REVISED NATIONAL HIV AND AIDS STRATEGIC FRAMEWORK
2019-2021

FUTURE DIRECTIONS FOR THE HIV/AIDS RESPONSE IN NIGERIA

NATIONAL AGENCY FOR THE CONTROL OF AIDS (NACA)
ABUJA, NIGERIA

FOREWORD

In the past, Nigeria has relied upon a combination of periodic epidemiological surveys - Antenatal Clinic (ANC) sentinel surveys, National HIV and AIDS and Reproductive Health Surveys (NARHS), Nigeria Demographic Health Surveys (NDHS), and Integrated Biological and Behavioral Surveillance Surveys (IBBSS) – together with routinely collected programme data to monitor and estimate the population level HIV epidemic trends in the country. This approach however had some limitations. To bridge the limitations the country with support from her partners conducted the largest ever population-based HIV survey known as the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS) in 2018.

Preliminary findings from the NAIIS and findings from recent studies such as key population (KP) size estimates, the national prison study and routine programme data suggests a shift in the direction and magnitude of the epidemic. Thus, there is a need to rethink our priorities, strategies and overall approach in responding to the HIV epidemic if we are to achieve our short and medium term HIV response targets and realise the long term vision of ending the epidemic by 2030.

As a first step, NACA and her stakeholders have therefore developed a revised National HIV and AIDS Strategic Framework that is aimed at supporting the fast-tracking of our response by urgently communicating the most essential new findings, providing renewed strategic guidance to the National AIDS response, and linking our new strategic directions to important changes in the institutional and financial mechanisms supporting the AIDS response in our nation.

This revised strategic framework is a work-in-progress that will be further updated with the rich insights from a number of soon to be completed major studies. Coupled with further detailed analytical work in the months ahead, these streams of work will dovetail into the development of a HIV National Strategic Plan at the national level and related State Strategic plans at the state level respectively. These will in turn guide the effective implementation of HIV programmes and interventions by all relevant stakeholders to achieve the common goal of ending AIDS in Nigeria.

NACA recognises and appreciates the technical and financial support of the Federal Government of Nigeria and our donors and partners in the development of this strategic document. The Federal Government of Nigeria led by NACA remains committed to our collective vision of an AIDS-free Nigeria, with zero new infections and zero AIDS related discrimination and stigma. It is hoped that all stakeholders will use this document and continue to provide their unflinching support to the HIV response in Nigeria.

Dr. Sani Aliyu
Director General
NACA

ACKNOWLEDGEMENTS

The process of developing the Revised National Strategic Framework: Future Directions for the HIV/AIDS Response in Nigeria, while it lasted, was an experience driven by the tireless effort of some key stakeholders in the national response. Worthy of note was the enthusiasm and support from all partners and donors who have all seen the urgent need for this very important document in providing strategic direction to the Nigerian HIV and AIDS Response beyond the NAIIS.

I would like to appreciate the board of NACA under the leadership of the chair, Her Excellency Dame Pauline Tallen, OFR, KSG.

The team acknowledges and appreciates the tremendous financial support and technical guidance provided by the NACA Management team ably led by the Director General Dr. Sani Aliyu. The unflinching support provided by UNAIDS, in the development of this document is not only worthy of mention but expected to be emulated by other donors. This work would not have been completed without the support of FMOH, UNICEF, WHO, PEPFAR, FHI 360, SFH, Heartland Alliance, NEPWHAN and University of Manitoba (UoM) who all contributed their wealth of expertise and experience to the entire process.

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Dr. Kayode Ogungbemi
Director Policy, Planning and Stakeholders Coordination
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ACRONYMS AND ABBREVIATIONS

AHF	-	AIDS Healthcare Foundation
AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Antenatal Clinic
ART	-	Antiretroviral Therapy
ARV	-	Antiretroviral Drug
BHCPF	-	Basic Health Care Provision Fund
BMPHS	-	Basic Minimum Package of Health Services
COP	-	Country Operation Plan
CTX/INH/B6	-	Cotrimoxazole Therapy /Isoniazid Prevention Therapy/B6
DOTS	-	Directly Observed Treatment
ECOWAS	-	Economic Community of West African States
EID	-	Early Infant Diagnosis
eMTCT	-	Elimination of Mother to Child Transmission
FLHE	-	Family Life HIV & AIDS Education
FSW	-	Female Sex Workers
GFATM	-	Global Fund to Fight AIDS, Tuberculosis and Malaria
GON	-	Government of Nigeria
HBV	-	Hepatitis B
HCT	-	HIV Counselling and Testing
HTS	-	HIV Testing Services
HCV	-	Hepatitis C
HIV	-	Human Immunodeficiency Virus
HMIS	-	Management Information Systems
IBBSS	-	Integrated Biological and Behavioral Surveillance Survey
ICF	-	Intensified Case Finding
IPV	-	Intimate Partner Violence
KP	-	Key Population
LTFU	-	Lost to Follow-up
MMS	-	Multi-Month Scripting
MNCH	-	Maternal Newborn and Child Health
MPPI	-	Minimum Prevention Package Intervention
MSM	-	Men who have Sex with Men
MTB/RIF	-	Mycobacterium Tuberculosis /Rifampicin
NACA	-	National Agency for the Control of AIDS
NAFDAC	-	National Agency for Food and Drug Administration and Control
NAIIS	-	Nigeria HIV/AIDS Indicator and Impact Survey
NARHS	-	National HIV and AIDS and Reproductive Health Survey
NEC	-	National Economic Council
NHAct	-	National Health Act
NiBUCAA	-	Nigeria Business Coalition Against AIDS
NISRN	-	National Integrated Sample Referral Network
NSF	-	National Strategic Framework
NSHDP	-	National Strategic Health Development Plan
NSP	-	Needle and Syringe Programmes
NTBLCP	-	National Tuberculosis and Leprosy Control Programme

NTPP	-	National Treatment and PMTCT Programme
OST	-	Opioid Substitution Therapy
OVC	-	Orphans and Vulnerable Children
PCR	-	Polymeric Chain Reaction
PEPFAR	-	United States President's Emergency Plan for AIDS Relief
PITC	-	Provider Initiated Testing and Counselling
PLHIV	-	People Living with HIV
PMTCT	-	Prevention of Mother to Child Transmission
PrEP	-	Pre-exposure Prophylaxis
PWID	-	People who Inject Drugs
RNSF	-	The Revised National Strategic Framework
SBCC	-	Social and Behavioural Change Communication
SRH	-	Sexual and Reproductive Health
STIs	-	Sexually Transmitted Infections
TB	-	Tuberculosis
TLD	-	Tenofovir, Lamivudine and Dolutegravir
TPT	-	TB Preventive Treatment
UHC	-	Universal Health Coverage
UN	-	United Nations
VL	-	Viral Load
WAHO	-	West African Health Organisation
WHO	-	World Health Organisation

EXECUTIVE SUMMARY

Nigeria has been engaged in the fight against AIDS for nearly three decades. We have come a long way in scaling-up the key building blocks of a strong AIDS response, with the end of AIDS as a public health threat by 2030 truly in sight for the first time.

In order to better inform and guide our collective efforts going forward, we have recently completed the largest HIV specific population-based survey in the world. The results established a new baseline for understanding the epidemic in our country, with greater precision and granularity.

This Revised Strategic Framework is aimed at supporting the fast-tracking of our national AIDS response by urgently communicating the most essential new findings and providing renewed strategic guidance. It links our new strategic directions to important changes in the institutional and financial mechanisms supporting the AIDS response in our nation.

This Revised Strategic Framework calls for prioritising proven measures to protect those at risk from infection. Additionally, it calls for implementing proven measures to suppress the virus, address co-morbidities and avert new infections in order to reduce morbidity and mortality. To achieve our goals, we need to enable informed demand from "HIV competent citizens" and ensure the full participation of all stakeholders.

It is envisioned that the revised framework launches a process of reviewing and refining strategic direction based on new evidence. When coupled with further detailed work to be done on targets, budgets, and accountabilities, it will lead to a National Strategic Plan to guide implementation of well-proven and efficient strategies. Linked to strong operating plans at state level, we will have a new and strengthened instrument to drive our collective work and reach our common goal, ending AIDS in Nigeria.

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1.0

BACKGROUND

Nigeria is one of the countries in the world with the highest number of people living with Human Immunodeficiency Virus (HIV). Over the past two decades, partners in the global AIDS response have intensively supported our Government and institutions, as elsewhere, to scale-up prevention, treatment, care and support, with a concomitant synergetic impact on a vast range of interrelated public health and development challenges. Nonetheless, HIV/AIDS remains a leading contributor to the burden of disease and a significant public health threat for our country. Much more must be done if we are to achieve our shared goal of ending AIDS as a public health threat by 2030. Our vision remains an AIDS-free Nigeria, with zero new infections, zero AIDS-related discrimination and stigma. The vision can be achieved by fast-tracking the national response towards ending AIDS in Nigeria by 2030.

As part of our efforts to continuously strengthen the national response, last year Nigeria re-established the National Treatment and Prevention of Mother to Child Transmission Programme under the Federal Ministry of Health of Nigeria. The programme commits our Government to expanding HIV testing, to eliminating mother-to-child transmission, to expanding HIV treatment, and to strengthening care, support and adherence with the goal of ending AIDS as a public health threat in Nigeria by 2030. The programme, which has been up and running, with over 65,000 patients on treatment in Abia and Taraba, is being expanded to Benue, Cross River, Lagos, Kaduna, Nasarawa and the FCT. The programme is funded by the Federal Government, which is committed to putting a further 50,000 patients on treatment annually.

In Nigeria, despite our collective efforts, the resources available to drive the HIV/AIDS response forward are limited. We continue to work together with our global partners in a framework of shared responsibility and global solidarity to secure and sustain the needed resources. Using the available resources strategically is essential to saving more lives and averting more new infections. Continuously improving and recalibrating such an evidence-informed strategy, driven by a more insightful understanding of the epidemic in our nation and recent global experience in the AIDS response, is the purpose of the revision of the 2017-2021 Strategic Framework.

In order to better inform and guide our collective efforts going forward, we have recently completed an unprecedented population-based survey, the Nigeria AIDS Indicator and Impact Survey (NAIIS), with the generous support of our partners in the global community, including the United States U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the World Health Organisation (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS), and other partners. The NAIIS survey is bringing us a new, data-driven understanding of our epidemic with greater precision and granularity.

The new data and a wealth of analytic insights still being drawn therefrom further enhances our ability to optimise and differentiate our programmatic actions at all levels with a view to maximizing the impact of available resources and hastening the end of AIDS in our nation. We can now better focus our efforts to expand testing to ensure people living with HIV know their status. We can better focus support for the necessary treatment and service delivery systems to ensure people living with HIV, who know their status, are provided the care and treatment they need. We can better put in place the support systems to ensure improved adherence to appropriate treatment; and we can scale-up, in a more targeted way, our ability to monitor viral loads and ensure people on treatment achieve viral suppression.

We have also recently completed revised size estimates of key populations in 16 States plus the Federal Capital Territory (FCT), as well as an important study in Nigerian prisons. Coupled with the new data and insights from the NAIIS

survey, we are better able to target strengthened efforts to prevent new infections, through differentiated approaches to key and vulnerable populations disproportionately affected by the epidemic.

Extensive work is underway which will lead, over the coming months, to a revised National Strategic Plan (NSP), incorporating the latest data and findings, and providing planning-level guidance to stakeholders in the National AIDS response.

This Strategic Framework has three complementary aims:

1) To urgently communicate the most essential new findings, with more to come as the analysis is fully completed;
2) To provide renewed strategic guidance to the National AIDS response, pending the more detailed consultations and consensus building through the National Strategic Planning process at national and state levels; and
3) To link our new strategic directions to important recent and forthcoming changes in the institutional and financial mechanisms supporting the AIDS response in our nation.

1.1 Guiding Principles

This Strategic Framework is built upon seven fundamental principles which guide our strategies and actions:

I. **Political leadership and ownership:** Strong political leadership of the national and state HIV and AIDS responses, driven by a sense of ownership, and with commitment to transparent and prudent management of financial resources at all levels of the response.

II. **Partnerships and multi-sectoral collaborations:** Synergy between all multi-sectoral partners for the purpose of stronger collaboration and partnerships between all stakeholders, including civil society organisations, networks of people living with HIV, and international development partners led by government.

