FEDERAL REPUBLIC OF NIGERIA

NATIONAL HIV AND AIDS STRATEGIC PLAN 2023 - 2027

NATIONAL AGENCY FOR THE CONTROL OF AIDS
NACA

National HIV & AIDS Strategic Plan

2023 - 2027

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FOREWORD

The development of the National HIV and AIDS Strategic Plan (NSP) 2023 -2027 in Nigeria was a top-bottom approach due to the emergence and subsequent domestication of the Global AIDS Strategy (GAS) 2021-2026 and Political Declaration (PD) 2021. Prior to this development, the State HIV and AIDS Strategic Plans (SSPs) 2021-2025 were developed using the National HIV and AIDS Strategic Framework 2021-2025. The NSP 2023-2027 development was a highly participatory and consultative process involving a wide cross-section of stakeholders. The process involved analysis of global targets, national HIV and related diseases, the framing of the national agenda and the development of critical elements for the plan. This was achieved through collaboration with relevant technical groups at the national and state levels as well as the engagement of consultants with relevant thematic expertise. More consultative processes at the national and state levels also firmed the strategic interventions required to align the national response to ending inequalities and getting on track to end AIDS by 2030.

The vision of the NSP 2023-2027 is "An AIDS-free Nigeria, with zero new infection, zero discrimination and stigma and zero AIDS-related deaths, with a broad goal to "Fast-track the national response towards ending AIDS in Nigeria by 2030". The NSP 2023-2027 is focused on three Strategic Priorities namely:

Equitable and equal access to HIV services for all,
Break down barriers to achieving HIV service outcomes,
Fully resource and sustain efficient HIV response and integrate them into systems for health, social services/protection, humanitarian and pandemic responses.

A number of cross-cutting issues and programme enablers have been identified that need to be addressed to fully implement the NSP 2023-2027. These include (i) Leadership, Country Ownership, Governance and Advocacy; (ii) Partnership, multi-sectorality and collaboration; and (iii) Data for impact, science, research and innovation.

The Federal Government of Nigeria led by NACA remains committed to our collective vision of an AIDS-free Nigeria. It is hoped that the relevant stakeholders will utilize this national document for the implementation of HIV and AIDS programmes, interventions and resource mobilization.

Dr. Gambo G. Aliyu MBBS, MS, PhD
Director General
NACA

ACKNOWLEDGMENTS

The National Agency for the Control of AIDS (NACA) appreciates all stakeholders at the local, state and federal government as well as partners, Civil Society Networks, Patient Communities and the private sectors whose enormous contribution and participation have provided abundant insight to the development of the National HIV and AIDS Strategic Plan 2023-2027.

I wish to acknowledge the visionary leadership of the NACA management team led by the Director General, Dr. Gambo Aliyu. The technical and financial support by UNAIDS in the development of this document is worthy of mention. Not forgetting the immense technical contribution of the National Steering Committee comprising representative of all stakeholders including but not limited to members of the State Agencies for the Control of AIDS (SACAs), Federal Ministry of Health and other Line Ministries, the Patient Community, the KP Secretariat, Civil Society and Faith-Based Organisations.

My appreciation goes to Donors and Implementing Partners, PEPFAR, AHF, GF-CCM, WHO, UNFPA, UNICEF, UN Women, UNDP and all other HIV and AIDS Stakeholders in Nigeria for sharing their wealth of experience and contributing to the development of this very important document.

I also want to acknowledge the resilience, commitment and dedication of NACA staff from all departments, especially the directorate of Policy, Planning and Stakeholders Coordination.

I sincerely appreciate the efforts of the team of technical consultants led by Professors Adesegun Fatusi and Morenike Ukpong.

Finally, my ultimate gratitude goes to Almighty God for giving us life, without whom this work for the good of humanity will be incomplete.

Dr. Adefunke Oki
Director Policy, Planning and Stakeholders Coordination
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ACRONYMS AND ABBREVIATIONS

AGYW	Adolescent Girls and Young Women
AHF	AIDS Healthcare Foundation
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drug
APIs	Active Pharmaceutical Ingredients
AYP	Adolescent and Young People
AYPLHIV	Adolescents and Young People Living With HIV
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
CCEs	Country Coordination Entities
CiSHAN	Civil Society for HIV and AIDS in Nigeria
COVID-19	Coronavirus Disease – 2019
CoCSHAN	Coalition of Civil Society Networks on HIV in Nigeria
CTX/INH/B6	Cotrimoxazole Therapy /Isoniazid Prevention Therapy/Vitamin B6
CSOs	Civil Society Organization
DOTS	Directly Observed Treatment, Short-course
DSD	Direct Service Delivery
ECOWAS	Economic Community of West African States
EID	Early Infant Diagnosis
ETG	Expanded Theme Group
eMTCT	Elimination of Mother to Child Transmission
FBO	Faith Based Organization
FCT	Federal Capital Territory
FLHE	Family Life and HIV Education
FSW	Female Sex Workers
GAS	Global AIDS Strategy (2021-2025)
GBV	Gender Based Violence
GDP	Gross Domestic Product
Gen-N	Generation of Negative Adolescents and Young People
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GF-CCM	Global Funds-Country Coordinating Mechanisms
GIPA	Greater Involvement of People living with AIDS
GoN	Government of Nigeria
HBV	Hepatitis B Virus
HCT	HIV Counselling and Testing
HEI	HIV Exposed Infants
HEAP	HIV Emergency Action Plan

HTS	HIV Testing Services
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HTF	HIV Trust Fund
IBBSS	Integrated Biological and Behavioural Surveillance Survey
ICF	Intensified Case Finding
ILO	International Labour Organization
IPV	Intimate Partner Violence
KP	Key Population
KPSE	Key Populations Size Estimates
LGA	Local Government Area
LTFU	Lost to Follow-up
MDAs	Ministries, Departments and Agencies
MICS	Multiple Indicator Cluster Surveys
MNCH	Maternal New-born and Child Health
MPPI	Minimum Prevention Package Intervention
MSM	Men who have Sex with Men
MTB/RIF	Mycobacterium Tuberculosis /Rifampicin
MTCT	Mother-to-Child transmission of HIV
NACA	National Agency for the Control of AIDS
NASCP	National AIDS and STI Control Programme
NASA	National AIDS Spending Assessment
NASSCO	National Social Safety Coordinating Office
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
NBM	New Business Model
NCA	National Council on AIDS
NCDs	Non-Communicable Diseases
NDHS	Nigeria Demographic and Health Survey
NDR	National Data Repository
NEC	National Economic Council
NEPWHAN	Network of People Living With HIV/AID in Nigeria
NHAct	National Health Act
NHIS	National Health Insurance Scheme
NiBUCAA	Nigeria Business Coalition Against AIDS
NISRN	National Integrated Sample Referral Network
NNRIMS	Nigeria National Response Information Management System
NSF	National HIV and AIDS Strategic Framework
NSHDP	National Strategic Health Development Plan
NSP	National HIV and AIDS Strategic Plan
NTBLCP	National Tuberculosis and Leprosy Control Programme

NTPP	National Treatment and PMTCT Programme
OHT	One Health Tool
OSGF	Office of the Secretary to the Government of the Federation
OST	Opioid Substitution Therapy
OVC	Orphans and Vulnerable Children
PABA	People Affected by HIV and AIDS
PCR	Polymerase Chain Reaction
PD	Political Declaration
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-exposure Prophylaxis
PWID	People who Inject Drugs
RNSF	Revised National HIV and AIDS Strategic Framework
RTK	Rapid Test Kit
SACA	State Agency for the Control of AIDS
SASCP	State AIDS and STI Control Programme
SBCC	Social and Behavioural Change Communication
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
SSPs	State HIV and AIDS Strategic Plans
STIs	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TG	Transgender
TLD	Tenofovir, Lamivudine and Dolutegravir
TPT	TB Preventive Treatment
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States Dollar
USG	United State Government
U=U	Undetectable=Untransmittable
VAPP	Violence Against Persons Prohibition
VL	Viral Load
WAHO	West African Health Organization
WHO	World Health Organization
WLHIV	Women Living with HIV

EXECUTIVE SUMMARY

Background

The Human Immunodeficiency Virus (HIV) remains a leading public health and development challenge in Nigeria despite the significant progress made in reducing its incidence. The COVID pandemic was a risk factor for new HIV infections. According to NAIIS, the national HIV prevalence of 1.3% translates to about 1.98 million people living with HIV (PLHIV). Adults aged 15 years and above make up about 1.8 million of PLHIV in Nigeria of which 1.1 million are adult women. This National HIV and AIDS Strategic Plan for Nigeria 2023-2027, is designed as a continuing guide to Nigeria's national response to HIV and AIDS; to propel Nigeria toward achieving the goals of the National Health Policy; and the targets of the Sustainable Development Goals (SDG) of ending the AIDS epidemic by 2030. It is the third of its kind.

