E system capable of generating all the desired data for subsequent reports.

Conclusion

This Global HIV/AIDS Response Progress Report has shown some remarkable improvement in some indicators. Lessons learned in the past, have positively impacted on report comprehensiveness, data quality and the process was highly participatory involving a broad spectrum of relevant stakeholders.

The findings from the report will be used for advocacy to policy makers to improve planning, resource mobilization and programme implementation. In addition the findings will be disseminated in various formats including factsheets to the stakeholders in the country for their specific and individual use.

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