III. **Rights-based and gender-sensitive:** Respect for gender equality and fundamental human rights through adoption of rights-based and gender responsive approaches in HIV programming by all stakeholders and at all levels.

IV. **Meaningful involvement of people living with HIV and AIDS:** Commitment to the meaningful involvement of people living with HIV and AIDS (MIPA) through institutionalization of the engagement of people living with HIV in the implementation of the HIV response; and respect for the rights and dignity of all persons living with HIV.

V. **Strategic Investment programming:** Targeted strategic investment driven by the latest evidence in the field of HIV and AIDS, with the aim of optimizing the utilization of resources and maximizing the returns on investment in the HIV response.

VI. **Optimization of the health system:** Strengthening of the health system as a basis for effective delivery of quality HIV prevention, treatment, care, support and adherence programmes.

VII. **Community involvement, engagement and participation:** Strengthening community systems, engagement, and full participation as fundamental to achieving the goal and objectives of our strategy.

1.2 Rationale for the Revised National Strategic Framework

In common with practices worldwide, over the years Nigeria has relied upon a combination of

periodic epidemiological sample surveys - Antenatal Clinic (ANC) sentinel surveys, National HIV and AIDS and Reproductive Health Surveys (NARHS), Nigeria Demographic Health Surveys (NDHS), and Integrated Biological and Behavioral Surveillance Surveys (IBBSS) – together with routinely collected programme data to monitor and estimate the population level HIV epidemic trends in the country. Estimation using modeling techniques is essential to understanding the overall epidemic and burden of disease as months or years may pass between infection and diagnosis - simply counting diagnosed cases is not meaningful.

Undertaking such surveys and collecting programme data is complex and costly, more so in a large population and decentralised health system like our own, with the size of samples, number of clusters, and additional complexities driving cost. In the early stages of the AIDS response, with few people on treatment and limited resources, using smaller samples with less frequency across sites to monitor and estimate HIV epidemic trends has been a common and relatively cost-effective approach, in Nigeria as in other countries, albeit with significant qualitative limitations. Despite the limitations, for reasons of cost, training of staff, and comparability for trend analysis, methods of monitoring once established are also hard to change.

Over time, many countries around the world have shifted to a location and population strategy, which has helped to ensure that investments in HIV services reach people and geographic areas with the greatest need. Location and population strategies require data at granular levels which were not typically available in Nigeria with existing methods.

Today, the HIV response in our country has been scaled-up to reach roughly 1 million patients on highly-active antiretroviral therapy (HAART) in about 1500 treatment sites. As testing and treatment programmes in our country have been scaled-up, the value of a more precise and granular characterization of the state of the epidemic, with a view to better guiding future investments, has risen significantly for all stakeholders. This justified the important investment in a new and comprehensive population-based HIV survey.

The NAIIS was designed as a two-stage, cross-sectional cluster survey of 88,775 randomly selected households, sampled from among 3,551 nationally representative sample clusters. When fully analysed the NAIIS will characterise HIV incidence, prevalence, viral load suppression, CD4 T-cell distribution, prevalence of detectable antiretroviral (ARV) drugs and antiretroviral drug resistance, as well as risk behaviors and the uptake of key HIV prevention, care and treatment services amongst our children and adults, men and women, at each life stage. The NAIIS will further estimate the prevalence of Hepatitis B (HBV) and Hepatitis C (HCV) infections, and HBV/HIV and HCV/HIV co-infections.

The NAIIS survey was an extraordinary undertaking in scale and complexity, made more impressive by the speed with which it was accomplished, the robust protocols followed, and the logistical and operational challenges that were overcome. The results will establish a new baseline for understanding the epidemic in our country. Initial findings from the survey, which are informing this revised strategic framework, have urgent important implications for programming. It is however important to recognise that, because the scale and methodology of the NAIIS is so much greater and more sophisticated than previous surveys, understanding of trends will require modeling and restatement for comparability. Simple comparisons with past estimates will necessarily be misleading given the discontinuities.

1.3 Key Findings of the NAIIS

Based on findings from the NAIIS, the current national prevalence of HIV is estimated at 1.4% (15-49 years), with a total estimated 1.9 million persons living with HIV in Nigeria. Prevalence

among females is significantly higher at an estimated 1.9%, with male prevalence estimated at 0.9%.

The new prevalence estimates by state may be categorised as follows: Seven states are considered to have high prevalence of 2.0% and above. These include Abia, Taraba, Benue, Enugu, Anambra, Akwa Ibom and Rivers; a further thirteen states plus the Federal Capital Territory have medium prevalence between 1.0% and 1.9%, including Borno, Gombe, Adamawa, Kaduna, Plateau, Nasarawa, Cross River, Imo, Edo, Delta, Bayelsa, Lagos, and Ogun; the other sixteen states are considered to have low prevalence, below 1.0%.(Figures 1 and 2).

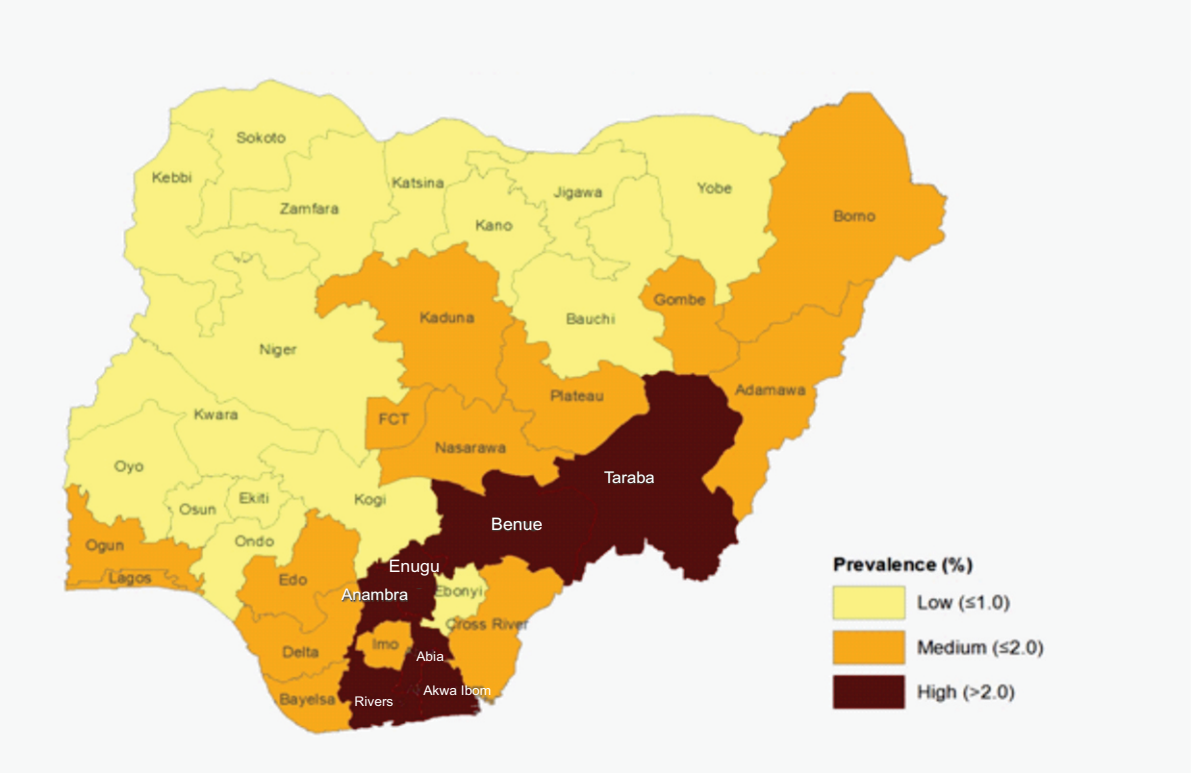


Figure 1: Map of Nigeria showing HIV prevalence distribution across the country

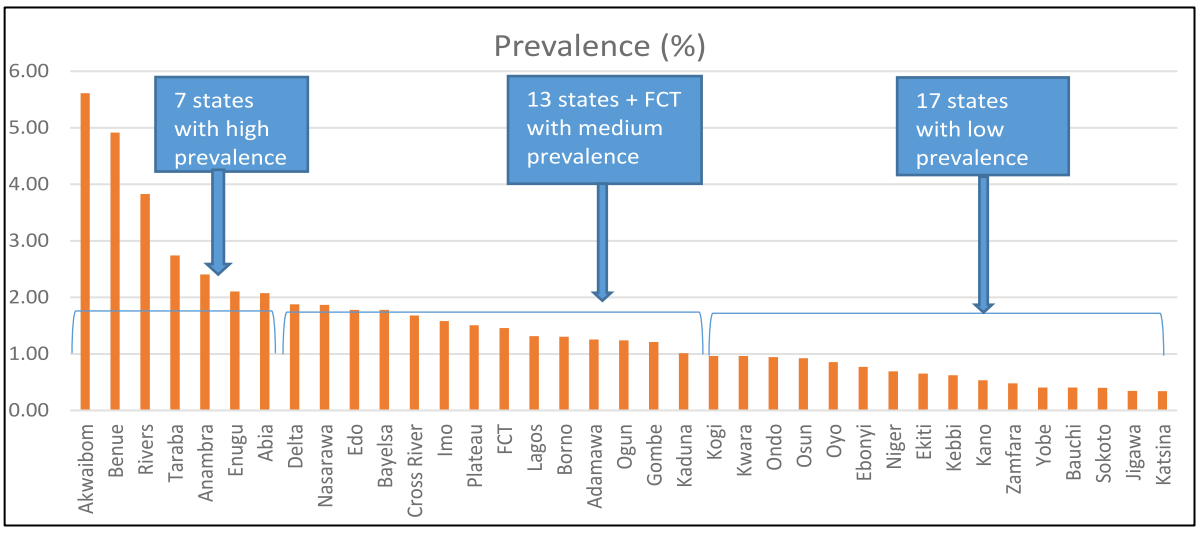


Figure 2: HIV prevalence by state (NAIIS 2018).

All states in the North-West, except for Kaduna have low HIV prevalence. All states in the South-West, with the exception of Lagos and Ogun also have low HIV prevalence. The North-Central zone has a mix of low, medium and high prevalence, with the low prevalence states being to the West of the zone, while the high prevalence states are to the extreme east.

Seven states account for 50% of the overall estimated number of persons living with HIV in Nigeria, with eighty percent (80%) of all persons living with HIV estimated to be living in nineteen (19) states plus FCT (Figure 3). In terms of geographical distribution, the estimated number of persons living with HIV is highest in the South-South geopolitical zone of the country followed by the North-Central and lowest in the North-East (Figure 4). Females make up the majority of the persons living with HIV overall and in all geopolitical zones with the exception of the North-West, where this trend is reversed.

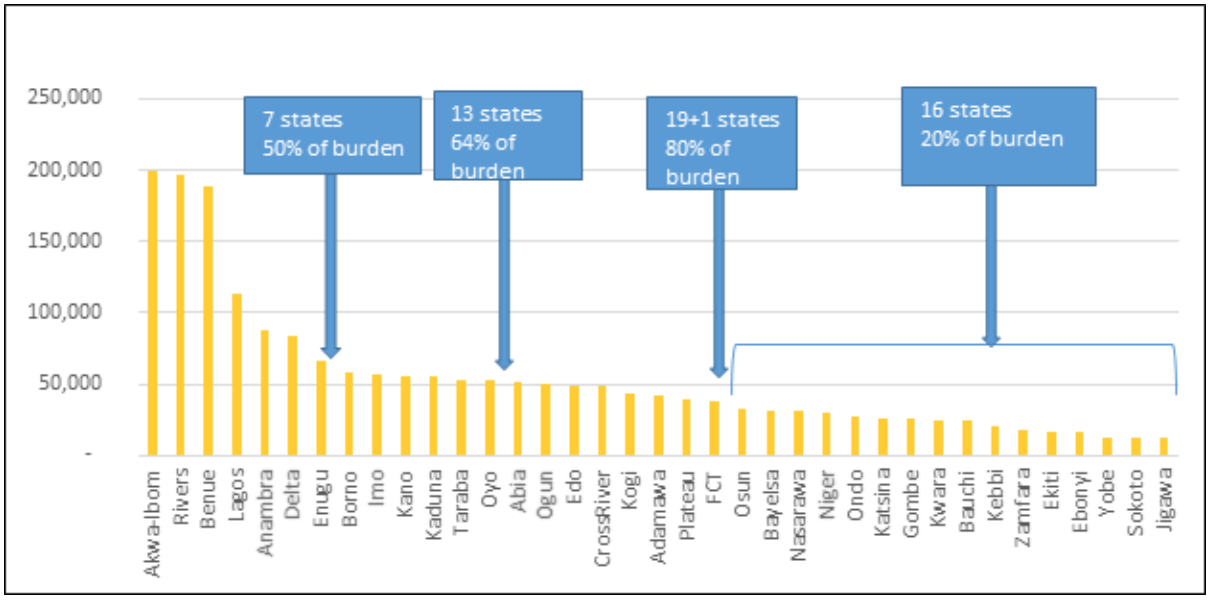


Figure 3: PLHIV burden by state (Spectrum estimates using NAIIS data).