HIV situation in Nigeria

The prevalence of HIV among adults in Nigeria aged 15 to 49 in 2022 was estimated at 1.3%, with a higher rate for females than males (1.75% vs. 0.95%). Nigeria's incidence-to-prevalence ratio in 2022 was 3.85, while the benchmark for epidemic control is a ratio of 3% (3 HIV infections per 100 people living with HIV per year). This suggests that Nigeria needs to considerably strengthen its HIV control effort before it can achieve "epidemic control."

In 2022, Nigeria had an estimated HIV incidence rate of 0.36 per 1,000 population for all ages. Of the estimated 77,200 new infections in 2022, children under the age of 15 accounted for 22,500 (29.1%) new infections, adult women (age 15 years and above) accounted for 35,000 (45.3%) of the new infections, and adult males (aged 15 years and above) accounted 19,000 (24.6%) new infections.

Between 2010 and 2022, there was a 39% reduction in new HIV infections. The 2020 Mode of Transmission study identified four population groups that account for about 91% of all new infections among the adult population in Nigeria. These are never-married females and never-married males, female sex workers (FSW) and men who have sex with men (MSM).

Of the estimated 1.98 million PLHIV in 2022, 1.16 million (58.7%) were adult females (aged 15 years and above), 660,000 (33.2%) were adult males (aged 15 years and above), and 160,000 (8.1%) were children aged 0-14 years. Among PLHIV, 95% know their status, 95% are on anti-retroviral therapy, and 95% have achieved viral suppression. The antiretroviral (ARV) coverage rate for adults is subject to ongoing data validation, 32% for children, and 61% for adolescents (aged 10-19 years).

At the end of 2022, the coverage of pregnant women who received ARV for the prevention of mother-to-child transmission of HIV (PMTCT) was 33%. Of the estimated 7.7 million pregnant women (spectrum 2022) only about 27% of them were reports to have been tested for HIV and received result. Also, HIV testing among pregnant women attending ANC in facilities offering PMTCT services consistently decreased from 93% in 2017 to 86% in 2021 but increased to 96% in 2022 (Health sector report 2021). Additionally, only about 12% of HIV-exposed babies had early infant diagnosis (EID) in 2022. According to the 2021 health sector report, the MTCT rate has increasing over the past years with a slight decline to 16.3% in 2021.

The antiretroviral therapy coverage amongst cohorts receiving services for Key Populations (KPs) ranged from 67.7% for people who inject drugs (PWID) to 89.4% for sex workers. Only a third (34.1%) of sex workers were using condoms, while condom use among other KPs ranged from 15.6% for PWID to 41.2% for the transgender population. Only 29.6% of PWID engage in safe injection practices.

Among the general population, the level of knowledge about HIV prevention and its transmission was below the 90% target set for men and women aged 15 - 49 years and among young people aged 15-24 years. Among young people, condom use at last sexual intercourse was 89% for males and 37.7% for females in 2021. Also, 91% of FSW used condoms at last sexual intercourse, 6% of PWID used sterile needles consistently in the last 3 months of the survey, and11% of PWID, 27% of MSM, 20% of FSW and 24% of transgender used pre-exposure prophylaxis.

The HIV expenditure in Nigeria in 2021 was estimated as $532 million, of which only $91.5 million (17.2%) was from public sources, $200,000 (0.04%) was from private sources and $441 million (82.8%) was from international sources. Thus, dependency on donor funding for the national HIV response is a major challenge. The launch of the ₦62.1 billion (150M USD at ₦460 exchange rate) HIV Trust Fund by the Federal Government signifies efforts towards the mobilization of domestic resources to reduce the dependency on donor funding.

The National HIV and AIDS Strategic Plan 2023-2027 Development Process

This National HIV and AIDS Strategic Plan 2023-2027 was developed through a participatory and consultative process involving a wide cross-section of stakeholders, including policymakers, federal and state government officials, technical experts from the academia and other sectors, representatives of the National HIV and AIDS Technical Working Groups, representatives of civil society and young people (adolescents and youth, people living with HIV, people with disabilities, key populations, faith-based groups and the interest groups), as well as bilateral and multilateral development partners. There were three broad-based consultative forums; at the national level, and for the Northern and the Southern stakeholders' clusters. The process also included a review of the trends of HIV in Nigeria, previous national response efforts and results, the existing State Strategic Plans and current developments in the global HIV and AIDS arena. The development of this NSP 2023 -2027 was particularly informed by the Global AIDS Strategy (2021-2026), and the Political Declaration on HIV/AIDS.

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The Vision, Goal, and Strategic Priorities

The vision is for an AIDS-free Nigeria with zero new infections, zero stigma and discrimination and zero AIDS-related deaths.

The goal is to strengthen the national HIV response to facilitate ending AIDS in Nigeria by 2030. This goal will be operationalised through a focus on three strategic priorities:

Strategic Priority 1: Equitable and equal access to HIV services for all. Three results areas will constitute the primary focus under this Strategic Priority: (i) HIV prevention; (ii) HIV testing, treatment, care, viral suppression, and integration; and (iii) Prevention of vertical HIV transmission and paediatric HIV. treatment.

Strategic Priority 2: Break down barriers to achieving HIV service outcomes. The four result areas have been identified to address this strategic focus: (i) Community-led response; (ii) Human Rights; (iii) Gender Equality; (iv) Young People.

Strategic Priority 3: Fully resource and sustain efficient HIV responses and integrate them into relevant systems e.g. health, education, social services and protection, humanitarian and pandemic responses. The three results areas will address this strategic priority: (i) Fully funded and efficient response; (ii) Integration of HIV into relevant systems for health, education, social services and protection; (iii) Humanitarian and pandemic situations.

Cross-cutting issues that should be addressed to fully implement this NSP include (i) leadership, Country Ownership, Governance and Advocacy; (ii) Partnership, multi-sectorality and collaboration; and (iii) Data for impact, science, research and innovation.

The goal is to strengthen the national response against HIV to facilitate the ending of AIDS in Nigeria by 2030. This goal will be operationalised through a focus on three strategic priorities:

Costing and Financial Resourcing of the NSP 2023-2027

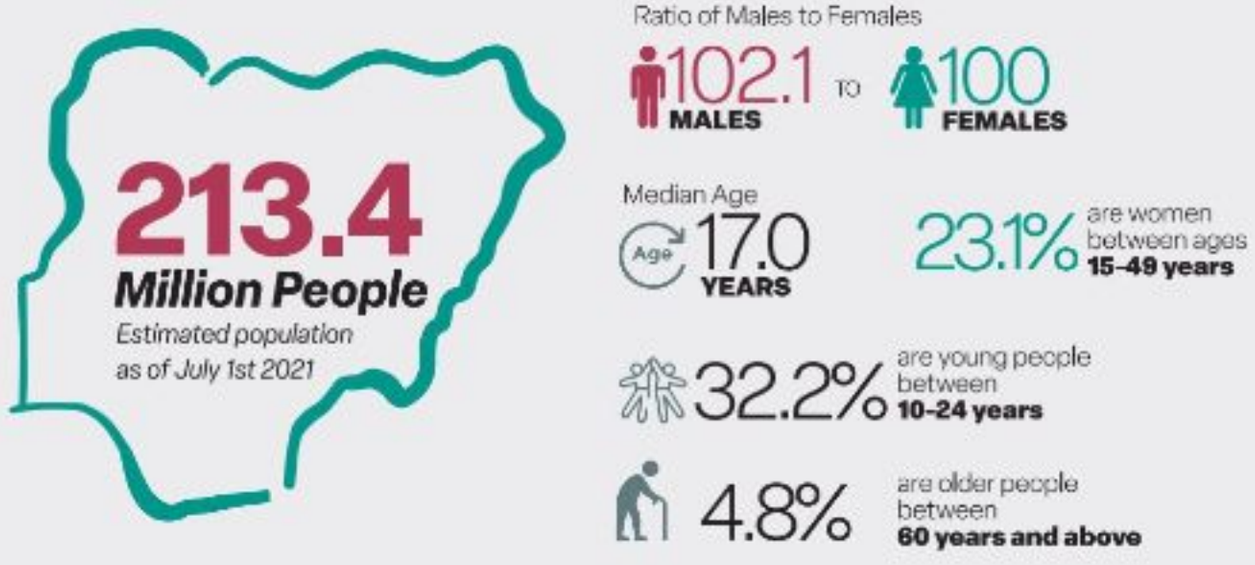
The total cost for implementing the NSP from 2023 to 2027 is estimated at the sum of ₦1.486T (One Trillion, Four Hundred and Eighty-Six billion Naira) ***approximate value*** (USD3,330.09 million), with HIV intervention cost accounting for 74% of the proposed investments for the duration of the plan. The sum of ₦250 Billion is estimated to address HIV program management activities, including policy-based prevention intervention.