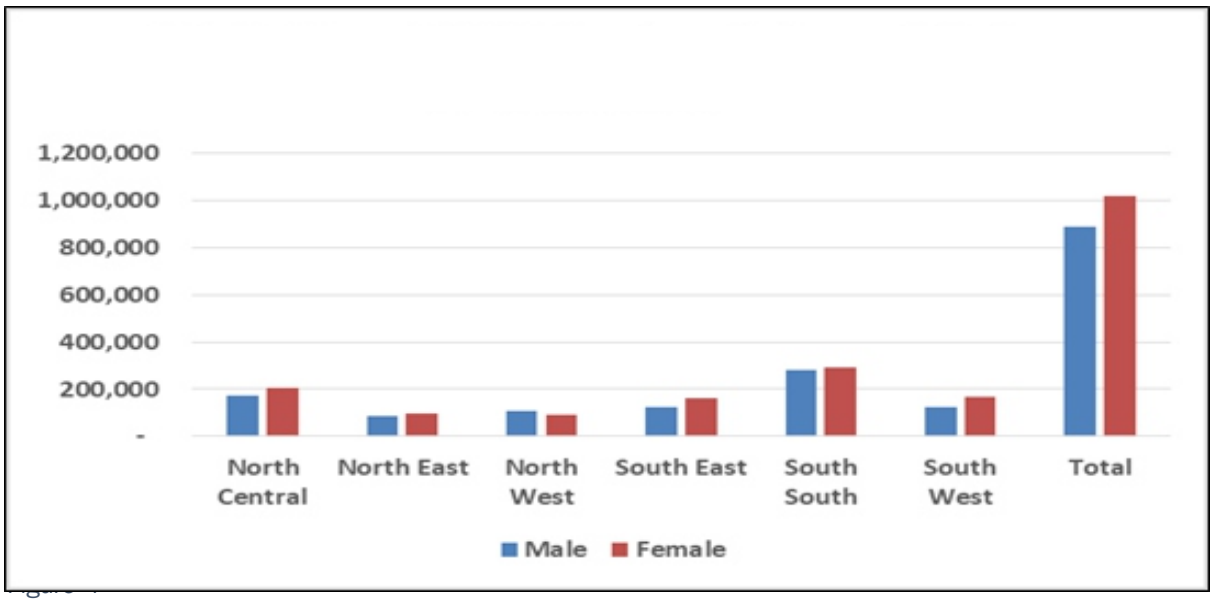


Figure 4: Distribution of PLHIV burden by geopolitical zone and sex (Spectrum estimates with data from NAIIS).

The distribution of HIV burden across age bands indicates 12% of persons living with HIV are between the ages of 0-14 years while 75% are between 15-49 years and 13% are 50 years and above. Adolescents (10-19 years) account for 8% of persons living with HIV. Females have a significantly higher burden compared to men between the ages of 15 to 44 years (Figure 5).

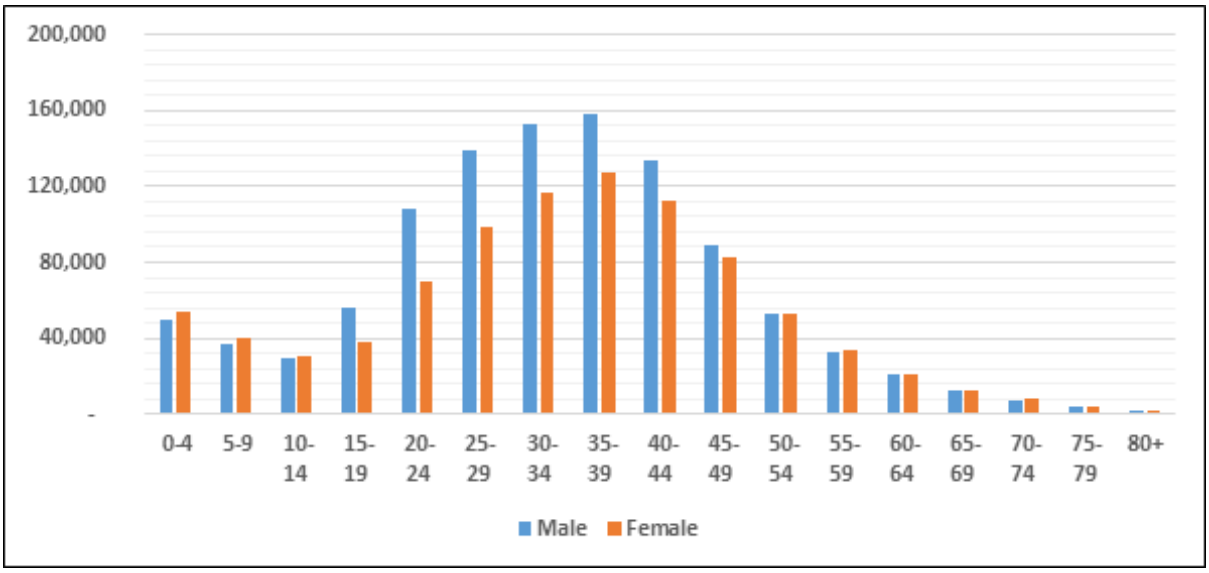


Figure 5: Distribution of PLHIV burden by age and sex (Spectrum estimates with data from NAIIS).

1.4 Drivers of Incidence

In 2017, Nigeria had an estimated 210,000 total new infections, of which 36,000 were among children. Based on findings from the NAIIS, HIV-1 incidence is 8.0 per 10,000 persons across both genders and age groups. Female incidence is significantly higher than male incidence, both in adolescents and young adults (15-29 years age) and in adults (30+ years age). Female incidence is lower in adolescents and young adults than in adults (10 per 10,000 persons vs 12 per 10,000 persons), whereas for men, incidence is higher among adolescents and young adults (7.0 per 10,000 persons vs 3.0 per 10,000 persons).

The HIV epidemic in our nation remains a mixed epidemic partly driven by significant urban key populations, particularly female sex workers (FSW), men who have sex with men (MSM) and people who inject drugs (PWID), with substantial overlap with urban casual sexual networks. In the rural towns and villages, risk is driven by variations in sexual behaviors such as casual, transactional and sex work.

The best available estimates of modes of transmission indicate two-fifths (42%) of infections occur amongst persons practicing 'low-risk' sex, a sub-population that includes cohabiting or married sexual partners. Key population (KP) groups contribute a significant portion of new HIV infections.[4] Directly, FSW, MSM and PWID, who constitute an estimated 1% of the adult population, contribute nearly 23% of new HIV infections. Roughly 20% of infections may be attributed to female sex workers, their clients and client partners alone, of which three-fourths may be attributable to brothel-based FSWs. People who inject drugs (PWID), MSM and their partners respectively contribute about 9% and 10% of the annual new infections. These KPs and their partners together, who constitute an estimated 3.4% of the adult population, contribute as much as 40% of new infections. As indicated in the 2016 National HIV Strategy for Adolescents and Young People 2016-2020, mother-to-child transmission "may account for a fairly high proportion of the infections among adolescents age 10–19 years" in Nigeria.

Beyond behavioral risk factors, environmental and systemic factors also constitute risks for HIV infection. Transfusion of infected blood and blood products and poor handling and disposal of highly infectious wastes generated in healthcare settings increase the risk for HIV transmission. In addition, structural drivers also play a role in the HIV epidemic in Nigeria. These include those socio-cultural factors that increase people's vulnerability to HIV infection such as poverty, gender inequality, human rights violations and the persistence of HIV and AIDS-related stigma and discrimination. A number of specific socio-cultural factors contribute to infection, with some variance across geo-political zones of the country. These include:

- Low dissemination of information about HIV, especially in rural areas.
- Low usage of condoms due to cultural beliefs.
- Inability of women to demand condom use. (Male dominance over women's reproductive rights).
- Extra-marital sex and/or multiple sex partners.
- Levirate Marriage (Widow Inheritance).
- Female genital mutilation.
- Gender inequality disempowering women from seeking HIV prevention or treatment services without the permission of their husbands/partners.
- Poverty, which may lead to risky behavior such as prostitution.
- Males being less disposed to going for testing and seeking treatment.
- Poverty, which limits access to treatment by women in clinics, especially clinics that are distant from their homes.
- Recently humanitarian crisis with implication for unsafe and violent sexual experiences.

1.5 Overview of the Revised Strategic Framework

Although many strategies will be needed to end AIDS as a public health threat, it is clear that preventing new infections will be key. At the most basic strategic level, we must put in place measures to protect from infection all those at risk, including the unborn, newborn, youth, adolescents, and sexually active adults as well as those exposed environmentally. Simultaneously, we must put in place measures to suppress the virus in those who are infected in order to avert new infection, reduce morbidity and mortality. We must also provide care and support to improve the quality of life of PLHIV.

Ensuring youth, adolescents, and sexually active men and women are functionally knowledgeable, "HIV-competent" citizens, is critical to the success of these strategic thrusts. Only informed, functionally knowledgeable citizens will demand condoms; demand pre-exposure antiretroviral prophylaxis (PrEP); demand harm reduction services for PWID; demand HIV testing and counseling; demand antiretroviral prophylaxis or therapy; demand safe delivery; demand safer infant feeding and postpartum interventions such as cotrimoxazole prophylaxis; demand early diagnosis for HIV-exposed infants; and demand links to treatment and care, as well as standard postpartum child survival interventions. Without informed demand from functionally knowledgeable, "HIV-competent" citizens, our strategies will surely fail to end AIDS as a public health threat.

At the core of our strategy to protect from infection all those at risk, is the delivery of combination prevention services and the elimination of mother-to-child transmission, through provision of preventive services.

Also, central to our strategy to suppress the virus in PLHIV, is achieving 90-90-90 - ensuring 90% of all people living with HIV know their HIV status; 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy have sustained viral suppression. When this three-part target is achieved, at least 73% of all people living with HIV will be virally suppressed. Modelling suggests that achieving these targets world-wide, and subsequently higher targets of 95-95-95, will enable the world as a whole to end

the AIDS epidemic by 2030, which in turn will generate profound health and economic benefits.

The 90-90-90 strategy is also the key to reducing mortality. In 2017, we lost 150,000 lives prematurely to AIDS and its complications. Achieving viral suppression is critical to sustaining life for infected individuals. Also, protecting HIV infected individuals from tuberculosis (TB), hepatitis, and other causes of premature mortality and morbidity is essential.

How we reach our people with information to create "HIV-competent" citizens, how we deliver our combination prevention services and prevention of mother-to-child transmission services, how we test, treat, and ensure adherence to treatment and viral suppression, and how we reach infected individuals to provide tuberculosis preventive treatment and other services are the critical choices that must be tailored at a location-population level to be effective. This is where the NAIIS and other surveys are of such vital importance.

The success of our strategies for preventing new infections and reducing premature morbidity and mortality will be conditioned by our ability to enable the full engagement of all who are concerned, whether infected or vulnerable. Every barrier to full engagement, including stigma, discrimination, disempowerment and social exclusion must be overcome.

Collectively, these strategies will enable healthier lives and faster development of our country in ways far beyond ending AIDS alone. The AIDS response is truly the tip of the spear, in helping us to strengthen our health systems to reach all Nigerians with quality services, to strengthen our ability to educate and inform, and strengthen the ability of all Nigerians to engage and contribute to our common purpose.

1.6 Goals and Objectives of the Revised Strategic Framework

This Revised National Strategic Framework (RNSF) is a pillar of our collective work towards Universal Health Coverage (UHC) for all Nigerians. It provides strategic direction for the HIV response towards meeting key national targets, pending the development of a comprehensive and new strategic plan. This Framework was developed with input from a wide cross-section of stakeholders. It will serve as the strategic template and guidance for the national response, with a goal of fast-tracking the national response towards ending AIDS in Nigeria by 2030. The objectives are:

- *To eliminate new HIV infections by 2030;*
- *To ensure 90% of the population, including key and vulnerable populations, have access to HIV combination prevention interventions by 2020, and 95% by 2030;*
- *To eliminate mother-to-child transmission of HIV by 2030;*
- *To ensure that 90% of people living with HIV know their status by 2020, and 95% by 2030;*
- *To ensure that 90% of HIV positive persons are on sustainable antiretroviral therapy by 2020, and 95% by 2030;*
- *To ensure that 90% of HIV positive persons on antiretroviral therapy are virally suppressed by 2020, and 95% by 2030;*
- *To make policy directives and funding recommendations for the HIV and AIDS response Post NAIIS; and*
- *To foster increased financing from domestic resources and strengthened national and state-level ownership of the HIV/AIDS response.*

2.0 PREVENTION OF NEW INFECTION

2.1 Combination Prevention Services

Combination prevention strategies involves a three-pronged approach - biomedical, behavioural and structural. The national HIV prevention programme strategically focuses on reducing the number of new HIV infections in Nigeria. National HIV prevention efforts are geared towards reducing the risk of HIV transmission acquired through HIV-risky sexual behaviors, unsafe blood and blood products, use of non-sterile needles in people who inject drugs, and mother-to-child transmission. Condom programming, which has been extensively implemented in Nigeria, has led to greater use during non-marital sex. Broadly, we must aggressively strengthen the coverage of our combination prevention services in recognition of coverage indicators which are largely still well below 50%.

A recent mapping and size estimation exercise for key populations in all Local Government Areas of Oyo, Edo, Anambra, Abia, Imo, Enugu, Kano, Kaduna, Gombe and Taraba states revealed an estimated number of 212,402 key populations across all typologies. This includes an estimated 118,171 female sex workers, 44,355 men who have sex with men and 49,876 people who inject drugs respectively across the 10 States. This estimate is significantly higher than previously estimated and the HIV prevalence amongst them remains relatively high especially amongst sex workers (4%) and men who have sex with men (6%), based on current programming efforts (2018) in selected states. There remains a high chance of a HIV epidemic amongst people who inject drugs due to continued high rate of needle and syringe sharing amongst them. The size estimate identified Kaduna state with the highest number of female sex workers and people who inject drugs active hotspots with Kano State identified as the State with the highest numbers of men who have sex with men active hotspots.

The high estimates of key populations (who are key drivers of the epidemic) in some of the states with overall medium and low prevalence argues strongly for a granular location-population approach to programming.
Our goals are to ensure 90% of the population, including key and vulnerable populations, have access to HIV combination prevention interventions by 2020, and 95% by 2030.

2.2 Priority Prevention Strategies for General and Key Populations

2.2.1 General Population

- Total condom market approach which segments the population based on socio-economic indices to access free, socially marketed (subsidised) or commercial condoms and lubricants
- Strategic behavior change communication for condom usage during non-marital sex targeted at youth (commercial and social marketing).
- Continued messaging for HIV testing for persons at risk, based on risk profiles including provider-initiated testing and increasing access to HIV self-testing commodities.
- Sexual and reproductive health interventions, including contraception, diagnosis and treatment of STIs, as well as cervical screening.
- Increasing awareness and knowledge of HIV and AIDS, prevention of HIV for pregnant women, breast feeding mothers and early infant diagnosis (EID).

2.2.2 Key Populations

- Enabling environment for access to services without stigma or discrimination.
- Comprehensive service package in the community and health facilities (One-stop shop and public /private health facilities).
- Harm reduction interventions for substance use, needle and syringe programmes - (NSP), opioid substitution therapy (OST) and naloxone.
- PrEP for male sex workers and their clients.
- Prevention and management of co-infections and other co-morbidities,

including viral hepatitis, TB and mental health conditions.
- Condom and lubricant programming (free and social marketing).
- Sexual and reproductive health interventions, including contraception, diagnosis and treatment of STIs, as well as cervical screening.
- Community level mobilization for HIV testing services (mobile services, index client /social network testing, self-testing).

2.3 Ensuring "HIV Competent" Citizens

A vision captured by NACA is for Nigeria to be a nation of people with functional knowledge of HIV/AIDS who provide care and support to individuals, families and communities confronted with the epidemic. Ensuring youth, men and women are informed and knowledgeable about the risks of HIV infection and how to protect themselves, get tested and be treated is essential to demand creation.

UNAIDS knowledge indicator defines comprehensive HIV knowledge as correctly identifying ways of preventing the sexual transmission of HIV (correct and consistent condom use; having one HIV-negative, faithful partner); and rejecting major misconceptions about HIV transmission (HIV can be transmitted by mosquitoes or by supernatural means).

Communication interventions impact HIV and AIDS response on several fronts and embrace both behaviour change communication and social change communication. Behavior change communication promotes tailored and culturally sensitive messages, personal risk assessment, greater dialogue and an increased sense of ownership of the response by the individual and the community. Social change communication, on the other hand, involves the strategic use of advocacy, communication and social mobilization to systematically facilitate and accelerate change in the underlying determinants of HIV risk, vulnerability and impact.

Communication interventions contribute towards shaping decision-making at individual and group levels, building risk reduction skills of individuals and populations, promoting appropriate HIV prevention behavior, addressing stigma and discrimination, and educating health-care providers and other care givers. Furthermore, communication efforts are key to improving both the supply and demand sides of all the HIV-related services – prevention, testing, treatment, care and support. As such, communication interventions are embedded into each of the thematic areas.

2.3.1 Family Life HIV & AIDS Education

The 2016 National HIV Strategy for Adolescents and Young People indicated inadequate HIV knowledge among adolescents and young persons in Nigeria, with only 22% of adolescents, and 27% of young people having comprehensive HIV knowledge[5]. This low level of knowledge is linked to social normative barriers that discourage adolescents and young people from seeking information from reliable sources. In rural areas, only 22% of adolescents and young people have comprehensive HIV knowledge due to a higher degree of isolation from contemporary society, compared to 29% in urban areas.

Demand creation efforts focus on in-school youth, out-of-school youth, adolescents and adults through different mechanisms. The Federal Ministry of Education plays a crucial role having an established HIV/AIDS unit and which introduced the Family Life HIV & AIDS Education (FLHE) curriculum in schools. Family Life and HIV Education is a curriculum-based process of acquiring information about sexual development and reproductive health issues and life skills to enable young people to be better informed and empowered to adopt positive health and social behaviors. The curriculum is comprised of three components: class room delivery; communication of reproductive health and HIV/AIDS prevention information to students on the school assembly ground; and peer education plus peer-led informal strategies for prevention messaging.

The Family Life and HIV Education programme needs to be urgently reinvigorated and better supported. The curriculum and in-school anti-AIDs club activities should be strengthened and new cost-effective approaches to in-school training of teachers put in place. Above all, on the principle that what gets measured gets done, a strengthened oversight, monitoring and evaluation mechanism for FLHE teachers should be put in place, including consideration of awards or incentives to motivate teachers. Greater involvement of young people and people living with HIV in programme oversight would likely be helpful in strengthening links and results.

2.3.2 Social Media & Traditional Media

Strengthening the use of social media platforms and traditional media to communicate a health promotion agenda, disseminate HIV information and strategic behavior change messages, including for condom usage during non-marital sex targeted at youth (commercial and social marketing), and tackling stigma is vitally important. Adolescents and young people specific strategic behavior change communication messages. Involving trained adolescents and young people to contribute to the programming and manage online interactions is fundamental to reaching target audiences effectively.

2.3.3 Leveraging the Network of People Living with HIV/AIDS in Nigeria

The Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) plays a central role in coordinating a social support and information system for persons living with HIV/AIDS. Through its support groups and persons living with HIV/AIDS advocates, NEPWHAN disseminates information and educational products to members about their health needs, which in turn empowers them to demand HIV services. In addition, NEPWHAN can be supported to develop out of school youth cohort cooperative support groups and back to school programmes. Such an approach, with cohorts limited to 10 individuals per group, will directly address one of the most vulnerable groups.

2.3.4 Strengthening Community Structures

Further programming should strengthen formal and informal community level structures including people living with HIV networks, mentor mothers, traditional birth attendants, community and religious leaders to provide basic and simple messaging using appropriate media and language as well as quality assurance mechanisms for home-based care and support services.

2.4 Elimination of Mother-to-Child Transmission of HIV

Nigeria has a high number of new HIV infections among children. Mother- to-child transmission of HIV accounts for 90% of HIV infections in children[5]. Prevention of mother-to-child transmission programmes at all levels are characterised by poor ownership, with funding gaps and dwindling donor funding. Although attendance at antenatal care by pregnant women has improved (76.5% in the NAIIS), prevention of mother-to-child transmission services are still highly concentrated in public health facilities. Even in states where HIV counseling and testing coverage is high, it is not accompanied by similar high coverage for those who received antiretroviral therapy. This can be attributed to weak referral system, linkages and follow up of positive pregnant women. A further challenge is inadequate coverage of EID.

For the elimination of mother to child transmission of HIV, it is critical to achieve high ART coverage among HIV positive pregnant women. The target among pregnant women by 2020 is 95%. The strategy for elimination of mother to child transmission of HIV (eMTCT) is built on a four-pronged approach:

1. Providing primary prevention of HIV infection among women of childbearing age;

2. Preventing unintended pregnancies among women living with HIV;
3. Preventing HIV transmission from women living with HIV to their infants; and
4. Providing appropriate treatment, care, and support to mothers living with HIV and their children and families.

The success of this strategy depends on accelerating both policy-level and program-level integration of prevention of mother-to-child transmission (PMTCT) with maternal, newborn and child health services (MNCH), supported by the inclusion of prevention of mother-to-child transmission in the minimum service package for maternal, newborn and child health services.

2.4.1 Strategic Intervention for eMTCT of HIV

- Reinforcement of HIV prevention communication to women with a special focus on younger pregnant women.
- Encouragement of women to attend antenatal care (ANC) by making ANC comprehensive, free and accessible to all women.
- Strengthen contraceptive demand and supply for HIV positive women.
- Promote integration and strengthen referral and linkages between antenatal care, family planning, sexual and reproductive health services, maternal and child health and HIV services, including EID.
- Foster an enabling environment for HIV positive pregnant and breastfeeding mothers and HIV-exposed infants to access PMTCT services.
- Expand access of HIV positive pregnant and breastfeeding mothers to access antiretroviral treatment.
- Expand access of HIV exposed infants to antiretroviral prophylaxis and co-trimoxazole prophylaxis within 2 months of birth.
- Expand access of HIV exposed infants to EID services.
- Promote a mix of conventional laboratory networks to expand access to early infant diagnosis as well as Point of Care testing for EID.
- Expanding access of HIV exposed babies to HIV serological test at 18 months.
- Strengthen community systems to support care for HIV exposed infant.
- Strengthen community involvement in PMTCT services.
- Institute and strengthen the quality management systems for all eMTCT facilities.
- Conduct appropriate research to identify strategies to facilitate eMTCT.

3.0 ACHIEVING HIV TARGETS OF 90-90-90– AND 95-95-95 SUBSEQUENTLY

This section describes the guiding strategies for achieving the 90-90-90 targets as well as the 95-95-95 targets by 2030.

3.1 The First 90: Key Strategies for Enabling People Living with HIV to Know Their Status

3.1.1 Rationale

A rate-limiting step to fast-tracking the national response towards ending AIDS in Nigeria by 2030 is the low access and coverage of quality HIV testing services estimated nationally at 37%. Linkage of diagnosed people living with HIV to ART is an essential component of HIV testing services and significant gaps still exist in this area. HIV testing services programming is focused on utilizing strategies that maximise efficiency while expanding access to accurate, high-quality services. These are designed to take into account factors such as local prevalence and HIV burden while using a rights-based approach to equitably address disparities in HIV testing services coverage in various relevant subpopulations including children, adolescents, young adults and key populations who are at risk of HIV infections. Priority strategies should be structured to achieve optimised coverage of interventions, focused on the right areas at macro level and at the right groups at location-population levels, ensuring high intensity and effectiveness of interventions through continuous quality improvement.