A significant proportion of the funding for the NSP is expected to come from domestic resources, with greater mobilisation of funds from both the public and private sectors in line with Nigeria's "Alignment 2.0" agenda and the New Business Model (NBM). The HIV Trust Fund (HTF) also aligns with the agenda for greater mobilisation of funds from the private sector while the mainstream of the public sector financing would include Basic Health Care Provision Fund, Health Insurance Scheme, and government budgetary allocations.

1.0 BACKGROUND

1.1 Introduction

Nigeria is situated in the West African sub– region. It is divided into 36 States and the Federal Capital Territory, comprising of 774 local government areas covering six geo-political zones namely: North-East, North-West, North Central, South-East, South-West and South-South. It is an ethnically and culturally diverse country, with about 374 identifiable ethnic groups[1]. The three largest ethnic groups are Hausa/ Fulani (Northern Nigeria), the Igbo (South-East Nigeria) and the Yoruba (South-West Nigeria)[2]. Nigeria's estimated population as of 1st July 2021 was 213.4 million, with a ratio of 102.1 males to 100 females and a median age of 17.0 years[3]. About quarter (23.1%) of the Nigerian population are women of reproductive age (15– 49 years) while young people while young people aged 10– 24) constitute 32.2% and older people (60 years and above) constitute 4.8%$_3$. Children aged 0 – 14years make up 43.2% of the population while 63% of the population is aged 0– 24 years4. Nigeria's annual population growth rate for 2022– 2025 is projected at 2.5%$_5$.



Though the country has the largest economy in Africa, after the Gross Domestic Product (GDP) rebasing in 2014, it has faced significant economic challenges in recent years ranking 161 among 189 countries on the human development index in 2019 – a drop from the 158th position in 2018[6]. About 40% of the population live below the poverty line of 137,430 Naira ($381.75) in 2018 and 25% are vulnerable[7] The increasing spate of violence, banditry and insecurity has resulted in the worst humanitarian crisis in the history of Nigeria, with an estimated 8.4 million people requiring humanitarian assistance in 2022 in the worst-hit states of Borno, Adamawa, and Yobe[8] The crisis and other experiences of violence in Nigeria have significant implications for increased HIV rates because of the associated risk factors. The COVID– 19 pandemic also increased the risk of new HIV infection[12].

Nigeria had an estimated national Human Immunodeficiency Virus (HIV) prevalence of 1.3% in 2022, translating to 1.98 million people living with HIV (PLHIV)[9] and ranking the country among the four countries with the highest HIV burden globally[10]. Overall, HIV remains a leading public health and developmental challenge for Nigeria despite the significant progress made in reducing the incidence over the years[11].

Overall, HIV remains a leading public health and developmental challenge for Nigeria despite the significant progress made in reducing the incidence over the years

This National HIV and AIDS Strategic Plan (NSP) 2023-2027 is the third plan designed to guide Nigeria's response to HIV and AIDS. It is designed to propel Nigeria further towards achieving the National Health Policy[13] and the Sustainable Development Goal (SDG)[14] target of ending the epidemics of AIDS by 2030. The NSP builds on the achievements of the 2001-2004 HIV Emergency Action Plan (HEAP), the 2005-2009 National Strategic Framework (NSF), the 2010-2015 NSF & NSP, the 2017-2021 NSF & NSP and Revised NSF (RNSF) 2019-2021. The RNSF was based the availability of new data from national studies – the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS)[15], Nigeria's first national population-based survey on home-based HIV counselling and testing, Key Populations Size Estimates (KPSE) in 16 States plus the Federal Capital Territory, the National AIDS Spending Assessment 2015-2018 and the Assessment of HIV and Health services situation in prisons and Borstal institution 2019. The 2021-2025 NSF provides the foundation for the framing of the current National Strategic Plan.

1.2 National HIV and AIDS Strategic Plan Development Process

The process commenced with the development of the NSF, which was an output of a highly participatory and consultative process involving a wide cross-section of stakeholders, including policymakers, federal and state government officials, technical experts from the academia and other sectors, representatives of the National HIV and AIDS Technical Working Groups, representatives of Civil Society, young people (adolescents and youth, PLHIV, people with disabilities, key populations, faith-based groups and the interest groups), as well as bilateral and multilateral development partners. Among others, the process included a review of the trends of HIV in Nigeria, previous national response efforts and results, the existing State Strategic Plans, and current developments in the global HIV and AIDS landscape. The development of this NSP was informed by the Global AIDS Strategy (2021-2026) and the Political Declarations on HIV/AIDS. The stakeholder engagement process included three broad-based consultative meetings – national, northern and southern fora – using a hybrid (combined face-to-face and virtual) interactive formats.

2.0 HIV SITUATION AND RESPONSE IN NIGERIA

2.1 HIV Situation in Nigeria

2.1.1 HIV incidence and prevalence

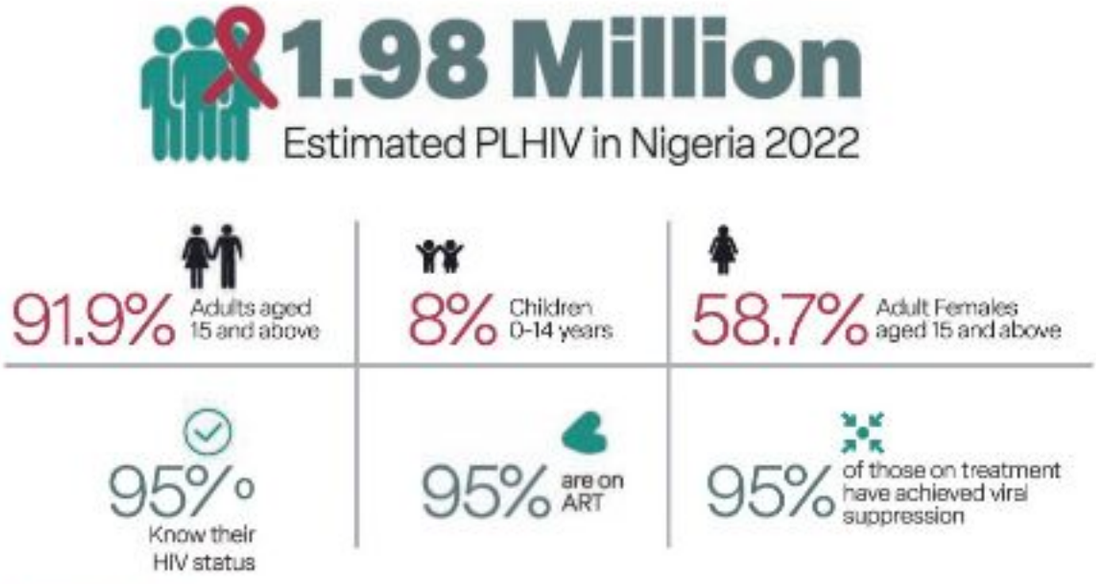
Nigeria, in 2022, had an estimated HIV incidence rate of 0.36 per 1,000 population for all ages[9]. Of the 77,200 new infections estimated in Nigeria by the end of 2022, children under the age of 15 accounted for 22,500 (29.1%) new infections, adult women (age 15 years and above) accounted for 35,000 (45.3%) new infections, and adult males (aged 15 years and above) accounted for 19,000 (24.6%) new infections[9]. Nigeria recorded a 39% reduction in new HIV infections between 2010 and 2022[9]. According to the 2020 modelling of the mode of HIV transmission in Nigeria, the largest number of new infections among the adult population occurs among never-married females and never-married males, followed by female sex workers (FSW) and men who have sex with men (MSM)[18]. These four populations account for about 91% of all new infections among the adult population.

The prevalence of HIV in Nigeria in 2022 was estimated as 1.3% among adults aged 15 to 49, the prevalence was 1.43% compared to 0.37% for young people aged 15-24 years. Among adults, females have a higher prevalence compared to males (1.75% vs. 0.95%) but gender-disaggregated data were not available for young people. Nigeria's HIV incidence-to-prevalence ratio in 2022 was 3.85, whereas the benchmark for epidemic control is a ratio of 3% (3 HIV infections per 100 people living with HIV per year[17,18]). This suggests that Nigeria needs to considerably strengthen its HIV control effort before it can achieve "epidemic control."

2.1.2 People living with HIV and coverage of treatment services

Nigeria had an estimated 1,984,000 people living with HIV (PLHIV) in 2022 of which 1,824,000 million (91.9%) were adults aged 15 years and above while 160,000 (8.0%) were children aged 0-14 years[9]. Overall, adult females (aged 15 years and above) constituted 58.7% of PLHIV in Nigeria in 2022. Among PLHIV, 95% are estimated to know their status, 95% of PLHIV are on anti-retroviral therapy, and 95% of those on treatment have achieved viral suppression by the end of 2022. The antiretroviral (ARV) coverage rate, however, differed considerably by age and slightly by sex – 100% for adults (100% for both females and males) and young people (age 19-24 years) as compared to 61% for adolescents aged 10-19 years (62% for females versus 59% for males) and 32% for children[9]. In 2022, the coverage of pregnant women who received ARV for the prevention of mother-to-child transmission of HIV (PMTCT) was 33%, while the early infant diagnosis rate at two months was 56%[9].

Among PLHIV, 95% are estimated to know their status, 95% of PLHIV are on anti-retroviral therapy, and 95% of those on treatment have achieved viral suppression by the end of 2022.



2.1.3 Key populations

Nigeria had the following estimated population for key populations (KPs) by the end of 2022 (Table 1): 337,942 MSM; 407,436 people who inject drugs (PWID); 663,085 sex workers; and 64,182 for transgender (TG) for the 20 states where figures were available[9]. According to the HIV/STI Integrated Biological and Behavioural Surveillance Survey (IBBSS) of 2020, the HIV prevalence for KPs was 10.9% for PWID, 15.5% for sex workers, and 25.0% for MSM, and 28.8% for TG[14]. Nigeria has a population of 77,519 as of June 2023 in correctional facilities[9], whereas the estimated HIV prevalence for this group was 2.8% in 2021. The HIV testing and status awareness for KPs by the end of 2022 was low, ranging from 19.1% for TG to 37.8% for MSM, while the ART coverage among KPs ranged from 67.7% for PWID to 89.4% for sex workers. Only about a third (34.1%) of sex workers regularly use condoms and condom use was also low among other KPs (15.6% for PWID to 41.2% for TG). Only 29.6% of PWID engage in safe injection practices.

Table 1: HIV Statistics for Key Populations in Nigeria, 2021

	Sex Workers	MSM	PWID	TG	Sources
Population size estimate (#)	663,085	337,942	407,436	64,182 (20 states)	Key Population Size Estimate
HIV prevalence (%)	15.5	25.0	10.9	28.8	IBBSS 2020
HIV testing and status awareness (%)	26.7	37.8	11.9	19.1	IBBSS 2020
Antiretroviral therapy coverage (%)	89.4	89.5	67.7	84.4	IBBSS 2020
Condom use (%)	34.1	33.6	15.6	41.2	IBBSS 2020
Safe injecting practices (%)	-	-	29.6	-	IBBSS 2020

The KP groups of FSW, MSM, and PWID are estimated to account for about 11% of new HIV infections, although they represent less than 2% of the total population[16]. Using the Goals model for modelling the mode of transmission, the results indicate that there has been a significant change in the proportion of new infections contributed by different population groups over time in Nigeria. (Figure 1).

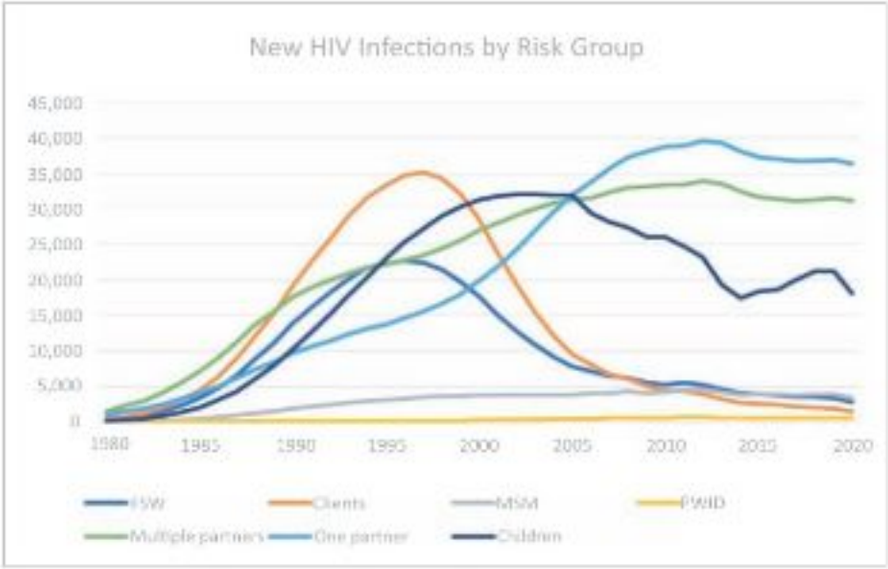


Figure 1: Trends in new infection by population groups: 1980-2020

(Source: Mode of Transmission Study, 2020)

2.1.4 AIDS-related deaths

Nigeria recorded an estimated 42,700 deaths among adults and children due to AIDS in 2022, of which 14,400 (33.7%) were children aged 0-14 years while 14,500 (34.0%) were adult females and 13,800 adult males (32.3%) aged 15 years and above.[9] The number of orphans due to AIDS aged 0 to 17 years in Nigeria was estimated to be 1.1 million in 2022.[9] Nigeria's HIV incidence-to-mortality ratio in 2022 was 1.03[9], which suggests that Nigeria's population of PLHIV is still slightly growing: when a ratio of less than one is obtained, the size of the PLHIV population shrinks – thus, an incidence-to-mortality ratio of less than 1 with the high treatment coverage is the desired goal.[17,18,19] In 2022, when the report of the estimated size of the PLHIV population is viewed in the context of the high rate of reported coverage of ARV, the results suggest that Nigeria is achieving a steady decline in the number of PLHIV and may achieve the desired benchmark of a ratio of less than 1 within the period of this NSP with more intensive and deliberate actions to implement the national response.

2.1.5 Factors Influencing HIV Trends in Nigeria

There are multiple factors associated with HIV transmission at individual/interpersonal, household, community, and macroeconomic levels. At the individual level, both biological and behavioural factors influence the risk of HIV transmission.

(i). Biological factors: play a major role in the higher risk of HIV transmission among females compared to males, and among younger women compared to older women. These biological factors include the large surface area of mucous membranes, the delicate tissue of the female genital tract may record small and often unnoticeable tears and abrasions during sex, and sexually transmitted infections in both males and females.

(ii). Behavioural risk factors: A key behavioural factor for HIV transmission is high-risk sexual behaviour such as unprotected sex and having multiple sex partners. As the 2018 NDHS[2] showed, only 36% of women and 64% of men of reproductive age (aged 15-49 years) who had sex with a non-marital or non-cohabiting partner used condoms at the last sexual intercourse 12 month before the survey. Of the men that pay for sex within the last 12 months of the survey, 74% used condoms at their last paid sexual intercourse. Also, only 27% of

females and 19% of males aged 5-24 years who had engaged in premarital sexual intercourse reported the use of condoms. Among young people with multiple sexual partners, only 36% of the females and 56% of the males used a condom during their last sexual intercourse[2].

A low level of reproductive health literacy also contributes to high-risk behaviour. The 2018 NDHS reported that only 46% of women and 45% of men of reproductive age (aged 15-49 years) had comprehensive knowledge of HIV (knowing that HIV can be prevented by the consistent use of condoms during sexual intercourse, and a healthy-looking person can have HIV as well as correctly identifying two common myths about HIV transmission)[2]. Also, a third of men and women in Nigeria have poor knowledge regarding mother-to-child transmission of HIV (MTCT)[2].

(iii). Interpersonal and household level factors: Gender-based violence (GBV), especially sexual violence, contributes to an increased risk of HIV transmission[20]. The Nigeria Demographic and Health Survey (NDHS) shows that the proportion of women (age 15-49 years) who had ever experienced sexual violence in Nigeria had steadily increased from 7% in 2008 to 7.4% in 2013 and 9.1% in 2018 (Figure 2). The risk of GBV is higher in rural than urban areas (9.7% vs. 8.5%)[21]. Other household-level factors for HIV include the poor ability of women to negotiate safer sex and take independent decisions about their health.

(iv). Community-level factors: Child marriage and female genital mutilation are norms and practices that increase the risk for HIV in Nigeria. Early marriage leads to girls dropping out of school. Poorly educated girls are less able to negotiate safer sex and participate in decision-making at the family, community and societal level, while secondary school education for girls is associated with a reduced level of HIV risks[22]. Girls who marry older men are at risk of traumatic sex and exposure to the HIV risk of other sexual partners of the older man.