3.1.2 Strategic Objective

The strategic objective is to increase access to HIV testing services, enabling 90% and 95% of persons living with HIV (PLHIV) to know their status by 2020 and 2030 respectively and be linked to relevant services – the first 90/95.

3.1.3 Strategic Interventions

- Support full implementation of national task-shifting/task-sharing policy to address gaps in human resources available for the scale-up of HIV testing services.
- Adopt modified testing approaches that promote improved testing efficiencies, taking into account local epidemic characteristics, and careful mapping of hotspots as well as risk screening at micro levels and sexual network testing.
- In high prevalence settings, prioritise facility-based testing through smart integration and Provider Initiated Testing and Counselling (PITC) in high yield streams such as TB, STI and malnutrition clinics as well as ANC.
- Prioritise index case testing services for children of positive women and partners of index clients in all settings.
- Targeted community-based HIV testing services strategies, including HIV self-testing, should be scaled up to reach underserved populations in high prevalence settings with a high unmet need for HIV testing services.
- Leverage opportunities for HIV testing services scale-up through private sector partnerships, including commercialization of low-cost HIV self-testing kits.
- Scale up EID services for exposed infants in all settings
- With the active participation of youth, adolescents and young adults, scale-up youth-friendly HIV and STI testing services for men and women nationally, with an immediate priority in high prevalence settings.
- Strengthen facilitated referral and linkage services between HIV testing services, HIV treatment and related services.
- Improve the logistics and supply chain management for all testing commodities.
- Institute and strengthen quality management systems for all HIV testing services sites.
- Strengthen monitoring and evaluation platforms to support use of data for decision making.
- Conduct appropriate research to identify new strategies that support improved access to HIV testing services.

3.2 The Second 90: Key Strategies for Enabling People Living with HIV to Receive Quality HIV Treatment Services

3.2.1 Rationale

Programmatic interventions to improve national achievement across the three 90's have faced specific challenges, including inefficiencies in the health systems, insecurity, mobile and hard to reach populations. While antiretroviral therapy (ART) coverage in Nigeria has been significantly scaled-up, coverage nationally is suboptimal, with spectrum data from NAIIS showing an estimated 47% of the total number of people living with HIV on treatment, and an unmet need of about 1.0 million people. Treatment coverage for children under 15 years is significantly lower at 31%. Most of the high burden states have a significant unmet need due to low treatment coverage while about half of the low burden states have similarly low treatment coverage, below the national average.

Over the last decade, increasing access and improvements to antiretroviral therapy has resulted in greatly increased life expectancy, reduced morbidity and mortality among PLHIV as well as reduced transmission rates of the virus. With the adoption of the WHO recommended "treat all" policy in 2016, the number of PLHIV accessing antiretroviral therapy has significantly increased. All diagnosed PLHIVs should have access to sustained, high quality comprehensive antiretroviral therapy services that provides support for prevention of onward transmission of HIV, prevention of illnesses, protection of their health and to live a healthy lifestyle. Adequate support for adherence, retention, treatment literacy and stigma reduction will achieve and sustain the ultimate goal of virologic suppression.

3.2.2 Strategic Objective

The strategic objective is to ensure that 90% and 95% of HIV positive persons are on sustainable and quality HIV treatment services by 2020 and 2030 respectively.

3.2.3 Strategic Interventions

- Support full implementation of national task-shifting/task-sharing policy to address gaps in human resource available for the scale up and decentralization of HIV treatment services.
- Expand access to antiretroviral therapy services to address the geographical areas with high unmet need for antiretroviral therapy.
- Support full implementation of WHO recommended "treat all" policy.
- Leverage opportunities for scale-up of treatment services through private sector partnerships
- Scale up access to quality cost-effective antiretroviral regimens.
- Institutionalise youth friendly services that target adolescents and young adults.
- Promote integration and strengthen referral and linkages for HIV, TB, non-communicable diseases and other comorbidities.
- Scale-up of nationally identified differentiated models of patient centered care for stable and unstable patients (including in-facility and community-based models) to improve patient adherence and retention.
- Support pharmacovigilance and active management of adverse drug reactions.
- Adopt and implement the WHO strategies to monitor evolution of HIV drug resistance in Nigeria.
- Institute and strengthen quality management systems for treatment sites.
- Improve the logistics and supply chain management for antiretroviral medicines and other related drugs.
- Strengthen monitoring and evaluation platforms to support use of data for decision making.
- Conduct appropriate research to identify strategies that support increased access to HIV treatment services, viral suppression and improve quality of life.
- Integrate non-traditional service delivery (faith-based organisations/maternities/traditional birth

attendants) with formal health systems.
- Integration of HIV services into routine health service provision.
- Develop a community component for keeping the persons on treatment, including community support, addressing user fees issues, inclusion of treatment costs in insurance mechanisms.

3.3 The Third 90: Key Strategies for Ensuring Sustained Viral Suppression

3.3.1 Rationale

Viral load has been adopted by Nigeria as the gold standard of ART monitoring in line with WHO recommendations. Coverage of viral load services is however suboptimal and must be scaled up to achieve our targets. Challenges encountered in improving the expansion of viral load services include operational inefficiencies, insufficient demand creation for viral load services, PCR laboratory equipment downtime and poor turnaround time of viral load results.

This strategic plan underscores the need for deliberate interventions to ensure timely access to viral load testing services, efficiency of the viral load systems and improved viral suppression rates for all client groups, especially among children and adolescents.

3.3.2 Strategic objective

The strategic objective is to ensure that 90% and 95% of HIV positive persons on antiretroviral therapy are virally suppressed by 2020 and 2030 respectively – The Third 90/95

3.3.3 Strategic Interventions

- Scale up viral load access and coverage.
- Strengthen the national integrated sample referral network (NISRN).
- Increase demand for viral load services by improving patient viral load literacy and health care facility operational efficiencies.
- Improve maintenance and support to PCR labs to ensure adherence to appropriate standards and optimal operation with minimal downtime.
- Scale up of the use of electronic health records systems to improve the management and dissemination of patient results from PCR labs to healthcare facilities and improve turnaround time.
- Scale up of dried blood spot specimen and point of care testing for viral load especially in healthcare facilities in hard to reach communities.
- Scale up effective strategies to promote adherence to treatment and prevention of loss to follow up.
- Improve the logistics and supply chain management for viral load commodities and consumables
- Institute and strengthen quality management systems for treatment sites
- Strengthen monitoring and evaluation platforms to support use of data for decision making.
- Conduct appropriate research to identify strategies that support increased access to viral load services.
- Integrating of HIV services into routine health service provision.

3.4 Reducing Mortality from HIV-TB

Nigeria is the 4th out of 30 high TB burden countries with an incidence rate of 219 per 100,000. The estimated incidence of TB among HIV positive patients is 34/100,000 population and mortality among HIV positive TB patients is 21/100,000 population. While there are many co-morbidities affecting people living with HIV, TB is by far, the leading single cause of death among people living with HIV and requires a singular focus beyond the broader strengthening of HIV service delivery.

A national study conducted in 2017 to determine the national prevalence of TB among PLHIV in 22 + 1 states showed that the TB prevalence among people living with HIV at last visit was 4.5% (CI: 4.3%, 4.7%). The study also showed that the mortality among people living with HIV co-infected with TB was three times higher than general population of HIV (11/1000 vs 4/1000). The proportion of HIV positives

newly enrolled in care on preventive treatment increased from 29% in 2016 to 39% in 2017, however, this is still sub-optimal. Some of the reasons for this low TB prevention therapy (TPT) coverage include few sites providing TPT, limited capacity for implementation (few people have been trained), reluctance of health care workers to implement TPT, logistic challenges such as occasional stock outs at health facilities.

The bottlenecks militating against effective TB/HIV programme in Nigeria are limited access to TB diagnostic services resulting in sub-optimal TB screening and case detection among people living with HIV, low uptake of TPT among people living with HIV, poor implementation of appropriate TB infection control measures in health facilities, incomplete referral of TB cases from points of diagnosis in HIV clinics due to most DOTS services not being co-located with HIV clinics, and poor collaboration between the TB & HIV programme at the sub-national units.

3.4.1 Strategic interventions

- Implement and monitor intensified case finding (ICF) cascade in all HIV service delivery centers, including the use of escort services (TB/HIV Referral Coordinators/Volunteers) to ensure complete referral, where necessary, for GeneXpert MTB/RIF diagnosis and linkages to treatment for all dually infected people living with HIV. The revised National TB Programme TB/HIV guideline has recommended chest x-ray along with symptomatic TB screening for all newly enrolled people living with HIV in care and treatment.
- The Intensified HIV case finding strategy will ensure that all TB patients, including those with presumptive TB, are tested for HIV and subsequently providing universal ART coverage (100%) for HIV-infected TB patients as part of an integrated model of care and optimization of linkage and retention in care. Special populations such as pediatrics, prisoners, miners, migrants, and pregnant women or women at antenatal clinics should be targeted with TB/HIV services.
- Routine household contact tracing (to identify presumptive TB patients) and index HIV testing should be conducted for all TB patients found to be HIV positive. Active case finding is crucial because delays in diagnosing TB disease and initiating TB treatment prevents people living with HIV on ART from attaining viral suppression (impediment to third 90), can increase non-adherence to ART, and can thereby contribute to morbidity, mortality and both HIV and TB transmission.
- Strengthening TB/HIV diagnostic integration within the country's national tiered laboratory network will be essential to ensure patient access to appropriate testing services. Support should be provided for sample referrals using the established National Integrated Sample Referral Network (NISRN). With a strengthened laboratory systems capacity, it will be important to leverage GeneXpert capacities to improve early infant diagnosis of HIV among HIV exposed babies.
- Programming for TB preventive treatment (TPT) should be prioritised. The national guideline recommends that all people living with HIV without active TB should be placed on TPT[12].

3.5 Toward a Location-Population Strategy

Triangulating the NAIIS data and key population estimate data at state, and eventually local government area levels, will provide critical insights enabling more precise and granular programming choices based on the specific characteristics of the location and population. At state level, we can already provide new programmatic guidance on priority interventions.

3.5.1 High Prevalence States

S/N	States	Prevalence %	Burden
1	Akwa-Ibom	5.6	200,051
2	Benue	4.9	188,482
3	Rivers	3.8	196,225
4	Taraba	2.7	52,856
5	Anambra	2.4	87,312
6	Enugu	2.1	66,768
7	Abia	2.1	51,261

Table 1: High HIV prevalence states (15-49 years)- spectrum estimates using NAIIS data.

The high prevalence states (Abia, Taraba, Benue, Enugu, Anambra, Akwa Ibom and Rivers- table 1) are among the most affected populations in the country - they need to prioritise proven targeted interventions and resources. There is a great need for increased state political and domestic investment in the response coupled with a strong partnership between the federal government and state governments, civil society, international donors and the research community.

The seven high prevalence states form a corridor from the Cameroon-Nigeria border to the Gulf of Guinea. A deep focus on the drivers of transmission in this corridor, based on an in-depth understanding of the presence, mobility and migration patterns of key and vulnerable populations, cultural nuances and interactions within the local population, is essential to addressing the high prevalence. Lessons learned from the regional HIV/AIDS project along Lagos-Abidjan Corridor are useful in developing HIV programming along other trans-African highway routes in the South-East and South-South geopolitical zones as well as Lagos and Ogun states.

Recommended Strategies for High Prevalence States

- Community-based service delivery should be at the cutting edge of HIV service provision in these states.
- Targeting of all groups of people should be included, however general population programming should occur where prevalence is higher.
- Greater integration of services for HIV and sexual and reproductive health and rights, including for young people, is important for reducing HIV and other health risks.
- Attention needs to be given to key populations with higher HIV prevalence than the general population, particularly in terms of prevention programming.
- Increasing uptake of HIV testing and treatment services, with special focus on reaching men is central. Self-testing and assisted partner notification remains important but an under-utilised method to increase HIV diagnoses among men.
- State-wide drive to eliminate mother-to-child transmission of HIV, including greater availability of point-of-care early infant diagnostics to further expand coverage of early infant testing.
- Advocacy for maintaining high level of resource commitment while significantly increasing both the effectiveness and efficiency of programmes.

3.5.2 Medium Prevalence States

S/N	States	Prevalence	Burden
1	Delta	1.9	83,300
2	Nasarawa	1.9	31,756
3	Edo	1.8	48,824
4	Bayelsa	1.8	31,830
5	CrossRiver	1.7	48,473
6	Imo	1.6	57,553
7	Plateau	1.5	39,594
8	FCT	1.5	38,293
9	Lagos	1.3	113,523
10	Borno	1.3	57,632
11	Adamawa	1.3	42,376
12	Ogun	1.2	50,798
13	Gombe	1.2	25,464

Table 2: Medium HIV prevalence states (15-49 years)- spectrum estimates using NAIIS data.

This cluster of medium prevalence states- table 2, includes a sub group of North Central and North Eastern states with key population driven incidence as well as a number of states with more mixed epidemics on or near to major corridors such as Lagos to Abidjan and Cameroon-Nigeria border to the Gulf of Guinea. Both new HIV infections and the burden of HIV remain high in a number of these states. The slow decline in new infections emphasizes the need for expanded combination prevention programmes.

Recommended Strategies for Medium Prevalence States

- Need for greater expansion of combination HIV prevention efforts;
- Tailored combination prevention packages for adolescent girls, young women and key populations are a priority.
- Community antiretroviral distribution points in higher burden states should be supported to avoid long waiting times and discrimination at clinics, as well as recurrent out-of-pocket expenses.
- HIV testing services should be targeted at high risk groups and patient's sexual partners for increased yield of positive persons.
- Greater integration of HIV and related health services in humanitarian responses.
- Careful programming attention should be given to mobile and cash-rich workers (fishermen, truck drivers, female sex workers).

3.5.3 Low Prevalence States

S/N	States	Prevalence	Burden
1	Kaduna	1.0	55,266
2	Kogi	1.0	43,373
3	Kwara	1.0	24,849
4	Ondo	0.9	27,789
5	Osun	0.9	32,197
6	Oyo	0.9	52,388
7	Ebonyi	0.8	16,479
8	Niger	0.7	29,463
9	Ekiti	0.7	16,756
10	Kebbi	0.6	20,476
11	Kano	0.5	55,910
12	Zamfara	0.5	18,509
13	Yobe	0.4	13,005
14	Bauchi	0.4	23,997
15	Sokoto	0.4	12,844
16	Jigawa	0.3	12,804
17	Katsina	0.3	26,597

Table 3: Low HIV prevalence states (15-49 years)- spectrum estimates using NAIIS data.

The low prevalence states are shown in table 3. In these states, new infections are primarily from key populations, especially female sex workers and their partners in the general population, with over a third of new infections in these states. Key strategies to be employed in this region should include adoption of PrEP as part of HIV prevention and enactment of policies for the inclusion of PrEP as part of comprehensive package of services for key populations.[16]

Recommended Strategies for Low Prevalence States

- Prevention programmes targeting key populations with higher HIV prevalence than the general population.
- Greater integration of HIV and related health services in humanitarian responses.
- More engagement with young people, communities of key populations and people living with HIV.
- Harm reduction services are essential in this region.
- Pre-exposure prophylaxis (PrEP) potentially vital prevention tool among key populations and their sexual partners.
- Allocate larger shares of HIV budgets to prevention programmes, especially for key populations.
- Increasing PMTCT coverage is essential.
- Engagement of private healthcare providers on treatment and anti-retroviral therapy.

4.0 CRITICAL ENABLERS

4.1 Enabling Full Engagement

As stated previously, the success of our strategies for preventing new infections and reducing premature morbidity and mortality will be conditioned by our ability to enable the full engagement of all who are concerned, whether infected or vulnerable. Every barrier to full engagement, including stigma, discrimination, disempowerment and social exclusion must be overcome. This is a major risk to programmes and will need greater attention to foster an enabling environment through implementation of policies and legislation that addresses stigma and discrimination in all settings.

The development of policies, up-to-date protocols, and guidelines to support provision of youth, adolescent, and key population-friendly HIV prevention services and one-stop services is urgently needed. Advocacy for the modification of relevant laws, such as reducing the age of consent for HIV testing, enforcement of supportive legal provisions such as the HIV and AIDS Anti-discrimination Act, and support for the integration and building of linkages needed by key and vulnerable populations will all be essential.

4.2 Gender and Human Rights

The respect for the rights of all citizens in Nigeria is fundamental to ensuring equitable access to HIV prevention, treatment, care and support programmes. Equitable access to HIV programmes can also be enhanced through the recognition of gender differences that may serve as barriers to access of programmes and commodities or hamper effective programming across the continuum of HIV prevention, testing, treatment, and care and support. The Framework recognizes the relative powerlessness and unequal socioeconomic status of women compared to men; the risk that gender-based violence poses to the ability of women to negotiate safer sex, prevent HIV or mitigate the impact of AIDS; and acknowledges that differences in sexual orientation and sexual practices should not limit access of anyone to HIV programmes. It recognizes the negative impact of inadequate attention to rights and gender issues on access to HIV prevention, treatment, care and support services; and how this worsens the impact of HIV on specific population groups, especially adolescents and young women. The Framework acknowledges that the lower rate of retention in care among males living with HIV is a pertinent gender-related issue and responding to the impact on gender dynamics on the HIV response implies that barriers to access of HIV programmes by males, females and trans- genders need to be recognized and addressed.

The Framework was therefore developed with a focus on respecting the rights of all persons regardless of age, gender, socio-economic status and sexual orientation. It also recognizes stigma and discrimination as human rights violations that pose significant challenge to effective HIV response, and thus commits to addressing stigma and discrimination against all people living with, presumed to be living with, at risk of, and affected by HIV, as a critical element in the national response. It aligns its programmes with the Guidelines for Gender Mainstreaming in the National HIV/AIDS Response and Training Manual for Capacity Building for Gender Mainstreaming in the national HIV/AIDS Response. The Framework also upholds that HIV and AIDS response "can be fast-tracked by protecting and promoting access to appropriate, high-quality, evidence-based HIV information, education and services without stigma and discrimination and with full respect for rights to privacy, confidentiality and informed consent." This Framework therefore provides for gender-sensitive and gender-responsive programming which improves access of people living with HIV, vulnerable children, and people affected by AIDS to comprehensive, rights-based care; it fosters an enabling environment for people living with HIV, people affected by AIDS, and vulnerable and key populations to access HIV services, while strengthening interventions targeted at reducing stigma and discrimination against

people living with HIV, vulnerable and key populations. The Framework also promotes advocacy for strengthening implementation of the HIV and AIDS Anti-discrimination Act; and, promotes access of all persons including people living with HIV, vulnerable and key populations to justice through use of community-based and institutionalised mechanisms.

4.3 Policy Advocacy

Policy advocacy is critical for the success of efforts promoting national ownership and sustainability of the HIV response in Nigeria, as it aims, among others, to secure the support of stakeholders and mobilise resources for the HIV and AIDS responses. This Framework recognizes advocacy for policy formulation and review as keys to creating the required enabling environment for effective HIV response. It also recognizes that the enactment of appropriate and supportive laws and development or revision of guidelines that will facilitate improved access of key, vulnerable and general populations to comprehensive and high- quality HIV prevention intervention, testing services, treatment, care, and support is required. Advocacy is also critical to the effective and continued engagement of relevant local, State, zonal and national stakeholders, including the leadership of people living with HIV communities and networks of key and vulnerable populations.

At the political level, policy advocacy is critical to ensuring Nigeria's fulfillment of her regional and international obligations, including obligations to the Abuja 2001 and Abuja +12 declarations for increased funding of the health system, and the obligation to the 2016 political declaration on HIV/AIDS to "Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030." Thus, this Framework recognizes the need for review of laws and advocacy for policy formulations and revisions for all the thematic areas of the national HIV and AIDS response; affirms the need for development of an advocacy strategy that would increase public and private, local government, state and national government investment in HIV management; including the need to invest in research that promotes development of and access to HIV prevention tools, and HIV treatment, care and support services. Ensuring increased and sustained local investment is a critical element of the 2017-2021 response.

4.4 Strengthening Health Systems

The delivery of critical HIV interventions that will impact on HIV risk, transmission, morbidity, and mortality is dependent on the effective performance of the health system. Access to services need to be expanded by scaling-up service delivery points and improving service delivery strategies in order to achieve the 90-90-90 target and the goal of ending the AIDS epidemics by 2030. Thus, the operationalization of this Framework is dependent on instituting strategies that strengthen the health system. This enabler is essential for the successful implementation of the five basic programme or thematic areas of the HIV response. The relevant areas that need to be taken to strengthen the health system are: Leadership and Governance; Human Resource for Health; Health Financing; Service Delivery; Medical products, Vaccines and Technologies and Health Information System.

4.5 Community Systems Strengthening

Community involvement and participation are well-recognised approaches in public health for improving programme effort and outcomes. The community system is key in expanding access to HIV, improving programming in HIV, and ensuring greater accountability of results. Community systems have been defined as "community-led structures and mechanisms used by communities through which community members and community-based organisations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities". Community systems strengthening (CSS) is "an approach that promotes the development of informed, capable and coordinated communities, and

community-based organisations, groups and structures." CSS programmes would need to address six core component areas namely: Enabling environments and advocacy; Community networks, linkages, partnerships and coordination; Resources and capacity building; Community activities and service delivery; Organisational and leadership strengthening; and, Monitoring and evaluation and planning.

This Framework embraces strengthening community systems as a critical enabler for achieving the 90-90-90 target by 2020, and incorporates relevant strategic interventions in each of its thematic areas, including:

- Enabling environments and advocacy: The strategic interventions include community engagement and advocacy for improving the policy, legal and governance environments, relating to every area of HIV prevention, treatment and care. This includes advocacy for more rigorous implementation of the HIV and AIDS Anti-discrimination Act, advocacy for review of laws creating barriers to access of HIV programmes, and advocacy for increased political support; and investment in and ownership by national, state and private organisations of the HIV response.
- Community networks, linkages, partnerships and coordination: Building linkages and partnerships between people living with HIV networks, key populations, community-based organisations, and other community actors, and strengthening the coordination mechanisms for optimal impact.
- Resources and capacity building: Building the knowledge and capacity of community actors, service providers, and community-based organisations, and supporting them technically to function effectively in HIV prevention, treatment, and care services.
- Community activities and service delivery: Expanding access to HIV prevention, treatment, and care services at community level using relevant and context-specific formal and informal community structures including people living with HIV networks, mentor mothers and traditional birth attendants; strengthening adherence counselling and support systems at community levels; and, strengthening the quality assurance mechanisms for home-based care and support services.
- Organisational and leadership strengthening: Strengthening formal structures such as the ward development committees, LACA, and networks for improved leadership role and performance in the HIV response and strengthening accountability within the community systems.
- Monitoring, evaluation, research and planning: Generating local data to monitor and drive quality assurance of community-based services, ensuring effective participation of community actors in the monitoring and evaluation of the HIV response, and conducting research to generate evidence needed for efficient and cost-effective programming.

5.0

COORDINATING THE HIV AND AIDS RESPONSE

5.1 National HIV Response System and Structure

In line with her three-tier federal structure, Nigeria's national response involves key actors at the federal, state, and the LGA level. The national response in Nigeria is coordinated through a system involving state and non-state actors. In line with the Principle of "Three Ones", NACA is the national coordinating entity, and leads the coordination at national level. The state level has the State Agency for the Control of AIDS as the coordinating body, while the Local Agency for the Control of AIDS is the coordinating body at LGA level. At every level of governance, the HIV response is multi-sectoral, with each state agency engaged in the response in its sector in line with its specified mandate. In this regard, the Federal Ministry of Health (FMoH) – through her National AIDS and STI Control Programme (NASCP) – is responsible for coordinating the health sector component of the response, while other line ministries are responsible for coordinating other inter-related sectoral responses. In all, thirty-one Federal ministries, departments and agencies are implementing HIV/AIDS activities that are in line with their mandates. NACA interfaces principally with five domains in its coordination responsibilities: CSO, private sector, and public sector, development partners, and SACAs/LACAs. (See figure 6).