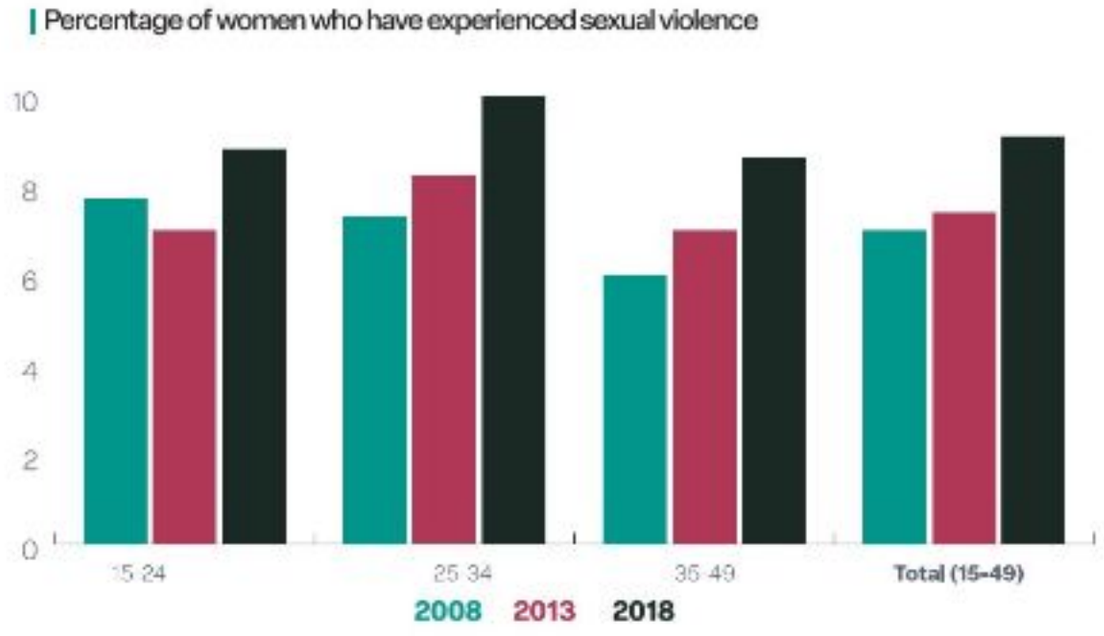


Figure 2: Women who ever experienced sexual violence in Nigeria by age group, 2008-2018

(Source Nigeria Demographic and Health Survey 2008, 2013, 2018)

(v). Macro-level factors: There are structural factors acting at macro and community levels that drive HIV risk[23]. These factors include poverty, cultural and religious norms, formal/customary laws, and the political context. The level of poverty is high in Nigeria, and higher among females compared to males.[17] Other gender issues that contribute to gender inequalities in the risk of HIV include lower access to education and employment opportunities; and widow inheritance practices. There is also the poor institutionalization and implementation of legal instruments and policies that can help create a supportive environment to reduce the risk of HIV. These include the 2014 HIV and AIDS (anti-discrimination) Act; the 2015 Violence Against Persons Prohibition (VAPP) law; and the National Policy on Social Protection Emerging issues of interest include epidemics and pandemics like the COVID-19 pandemic that worsen existing inequalities and possibly create new ones. The increased risk of gender-based violence, diversion of HIV-related resources to manage the pandemic, economic hardship as a result of the lockdown, and food and housing insecurities during the COVID-19 pandemic, compromised the efficiency and effectiveness of HIV programmes and increased the risk for new HIV infections.

2.2 Response Analysis

The Revised NSF (2019-2021) focuses key actions on the following: (a) prevention of new infection; (b) achieving HIV targets of 90-90-90 and 95-95-95 subsequently. Table 2 shows that Nigeria performed considerably below the set targets for all the HIV prevention indicators assessed. The level of knowledge about HIV prevention and its transmission was below the 90% target set for men and women aged 15–49 years and among young people aged 15-24 years. Among young people, condom use at last sexual intercourse was reported by 64.9%% of males and 52.8% of females in 2021. This was less than the target of 90% set for both sexes.

Table 2: Trends in Selected HIV Prevention Measures in Nigeria: 2019 - 2021

Indicators	Target (2021)	Achievements (End of 2019)	End-Term Achievements (2021/22)	Data source
% of the general population with comprehensive knowledge of HIV transmission and prevention	90%	Female (46.2%); Male (45.8%)	Female (46.2%); Male (45.8%)	NDHS 2018
% of young people (15 – 24 years) with comprehensive knowledge of HIV transmission and prevention	90%	Female (42.6%); Male (33.7%)	Female (42.6%); Male (33.7%)	NDHS 2018
% of women and men aged 15-49 who have had sexual intercourse with more than one non-marital, non-cohabiting partner in the past 12 months who used a condom during their last sexual intercourse	90%	Female 33.3 Male 35.3 MICS 2016-17	Female 52.8, Male 64.9	MICS 2021
% of never-married sexually active young people (15-24 years) who used a condom at last sexual intercourse	90%	Female 46.6 Male 61.4 MICS 2016-17	Female 52.8 Male 64.9	MICS 2021
% of women and men with STIs who sought treatment from a health facility or health professional in the past 12 months	90%	Women (33.1%); Men (30.8%)	Women (33.1%); Men (30.8%)	NDHS 2018

The RNSF (2019-2021) target was that 90% of vulnerable and KPs would adopt appropriate HIV risk reduction behaviours by 2021. While 91% of FSW used condoms at the last sexual intercourse, the achievement on this target was lower for MSM and PWID as indicated in Table 3. Similarly, only 6% of PWID used sterile needles consistently in the last 3 months against the set target of 90%. In addition, only 11% of PWID, 27% of MSM, 20% of FSW and 24% of transgender used pre-exposure prophylaxis though the target was 90% for each of the population.

Table 3: Trends in Selected HIV Prevention Indicators among Key Populations in Nigeria: 2019 - 2021

Indicators	Target (2021)	Achievements (End of 2019)	End-Term Achievements (2021/22)	Data source
% of FSW who used condoms at the last sexual intercourse	90%	92% (2014)	91%	IBBS 2021
% of MSM who used condom at last anal sex with a male partner	90%	83% (2014)	82.9%	IBBS 2021
% of PWID who used condom use at last sexual intercourse	90%	83% (2014)	79.8%	IBBS 2021
% of PWID who used sterile needles consistently in the last 3 months	90%	Data not available	6%	IBBS 2021
% of key populations using PrEP in priority population	90%		FSW 20% MSM 27% TG 24% PWID 11%	IBBS 2021
% of FSW, MSM, and PWID who tested for HIV and received their test results within the last 12 months	100%	FSW (86.2%); MSM (78.9); PWID (65.3%) (IBBSS 2014)	FSW 69% MSM 58.5% PWID 37.2%	IBBS 2021

As shown in Table 4, the proportion of PLHIVs that know their status as at the end of 2021 was 98% compared to the set target of 95%. The proportion of PLHIV on ART who received their viral load test result increased from 69% in 2020 to 89% in 2021. This achievement was lower than the set target of 95%. The proportion of PLHIV on ART who were virologically suppressed (<1000c/ml) was 86% in 2020 and 89% in 2021.

Table 4: Trends in Selected HIV Testing and Treatment Indicators in Nigeria: 2019 - 2021

Indicators	Target (2021)	Achievements (End of 2019)	End-Term Achievements (2021/22)	Data source
% of PLHIV that know their status	95%	73%	98%	2021 Health sector report
% of PLHIV currently on ART	95%	61%	93%	2021 Health sector report
% of PLHIV on ART with a viral load test result	95%	69%	89%	2021 Health sector report
% of PLHIV on ART are virologically suppressed (<1000c/ml)	95%	86%	89%	2021 Health sector report
% of people in HIV care who were clinically screened for TB in an HIV care setting	100%	NA	60%	2021 Health sector report

Proportion of pregnant women who tested for HIV and received their test results in the last 12 months

34% → **26.8%**

2019 2021

The proportion of HIV-positive pregnant women who received ART

43% → **32%**

2019 2021

14%

Of HIV-exposed babies had early diagnosis in **2021**

The rate of MTCT at 6 weeks of birth

16.5% → **16.3%**

2019 2021

Nigeria has not made progress with its PMTCT program based on the reported indicators on Table 5. As Table 5 shows, the proportion of pregnant women who tested for HIV and received their test results in the last 12 months reduced from 34% in 2019 to 26.8% in 2021. The proportion of HIV-positive pregnant women who received ART reduced from 43% in 2019 to 32% in 2021. However, only 14% of HIV-exposed babies had early infant diagnosis in 2021. The rate of MTCT at 6 weeks of birth reduced slightly from 16.5% in 2019 to 16.3% in 2021.

Table 5: Trends in Selected PMTCT Indicators in Nigeria: 2019 - 2021

Indicators	Target (2021)	Achievements (End of 2019)	End-Term Achievements (2021)	Data source
% of pregnant women tested for HIV and received their test results in the last 12 months	95%	34%	26.8%	2021 Health sector report
Rate of Mother to Child transmission (MTCT) of HIV at 6 weeks of birth	0%	16.5%	16.3%	2021 Health sector report
% of HIV-positive pregnant women who received ART	95%	43%	32%	2021 Health sector report
% of infants born to HIV-positive women who received ARV prophylaxis	95%	Data not available	Data not available	2021 Health sector report
% of HIV-exposed babies receiving virological test for HIV within 2 months of birth	95%	Data not available	14%	2021 Health sector report

A major challenge with the national HIV response is the overwhelming dependence on donors for the funding of interventions and other programmatic elements. The National AIDS Spending Assessment 2015-2018 found that state and LGA expenditure on HIV averaged less than USD 14 million per year from 2015 to 2018. States are on the front line and have direct responsibility for primary health care. The HIV expenditure in Nigeria in 2018 was estimated as $532million, of which only $91.5 million (17.2%) was from public sources, $200,000 (0.04%) was from private sources, and $441 million (82.8%) was from international sources[9].