At the national level, Technical Working Groups have been established to plan and provide technical advice on thematic areas within the national response. Civil society coordination arrangements are established in the form of Constituency Coordinating Entities (CCEs), including the Civil Society Coalition, Faith Based Organisations and Network of People Living HIV/AIDS in Nigeria (NEPWHAN). The private/for-profit business sector is organised as the Nigeria Business Coalition against AIDS (NIBUCCA). The CCEs are responsible for reporting on activities of their constituency to NACA.

The national response is accountable to the National AIDS Council that meets annually with all SACAs, Sectors, and CCEs in line with the stipulations of the 2007 Act that established NACA. There is also the HIV/AIDS Committee in the National Assembly and the AIDS, Tuberculosis and Malaria Committee of the House of Representatives. These bodies all play roles as coordination and accountability structures for the national response.

5.2 Mandates of NACA

The specific mandates of NACA as stipulated by the 2007 NACA Act are to:

- Coordinate and plan identified multi-sectoral HIV & AIDS activities of the National response;
- Facilitate the engagement of all tiers of government on issues of HIV & AIDS;
- Advocate for the mainstreaming of HIV & AIDS interventions into all sectors of the society;
- Develop and periodically update the Strategic Framework of the National Response Programme;
- Provide leadership in the formulation of policies and sector-specific guidelines on HIV and AIDS;
- Establish mechanisms to support HIV and AIDS research in the country;
- Mobilise resources (local and foreign) and coordinate its equitable application for HIV and AIDS activities;
- Develop its own capacity and facilitate the development of other stakeholders' capacity;
- Provide linkages with the global community on HIV and AIDS; and
- Monitor and evaluate all HIV and AIDS activities.

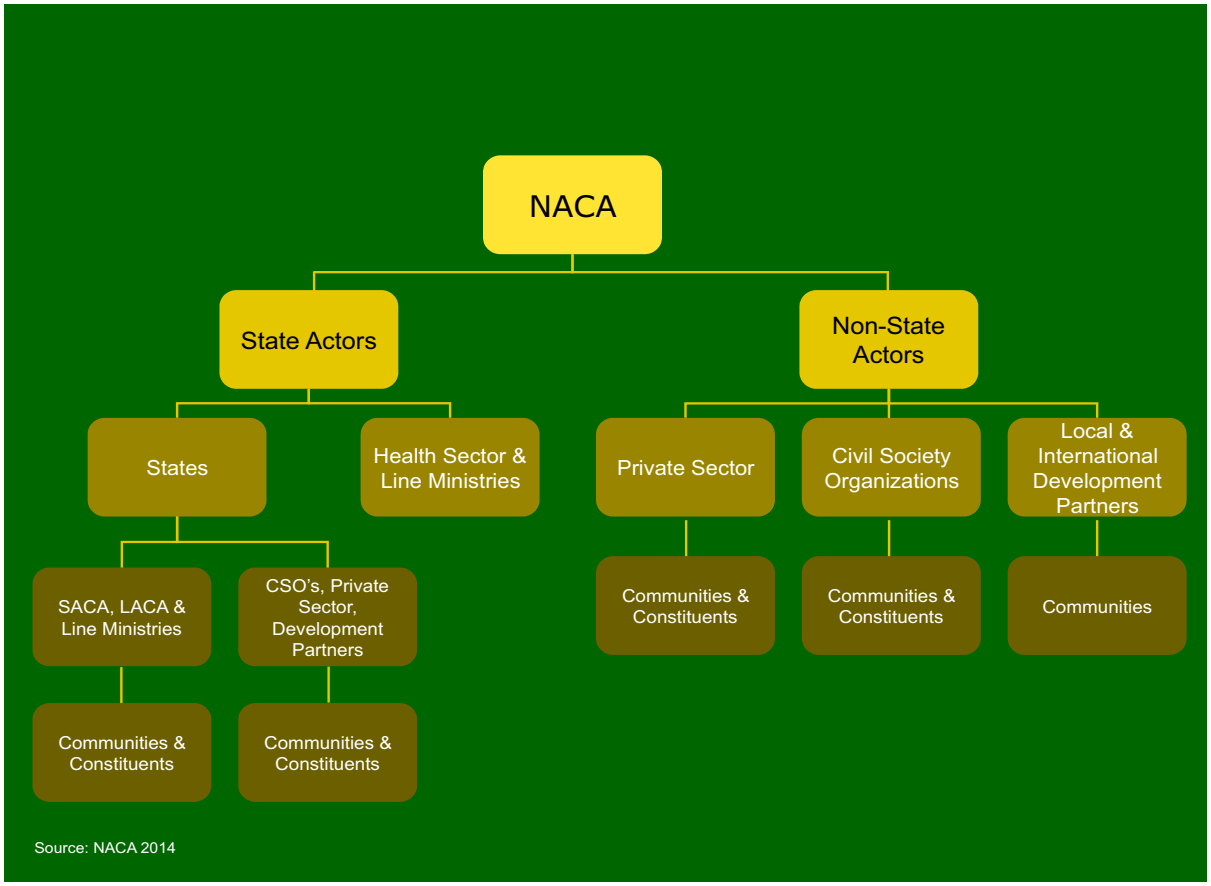


Figure 6: Coordinating structures of the national HIV/AIDS response (NACA, 2014).

5.3 Monitoring and Evaluation

Rationale

A functional and effective monitoring and evaluation (M&E) system serves to provide the data needed to guide the planning, coordination, and implementation of the HIV response; assess the effectiveness of the HIV response; and identify areas for programme improvement. It also enables enhanced accountability to those infected or affected by HIV/AIDS, as well as the funders. However, the effectiveness of the M&E system is itself dependent on the seamless and systemic integration of the components of its organizing framework.

The implementation of the Nigeria National Response Information Management System (NNRIMS) Operational Plan (2011-2016) has resulted in improved functionality of the national HIV M&E system. However, human capacity gaps remain for ensuring the generation and use of quality M&E data for decision-making. Weak coordination mechanisms and systems at the sub national level limits routine data collection and obtaining quality data at all levels and from all sectors, including private sector and civil society. Insufficient financial resources for monitoring and evaluation activities at all levels has also been identified as a gap. Similarly, the infrastructure to underpin the national and sub-national M&E databases, routine HIV programme monitoring, programme evaluation, and research are still weak. Furthermore, the national response still contends with a proliferation of M&E sub-systems which are mostly donor-driven and not responsive to NNRIMS. The low participation of the private sector, especially the private-for-profit players, in the submission of information using National Health Information system including the National HIV/AIDS data collection tools is another critical issue as a huge chunk of information is lost from the services rendered by this group. These as well as the other findings of a response analysis have informed the

development of the strategic objectives and interventions below.

Goal

The goal of the thematic focus is to strengthen and embed a sustainable systems-based approach to delivering a cost-effective, multidimensional and gender sensitive monitoring and evaluation system which supports the continuous improvement of the national response.

Strategic Objectives

1. To improve the coordination, and cost-effectiveness of data collection, analysis and use of programme data and information to inform programme planning and decision-making by HIV/AIDS Stakeholders at all levels of the response
2. To improve the HIV surveillance, evaluation, research and learning agenda, and use the information to continuously enhance national response.

Strategic Interventions

1. Implement the NNRIMS Operational Plan (NOP).
2. Implement the research agenda.
3. Scale-up the Electronic Medical Records (EMR), national data repository and streamlined process for data collection at state level.
4. Review and strengthen national reporting schedule with continuous mapping of HIV and TB service delivery points for health promotion purposes and program M&E.

5.4 Post-NAIIS Adjustments

Impact level results from the 2018 NAIIS shows that the HIV response under the leadership of NACA has made significant progress in controlling the epidemic. This achievement has been largely due to the effective coordination of available resources and programmes of development partners and response at state level being coordinated by SACA in the 36 states plus FCT. The NAIIS results have provided an opportunity for NACA to reexamine its operational and coordination strategies and improve coordination of the response as the country makes determined effort towards ending AIDS in Nigeria by 2030.

Taking HIV to the next level of ending AIDS in Nigeria by 2030 requires a review and strengthening of coordination roles of NACA at national level and SACA at the state level respectively. It is also important to review and strengthen the existing coordination mechanisms to make them more result oriented.

The following are some key policy directives to improve HIV coordination in Nigeria.

- Finalize, disseminate and utilize the results of the NAIIS and other ongoing and planned studies to inform strategic and operational planning at national and state level respectively;
- Develop a harmonised Nigeria AIDS country operational plan starting from 2020 to guide joint annual performance review of the response. This will also help foster accountability, transparency and measure progress towards national and global targets;
- Develop a medium and long term NACA strategic plan that will help NACA and SACAs to redefine and refocus their coordination scope and roles;
- Develop a robust resource mobilization plan including the HIV Trust Fund to ensure adequate and sustained resources to fund HIV programmes and plans;
- Strengthen surveillance and monitoring of the epidemic to prevent surreptitious resurgence of the epidemic in any geographic location and social population in the country; and
- Strengthen engagement and collaboration with global and national partners towards ending AIDS in Nigeria by 2030.

6.0 FINANCING THE HIV RESPONSE

6.1. Increasing Financing from Domestic Sources

Over the last two years, our government has increased federal budget allocations for the HIV response, following the commitment of the President of the Federal Republic of Nigeria to maintain 60,000 people living with HIV currently on treatment and to place an additional 50,000 persons on treatment annually using our own resources. Our increased commitment is evidenced by the ₦4 billion (approximately US$11 million) allocated in the 2018 appropriations budget bill and the establishment of the national treatment and PMTCT programme (NTPP).

This programme marks an important milestone in ensuring sustainable and coordinated national leadership and ownership of the HIV response. Additionally, in June 2017, the National Economic Council (NEC) of Nigeria approved the resolution of the 59th National Council of Health for at least 0.5 to 1% of the monthly Federation allocation to states be earmarked for financing the implementation of the HIV/AIDS sustainability roadmaps at sub-national/state levels. The Council further recommended free antenatal services universally in all states and the abolishment of user fees associated with accessing PMTCT services. The inclusion of HIV testing and treatment as an indicator in state health insurance schemes was also recommended.

In October 2014, the National Health Act (NHAct) was signed into law in Nigeria, also establishing the Basic Health Care Provision Fund (BHCPF) as part of our commitment to developing Universal Health Coverage for all Nigerians. The main source of financing of the BHCPF is from a Federal Government annual grant of at least 1% of the Consolidated Revenue fund. The BHCPF will cover a Basic Minimum Package of Health Services (BMPHS) in eligible primary and secondary health care facilities through the National Health Insurance Scheme (NHIS). The Basic Minimum Package of Health Services for Nigeria consists of nine interventions, including four Maternal Health interventions for pregnant women. There is ongoing advocacy for the inclusion of EID and pediatric treatment into the Basic Minimum Package of Health Services, as a part of the post-natal mother and baby care interventions.

The Government of Nigeria is currently working with the Nigeria Business Coalition Against AIDS (NiBUCAA) to establish an HIV/AIDS trust fund. The trust fund is intended as a private sector contribution to fill current and future HIV programmatic funding gaps with an emphasis in closing the commodities gap. It is envisaged that this will result in significantly increasing private sector HIV investment, with a goal of contributing at least 10% to overall domestic funding. This initiative, which is purely managed by the private sector, will initially focus on contributing to the elimination of mother to child transmission of HIV, scaling up pediatric HIV treatment and contribute HIV commodities to the national pool.

6.2 Sustained Support to the Response from Donors

International resources for treatment account for roughly 95% of the national HIV response, with PEPFAR and the Global Fund the leading contributors with an annual investment of $300-500 million annually since 2004. Nigeria is the largest recipient of Global Fund resources due to its large disease burden for the three diseases (HIV, TB and Malaria) with investment of over $2.5 billion since 2002. Similarly, the US government has invested over $4.7 billion in Nigeria through the Country Operational Plans. Financing the HIV response in Nigeria cannot be successful without the continued support of international partners. The Government of Nigeria will continue to rely on the support of our partners in a framework of shared responsibility and global solidarity to maintain the trajectory towards achieving the 2020 and 2030 targets.

6.3 Taking HIV out of Isolation

Integrating HIV services into existing government health programmatic and financing strategies is important in taking HIV out of isolation and ensuring efficiency gains in public health programmes. Health delivery platforms will be strengthened for greater integration of services within a resilient and sustainable health system. The HIV, TB and MNCH programmes must collaborate better in joint planning, implementation, monitoring and evaluation. These strategic approaches will potentially improve access and quality of service delivery and ultimately reduce morbidity and mortality associated with HIV related-diseases.

6.4 Local production of HIV Commodities for the West African Region

Provide an enabling policy environment for local production of antiretroviral drugs. Since HIV is now a chronic but manageable disease requiring life-long treatment, addressing the financing needs for treatment in a sustainable manner will be critical. It is worthy of note that with more than 1,000,000 patients on HIV treatment in Nigeria, almost all antiretroviral drugs are sourced externally, and treatment cost currently account for not less than 60% of the funding requirements. It is therefore important for the Government of Nigeria to lay the necessary policy, fiscal and regulatory environment for cost-competitive local production of antiretroviral drugs meeting WHO prequalification requirements. This can eventually be a significant game changer for Nigeria and the entire West and Central Africa region but it must be envisaged as a large scale industrial development initiative that will take time and sustained efforts. Simple packaging and local formulation are unlikely to bring competitiveness vis-a-vis integrated volume suppliers producing their own active ingredients. Additionally, Government through NAFDAC and the Federal Ministry of Health will facilitate the setting up of a bioequivalence studies laboratory to ensure that the quality of all essential medicines produced locally in Nigeria will be quality assured for its desired pharmacological efficacy.

6.5 Strengthening interregional collaboration with border countries and related funding mechanisms i.e., Lagos-Abidjan corridor project

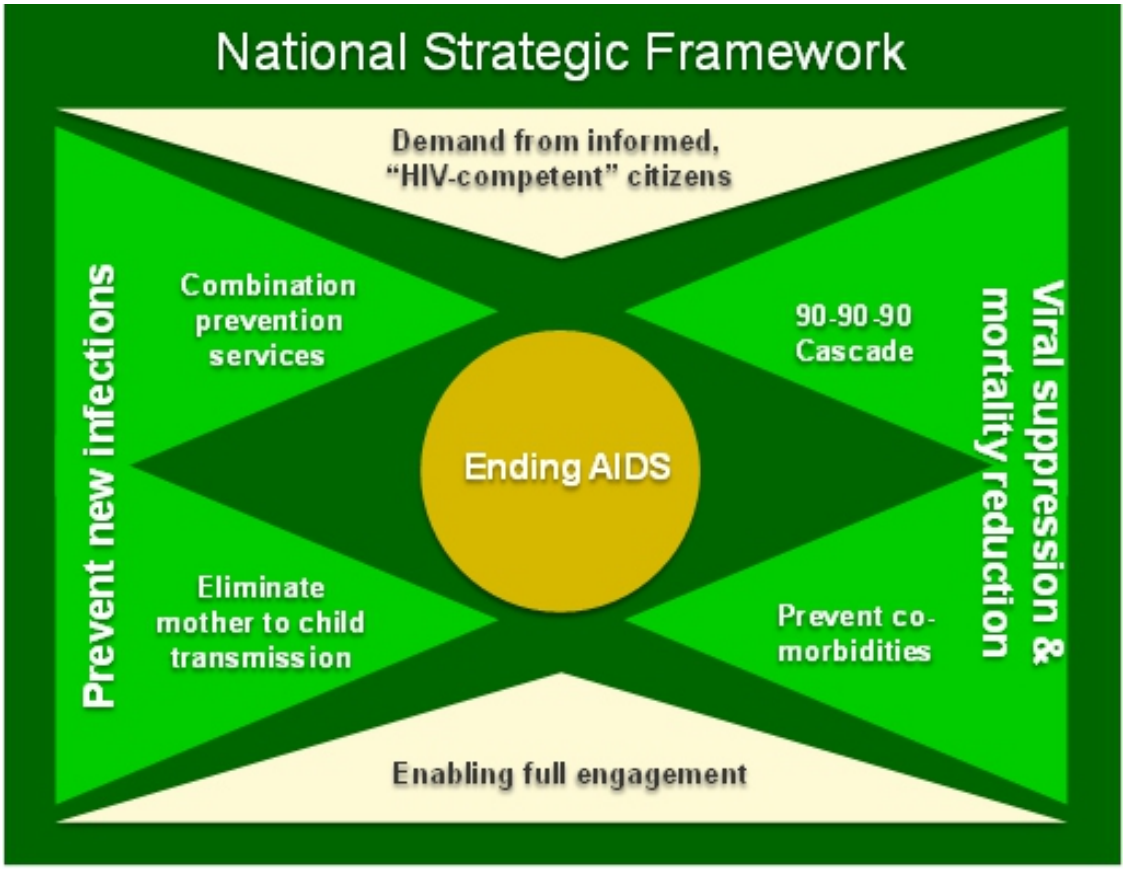
The importance of regional collaboration on HIV programmes has reached unprecedented levels. This has arisen as a result of the recently adopted UN migration compact that enforces free migration as a human right, as well as other ECOWAS and African Union Policies that are geared towards ensuring free-flow of Africans between member Countries. The impact of migration as a driver of the spread of HIV has led to the development and deployment of initiatives to which Nigeria is a party. Such initiatives include the West African Health Organisation (WAHO) Initiative, and the Lagos-Abidjan Corridor Project to mention a few. The latter in particular, is aimed at increasing access along the Abidjan-Lagos transport corridor, to HIV/AIDS prevention, basic treatment, care and support services by underserved vulnerable groups. Particular attention is given to the transport sector workers, the migrant population, commercial sex workers and the local populations living along the corridor, especially at the border towns. This project is an essential component of NACA's operational plan and shows the Agency's drive to strengthen regional collaboration.

With the increasing ease of migration in the region, regional collaboration is of crucial importance, with the attendant need to ensure uniformity in development and deployment of inter-regional funding mechanisms such as the Abidjan-Lagos Corridor Project which addresses the needs of key populations in the region. Nigeria will continue to take part in such regional public health initiatives to strengthen regional cooperation and collaboration and will seek the establishment of similar projects along its transport/transmission corridors.

7.0
ENDING AIDS IN NIGERIA: A REALITY IN SIGHT

Results from the NAIIS are encouraging – we are well up the curve in terms of scaling-up treatment and viral suppression, with challenges still ahead, particularly in enabling all people living with HIV to know their status. That said, we can now truly see ending AIDS in Nigeria as achievable by 2030. It will require mobilization of adequate and sustained resources, reaching both people at risk and people living with HIV with information and services. This in turn will require continued investment in strengthening our health system, to the benefit of all.

The foregoing discussion resulted in a revised strategic framework, which is summarised in figure 7 below:



This revised strategic framework is a work-in-process. It will be supplemented with the full and rich insights of the NAIIS, key population size estimates, prison study and forthcoming Integrated Biological and Behavioral Surveillance Survey as they become available. When coupled with further detailed work to be done on targets, budgets, and accountabilities, it will become a National Strategic Plan that will guide implementation of well-proven and efficient strategies. Linked to strong operating plans at the state level, it will serve as a new and strengthened instrument that will drive collective work towards reaching the common goal of ending AIDS in Nigeria.

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ANNEX I: Risks and Assumptions

Increased donor fatigue and fund withdrawal. Deepened ownership of the national HIV response by the government of Nigeria will be essential to ensuring timely HIV services, funding sustainability, credibility of the National appraisal system and the affirmation of the legitimacy of HIV data and reports. Effectively implementing the resource mobilization plan to generate increased domestic funds from public non-profit and development focus foundation for sustainability is essential.

Increased new infections due to negative behavior modification as a result of perceived low vulnerability. Promotion of behavior change and prevention of new HIV infections, updating the mapping and size estimation of key and vulnerable population, revising and implementing the minimum prevention package intervention, developing targeted and appropriate HIV prevention communication plan and promoting work place programmes to support workers of organised sectors to access HIV prevention services are key.

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Reduced political will to prosecute the fight against HIV. Strong political leadership of the National and State HIV/AIDS response, country's determined ownership of the HIV response and strong Civil Society Organisations role as government watchdog will help mitigate.

Loss of key technical expertise to other programme areas. An emerging issue (e.g., a global pandemic or geopolitical conflict) could significantly divert attention of technical expert from HIV programmes. This will require advocating for the continued need to invest in the HIV response, strengthening political commitment and accompanying resource allocations to the response. The epidemic may draw more attention towards end of HIV/AIDS by 2030.

Reduced access to HIV services. Map and increase community base care and support service sites to improve the coverage of targeted social and behavior change communication for people living with HIV, build the capacity of people living with HIV and networks for service delivery and provide resources to people living with HIV support groups and networks for home based care. This should be integrated into HIV health services into routine health services.

Integration of HIV health services into routine health services. Government to come up with legislation to integrate HIV health services into routine health services that will ensure availability of HIV services, accessibility of HIV services, and affordability of HIV services and removal of all bottlenecks around accessing HIV services.

Opportunities

- NTTP
- HIV Trust Fund
- New CSO Coalition and plans for targeted CSO mobilization projects
- Patient education and empowerment agenda
- National Data Repository and streamlining of national programme data reporting systems and processes
- Improved and streamlined coordination arrangements
- Renewed commitment to improve programme efficiency by adopting less expensive funding and programme support arrangements.
- New Patient's Rights Act

ANNEX II:
Recommended Policy Directive and Strategic Approaches

- Incorporate Nigeria AIDS Indicator & Impact Survey (NAIIS) estimates into national and sub-national levels strategic and operational planning cycles.
- Use data from NAIIS and estimates to develop a new national and state strategic plans 2020 – 2025.
- Develop a harmonised Nigeria AIDS Country Operational plan for an annual joint performance review of national response.
- Mobilise adequate and sustained resources to fund national and strategic plans
- Refine case-finding and linkage strategies to decrease inefficient case-finding and reduce LTFU (<25 y/o).
- Accelerate efforts to stem attrition at provider, patient, and facility levels.
- Scale-up viral load coverage and increase suppression rates (e.g., <19 y/o).
- Optimise partner management to improve performance and sustainability, planning to shift namely to local partners.
- Accelerate TLD transition, ensuring access for women of all ages, focusing on women of reproductive age.
- Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.
- Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.
- Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine based regimens.
- Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.
- TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.
- Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.
- Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.
- Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.
- Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.
- Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17.

ANNEX III: CCM Policy And Programmatic Direction For The HIV Response In Nigeria 2019-2020

1. HIV Prevention

a. Focus will be on key populations (FSW, MSM, PWID) as they are disproportionately impacted. PrEP and HIV self-testing will be prioritised. Harm reduction will be initiated via an operational research approach. Addressing the human rights needs of key populations will be prioritised. Health facilities will be made key populations -friendly while One-Stop-Shop approach will be strengthened.

b. Efforts will be made to follow through with the outcome of the UNODC supported Prison's study and an HIV programme for people in closed setting will be initiated.

c. HIV response in humanitarian settings will pursued to address the spread of HIV among displaced persons.

2. HIV Treatment

a. The First 90 will be aggressively pursued among populations and locations with high yields for HIV. This will include Index testing and partner notification services, HIV testing among TB patients, provider-initiated counselling and testing at the facility level and in high burden states, demand creation and HIV testing will be pursued. Early infant diagnosis will be prioritised and HIV those found to the HIV positive will be actively referred for care and treatment. Based on the NAIIS findings, other population age groups and sociodemographic characteristics necessitating focused attention will be prioritised.

b. For the Second 90, All HIV positive patients presenting at the HIV treatment sites and OSS will be prioritised for treatment and provided with adherence and psychosocial support to ensure long term retention in care. Case managers especially from the patient community will be leveraged to enhance retention and to follow up of patients who have been lost to follow up. RADET will be routinised as part of programming.

c. For the Third 90, viral load testing will be prioritised, and viral suppression rated monitored for both adults and children. Case managers will be used to sensitise patients to demand for viral load testing. Mechanisms for tracking pharmacovigilance will also be enhanced.

3. eMTCT

a. All HIV pregnant women accessing ANC services in the priority states where Global Fund is covering will be provided with HIV testing. In high burden states, community mobilization for HIV testing for pregnant women will highlighted. Case managers and mentor mothers (peers) will be used to support all HIV positive pregnant women and to ensure that HIV exposed babies will be proactively linked to EID. Genealogical/family-based HIV testing will also be prioritised.

4. Resilient Health System Strengthening

a. Support systems which will facilitate rapid scale up of the three diseases and the delivery of quality improved services.

For more information about
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