However, Nigeria has intensified efforts towards the mobilization of domestic resources for the HIV response, a strategic element of which is the launch of the ₦62.1 billion (150M USD at ₦460 exchange rate) HIV Trust Fund in February 2022 by the Federal Government.

The current implementation arrangement of the HIV programme has resulted in the "crowding out" of the statutory government agencies resulting in limited experience and technical capacity of state actors and the lack of ownership of the response across all tiers of the government. The sustainability agenda under Alignment 2.0, as collectively agreed by NACA, NASCP, UNAIDS, GF, PEPFAR and CSOs, seeks to strategically change the hitherto existing HIV intervention delivery architecture to that which is owned, driven, resourced and led by the people and the government of Nigeria at different levels, with support from her partners.

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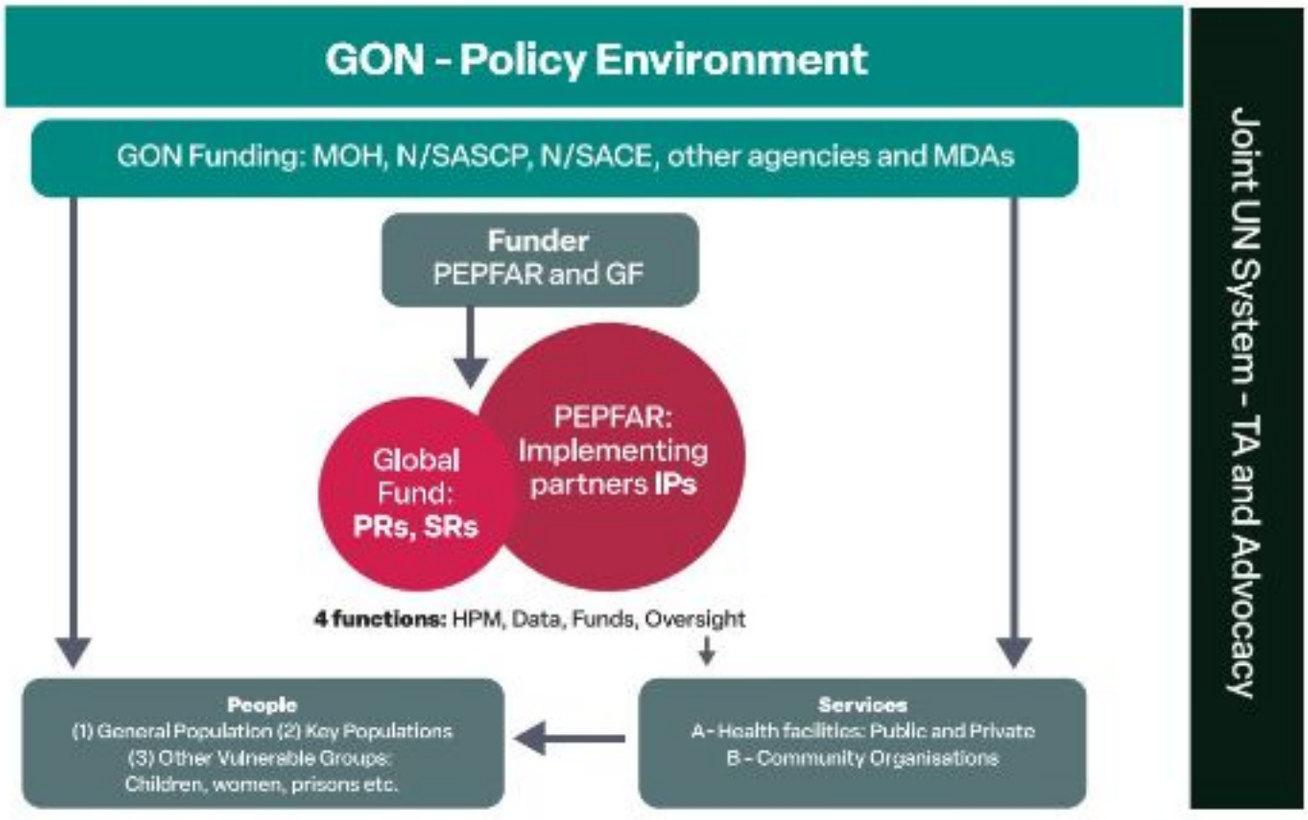


Figure 3: Current delivery architecture/The New Business Model

(Source: NACA, 2022: New Business Model for the Nigerian HIV/AIDS National Response, 2023-2030)[11]

3.0 DEVELOPMENT CONTEXT, GUIDING PRINCIPLES AND STRATEGIC AGENDA

3.1 Development Context for the Strategic Plan

The National HIV and AIDS Strategic Plan 2023-2027 took cognizance of the following:

(i) *National Health Policy, 2016*: One of the targets of the policy is to reduce the incidence of HIV by addressing possible barriers through universal access to comprehensive and quality HIV prevention, treatment, care and support services using multi-sectoral interventions. The aim is to end AIDS as a public health problem in Nigeria by 2030.

(ii) *National Policy on HIV/AIDS 2020:* The current HIV/AIDS policy in Nigeria was launched in 2020.[25] The policy adopted a multisectoral approach to the fight against HIV in Nigeria. The protection of the rights of PLHIV and reduction of stigma and discrimination are among the guiding principles of the national policy. The seven strategic thrusts of the policy were: (i) Elimination of new infections of HIV; (2) Treatment of HIV and AIDS and related health conditions; (3) Care and support for infected and affected persons; (4) Resourcing the national response; (5) Critical Enablers for full engagement; (6) Coordination and harmonization of the response and, (7) Research, knowledge management.

(iii) *HIV and AIDS (Anti-discrimination) Act, 2014*: The Act seeks to protect the fundamental human rights and dignity of people living with and affected by HIV and AIDS as guaranteed in Chapter 4 of the 1999 Constitution of the Federal Republic of Nigeria(as amended), and obligations under international and regional human rights and other instruments by eliminating HIV-related discriminations in all settings, including workplace, health and educational institutions, policies and practices

(iv) *National Policy on the Health and Development of Adolescents and Young People in Nigeria (2020-2024).* The vision of the policy is "healthy life and optimal development for all adolescents and young people in Nigeria and successful transition towards a healthy, active, productive, successful and fulfilled adulthood." Its strategic objectives include reducing morbidity, disability, and preventable mortality rates among adolescents and young people, and the policy has specific targets regarding improving HIV knowledge and reducing risk behaviours.

(v) *HIV Programming in Adolescent and Young People in Nigeria – an Investment Case 2021-2025*: The document presents an investment case for a strengthened HIV prevention, treatment, care and support programme for adolescents and young people in Nigeria for 2021-2025 towards achieving the 95-95-95 targets. Informed by evidence, the investment case proposes a package of interventions that are grounded in the socio-ecological model, addressing the needs of adolescent girls and young women as well as young men, their sexual and social networks and their families, taking cognizance of their social and cultural context.

(vi) *Violence Against Persons Prohibition (VAPP) Law 2015*: The main thrust of the VAPP law is to eliminate violence in private and public life. The law prohibits all forms of violence against persons to provide maximum protection and effective remedies for victims and punishment of offenders and other related matters.

(vii) National Policy on Social Protection: The Social Protection Policy for Nigeria provides an umbrella policy framework intended to reduce poverty and provide a life of dignity for all citizens of Nigeria. The overarching goal is to provide a framework for gender-sensitive and age-appropriate programming that ensures a minimum social level for all citizens of Nigeria to live a life of dignity.

(viii) *Generation of Negative Adolescents and Young People (Gen-N) campaign RoadMap*: Gen-N is a national campaign designed to destigmatize HIV services and drive Nigeria towards a generation of adolescent and young people (AYP) that is HIV-negative; The overarching goal of Gen-N is to contribute to the attainment of HIV epidemic control through increasing the uptake of HIV prevention, treatment and care services by AYP in Nigeria.

(ix) *National HIV and AIDS Community Care and Support Guidelines (2020-2023)*: The National HIV and AIDS Community Care and Support Guidelines defines the minimum standard of care including medical, psychosocial and economic for PLHIV, people affected by AIDS (PABA) and key and vulnerable populations. It contains information on care and support services to be accessed by PLHIV (including adolescents and young people living with HIV), key and vulnerable populations and PABA at the facility, community and household levels.

(x) *National HIV and AIDS Access to Justice Guidelines & Capacity Building Manual:* The guidelines contain a step-by-step guide on how PLHIV, adolescents and young people living with HIV (AYPLHIV), PABA, key populations and vulnerable groups can know their rights and take action when those rights are violated.

(xi) *"Alignment 2.0"*: "Alignment 2.0" aims to sustain the gains made in Alignment 1.0, reduce duplication/ co-location, aim for better service harmonization and integration, empower and transit management and leadership to community, private, state and federally mandated structures while embarking on strategic engagement and communication with all stakeholders

(xii) *Sustainable Development Goals (2015-2030)*: The Sustainable Development Goals (SDG) underscore the need to address the predisposing factors for HIV and AIDS, and end AIDS as a public health threat. Specifically, target 3.3 of the SDG states that: "by 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases."

(xiii) *Global AIDS Strategy, 2021-2026.* The strategy aims to achieve: (i) Zero discrimination; (ii) Zero new HIV infection; and (iii) Zero AIDS-related deaths. The strategy has three priorities: (i) Maximize equitable and equal access to HIV services and solutions; (ii) Break down barriers to achieving HIV outcomes; and (iii) Fully resource and sustain efficient HIV responses through integration into health, social protection, humanitarian and pandemic response systems. The strategic cross-cutting issues to address include leadership, promoting country ownership, reducing stigma and discrimination, and promoting rights and gender equality. The strategy aims to achieve the 95-95-95 goal and less than 10% prevalence of HIV-related stigma and discrimination by 2030.

(xiv) *Political Declaration on HIV and AIDS:* *Ending Inequalities and Getting on Track to End AIDS by 2030*: The Declaration, among others, expresses commitment to achieve the 95–95–95 testing, treatment and viral suppression targets within all demographics, groups and geographic settings, including children and adolescents living with HIV; deliver and scale-up integrated services that prevent HIV, comorbidities and coinfections, sexually transmitted infections and unintended pregnancy among adolescent girls and women; and eliminate all forms of HIV-related stigma and discrimination.

(xv) *Global Alliance for Ending AIDS in Children by 2030*: The Alliance aims to ensure that no child living with HIV is denied treatment by 2030 and to prevent new HIV infections in infants. These will be achieved by: (i) closing the treatment gap for pregnant and breastfeeding adolescent girls and women living with HIV; (ii) preventing and promptly detecting new HIV infections among pregnant and breastfeeding adolescent girls and women; (iii) ensuring accessible testing, optimized treatment, and comprehensive care for infants, children, and adolescents exposed to and living with HIV; and (iv) addressing rights, gender equality, and the social and structural barriers that hinder access to services.

(xvi) *Global Health Sector Strategies on HIV, Viral Hepatitis and Sexually Transmitted Infections (2022-2030)*: The strategies underline the critical role of the health sector in ending HIV, viral hepatitis, and sexually transmitted infections. They emphasize that people-centred health services are an important feature of primary health care and contribute to expanding universal health coverage and recommend shared and disease-specific country actions against these three infections of public health importance.

(xvii) *National PMTCT Scale-up Plan 2022:* The goal of the Nigeria PMTCT scale-up is to accelerate progress towards the achievement of the eMTCT target through:

i) differentiated approach in intensifying service delivery efforts at the health facility and community level and

ii) strengthening of leadership, coordination and PMTCT programme management at state level, and as an entry point for strengthening of the overall HIV programme coordination for increased ownership and sustainability.

(xviii) *National Domestic Resource Mobilization and Sustainability Strategy for HIV 2021-2025:* This strategy's central objective is to ensure there is a clear, systematic, predictable, and well-coordinated approach to more flexible and predictable multiyear funding from domestic resources so that Nigeria can respond to the current and future needs of the HIV response.

(xix) Report of the Gender Assessment of the HIV Response in Nigeria (2022): This assessment seeks to identify strategic investment areas that will improve gender responsiveness in the national HIV/AIDS response; identify strategic planning and budget processes that have essential information surrounding the potential epidemic, context and response from gender perspective; to generate evidence and facilitate learning on the extent to which the national response recognises and acts on gender inequality and gender based violence as a critical enabler of HIV response; to understand the challenges and opportunities that could be useful in ensuring improved gender mainstreaming at state and community levels in the HIV response amongst others

3.2 Guiding Principles

The provisions of the National Strategic Plan are guided by the following principles:

(i) *Political leadership and country ownership*: Strong political leadership of the National and State HIV and AIDS responses, driven by a sense of ownership, and with a commitment to transparent and prudent management of financial resources.

(ii) *Partnerships and multi-sectoral collaborations*: Synergy between all multi-sectoral partners, government, Civil Society Organizations, Networks of PLHIV and development partners - for stronger collaboration, partnerships and sustainability of the national response.

(iii) *Rights-based and gender-responsiveness*: Respect for gender equality rights and dignity through the adoption of rights-based and gender-responsive HIV programming by all stakeholders.

(iv) *Meaningful involvement of people living with HIV and AIDS*: Commitment to the meaningful involvement of PLHIV and AIDS through the institutionalization of the engagement of PLHIV in the design and implementation of the HIV response.

(v) *Strategic investment programming*: Targeted strategic investment driven by the latest evidence 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 including service integration for effective delivery of quality HIV prevention, treatment, care and support services.

(vii) *Stakeholder involvement, engagement and participation*: Strengthening the community *and* private sector systems to support achieving the goal and objectives of the HIV response.

(viii) *Research and innovation*: Tracking the epidemic and improving the targeting of services to maximize the impact of the national response through the harnessing and use of data acquired through the conduct of innovative research, surveillance, monitoring and evaluation exercises.

3.3 Strategic Agenda

3.3.1 Vision

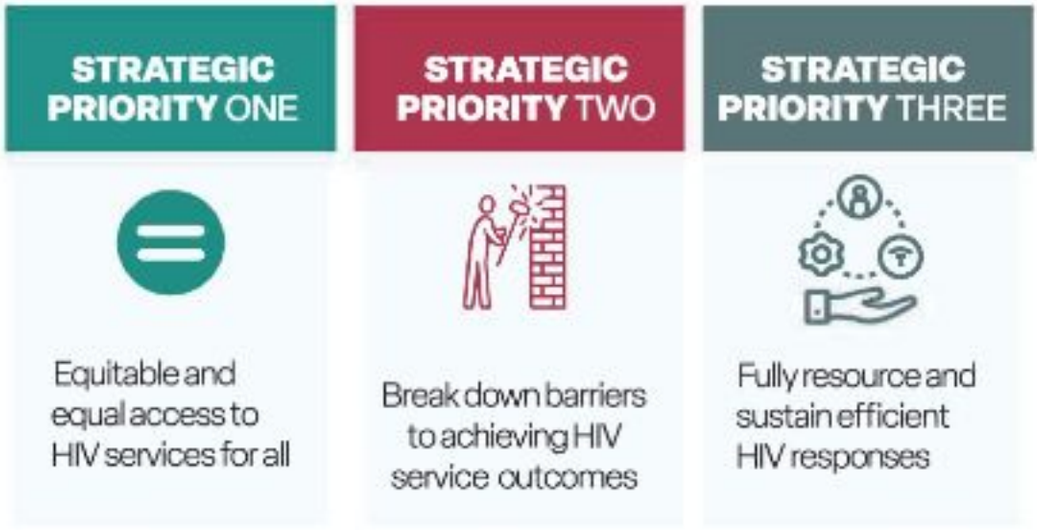
An AIDS-free Nigeria with zero new infections, zero stigma and discrimination and zero AIDS-related deaths.

3.3.2 Goal

Strengthen the national HI**V** response to facilitate ending AIDS in Nigeria by 2030.

This goal will be operationalised through a focus on three strategic priorities, which are the focus of Section 4:

i. Strategic Priority 1: Equitable and equal access to HIV services for all
ii. Strategic Priority 2: Break down barriers to achieving HIV ser**vi**ce outcomes
iii. Strategic Priority 3: Fully resource and sustain efficient HIV responses



4.0 STRATEGIC PRIORITY I: MAXIMISE EQUITABLE AND EQUAL ACCESS TO HIV SERVICES AND SOLUTIONS

There are three result focus areas under this strategic priority: (i) HIV prevention; (ii) HIV testing, treatment,care, viral suppression and integration; and (iii) prevention of vertical HIV transmission and paediatrics HIV treatment. HIV prevention is a critical intervention for the National HIV response as it averts new infections. The zero new infection goal of the National HIV response will support a combination of evidence-based behavioural, biomedical and structural interventions that promote access, uptake and use of personal prevention tools. It will also create a supportive environment to enhance access to and use of services. Behavioural interventions will focus on improving comprehensive HIV knowledge among young people and facilitating and sustaining low HIV risk behaviours (sexual and non-sexual). Biomedical interventions will promote HIV testing, condom and lubricant programming, access to the prevention and treatment of sexually transmitted infections, pre-and post-exposure prophylaxis, safe use of blood or blood products and elimination of mother-to-child transmission of HIV. Structural interventions include the promotion of gender equality, elimination of stigma and discrimination and discriminatory cultural norms and practices, as well as strengthening linkages between community and facilities services.

The zero new infection goal of the National HIV response will support a combination of evidence-based behavioural, biomedical and structural interventions that promote access, uptake and use of personal prevention tools.

4.1 Result Areas and Major Interventions

4.1.1 Result Area I: HIV prevention

| Major interventions

4.1.1.1. Combination HIV prevention for KPs, Expand and strengthen HIV prevention programmes for men who have sex with men, including the rapid expansion of access to and uptake of PrEP, Undetectable=Untransmittable (U=U) programming, condom and lubricant programming; sexual and reproductive health services; mental health and psychosocial services, violence prevention; legal support, community-led outreach; and use of new communication technologies and empowerment.

4.1.1.2. Intensify and expand comprehensive programmes for and with sex workers nationwide, especially among the most affected sex workers, to address persistent gaps through expanded community-led outreach, condom and lubricant programming; increased access to PrEP, sexual and reproductive health services; violence prevention, mental health and psychosocial and other social services, legal support and empowerment.

4.1.1.3. Intensify and redouble efforts to scale up comprehensive harm reduction for people who inject drugs in all settings, including promoting needle-syringe programmes, opioid substitution therapy, a medication used to block the effects of opioid overdose and interventions for alcohol and noninjecting drug use; as well as prevention, diagnosis and treatment of TB and viral hepatitis, increased access to PrEP, community-led outreach, mental health, psychosocial services, and other social services and support.

4.1.1.4. Intensify and expand comprehensive programmes for and with transgender people, including condom and lubricant programming, increased access to PrEP, gender-affirming health services, violence prevention, community-led outreach, empowerment and psychosocial and other social services and support.

4.1.1.5. Ensure universal access to comprehensive prevention in correctional facilities and other closed settings including voluntary HIV testing and treatment; harm reduction; prevention, diagnosis and treatment of TB and viral hepatitis; and related health services, legal, psychosocial and other social services and support.

4.1.1.6. Address the multiple needs of adolescent girls and young women by scaling up combination programme packages, which link effective HIV prevention services with programmes that address HIV and sexual and reproductive health, including access to contraception, comprehensive sexuality education, prevention of schistosomiasis, sexually transmitted infections, gender-based violence and sociocultural gender norms, and promotion of women's empowerment and meaningful engagement.

4.1.1.7. Where existing services fail to reach people, provide alternative programmes and use creative approaches (including but not limited to virtual platforms) to reach key and priority populations (PLHIV and others), and enable access to HIV, sexual and reproductive health and related prevention initiatives and services.

4.1.1.8. Strengthen access to good-quality, gender-responsive, age-appropriate comprehensive sexuality education services, both in and out of school, which address the realities of adolescents and young people in all their diversity, in line with international guidance, and national laws, policies and context.

4.1.1.9. Intensify outreach to young and adult men to increase their access to and uptake of HIV prevention, testing and treatment programmes that are adapted to their needs, including sexual, reproductive and other health-care services.

4.1.1.10. Intensify the quality and coverage of HIV prevention among women, especially adolescent girls and young women, including access to modern family planning and antenatal services.

4.1.1.11. Accelerate and facilitate consistent use of male and female condoms and lubricants by priority populations (PLHIV and others), using demand-generation approaches that are adapted to the needs of new generations of young people.

4.1.1.12. Maximize the benefits of the latest PrEP scientific advances and urgently accelerate PrEP uptake for all people who are at substantial risk of HIV infection, including through simplified and differentiated delivery approaches.

4.1.1.13. End prevention inequalities by using granular data to accurately estimate sizes of key and priority populations who are not receiving the HIV prevention services they need and develop and implement focused strategic road maps in collaboration with affected communities to scale up combination prevention packages that are tailored to their needs.

4.1.1.14. Update HIV behaviour change communications regularly, including promotion of PrEP and U=U, and utilize internet-based and mobile applications that are relevant to young people and KPs to optimally expand the reach and impact of HIV services.

4.1.1.15. Address the structural and age-related legal barriers faced by adolescents and young KPs and ensure active participation of adolescent and young KPs in the development of community-led programmes, peer-led outreach and digital technology approaches to promote prompt access of adolescent and young KPs to effective services.

4.1.2 Result Area 2: HIV testing, treatment, care, viral suppression and integration

Major interventions

4.1.2.1. Reduce inequalities by using granular data to identify and address the characteristics that lead to inequalities in testing, treatment and care access and outcomes.

4.1.2.2. Rapidly maximize the impact of affordable, effective HIV testing technologies and practices, increase the uptake of differentiated HIV testing strategies where available (particularly HIV self-testing, community-led testing services, partner services and social network approaches) and strengthen the linkage of people who access testing services to HIV prevention and treatment services.

4.1.2.3. Complement the traditional facility-based, standalone HIV treatment service model with innovative approaches, including those implemented during the COVID-19 pandemic, to expand services that are convenient so people can start, continue or resume treatment and achieve and sustain HIV viral suppression.

4.1.2.4. Remove legal, social and structural barriers impeding the uptake of testing and treatment and ensure access to other relevant health and social services.

4.1.2.5. Scale up and fully resource community-led service delivery and monitoring, which has been proven to improve HIV and wider health outcomes of PLHIV and KPs.

4.1.2.6. Strengthen the capacity of the education sector to meet the needs of young people living with and affected by HIV, including through scaling up access to school health and nutrition programmes, linkages to health and social protection services, and provision of good-quality comprehensive sexuality education.

4.1.2.7. Expand and promote equitable, affordable access to high-quality medicines, health commodities, science, technology, innovations and solutions for PLHIV, KPs and other priority populations.

4.1.2.8. Accelerate research and development for more effective HIV technologies, including treatment regimens and solutions, an HIV cure and vaccine, and invest further in implementation research to build the evidence base for the effective delivery and optimal impact of new technologies.

4.1.2.9. Address the impact of social and structural drivers of the HIV epidemic, including unequal gender norms and power dynamics, and human rights violations affecting access to and uptake of HIV treatment and care efforts.

4.1.2.10. For people living with and at risk of HIV, promote and intensify comprehensive, integrated health and social services, community engagement for peer support and address stigma and discrimination, including linkages between HIV services and support services for other communicable and noncommunicable diseases, mental health, alcohol, drug use and substance dependence, and services for sexual and reproductive health, gender-based violence, harm reduction and mental health across the life course.

4.1.2.11. Expand rights-based community contact tracing and scale up access to the latest technologies for tuberculosis screening, diagnosis, treatment and prevention for PLHIV and ensure optimal linkages to HIV care.

4.1.2.12. Scale up integrated services for HIV, syphilis, viral hepatitis, sexually transmitted infections and other infections in antenatal and postnatal services and other settings, where needed.

4.1.2.13. Leverage both HIV and broader health investments to transform data recording and reporting systems of vertical programmes and adapt integrated health data systems (including with other sectors such as social welfare and protection) to identify gaps, barriers and solutions to achieve effective integrated health services for people living with and at risk of HIV.

4.1.3 Result Area 3: Prevention of vertical HIV transmission and paediatric HIV treatment

Major interventions

4.1.3.1. Implement innovative tools and strategies to find and diagnose all children living with HIV, including the use of point-of-care early infant diagnostic platforms for HIV-exposed infants, and rights-based index, family and household testing and self-testing to find older children and adolescents living with HIV not on treatment.

4.1.3.2. Use tools such as the stacked bar analysis to identify and address when and where new child infections are occurring and use age-disaggregated data to identify and close the gaps in HIV testing and treatment for children and adolescents.

4.1.3.3. Prioritize rapid introduction and scale-up of access to the latest WHO's recommended, optimized, child-friendly HIV treatment and achieve sustained viral load suppression.

4.1.3.4. Support transitioning of children living with HIV through adolescence to adult care and address their complex, multiple and changing needs, including peer adherence counselling, psychosocial support and support for age-appropriate disclosure.

4.1.3.5. Use granular data to identify barriers and gaps and adapt tailored, effective approaches to national and subnational needs to expand solutions for HIV prevention, treatment and care among children.

4.1.3.6. Target adolescents and young people in all their diversities with a complete package of combination HIV prevention services that are tailored to their evolving needs and is integrated with comprehensive sexuality education (for in and out-of-school youth and those in custodial and closed settings), enhanced access to sexual and reproductive healthcare services (including contraception), and with HIV treatment and care.

4.1.3.7. Reach, test and retain all pregnant and breastfeeding women living with HIV including female KPs in integrated antenatal and HIV care with optimized treatment regimens that achieve sustained viral load suppression through differentiated and community-led services that meet the needs of women in all their diversity.

4.1.3.8. Intensify provision of optimized, tailored prevention services for pregnant and breastfeeding women at risk of HIV, including female KPs.

4.1.3.9. Implement repeat HIV testing during pregnancy and breastfeeding per guidelines to identify women newly infected for rapid intervention with HIV treatment and prevention of vertical transmission.

4.1.3.10. Address stigma, discrimination and gender norms that promote inequity and prevent pregnant and breastfeeding women, especially adolescent girls, young women and KPs, from accessing HIV testing, prevention and treatment services for themselves and their children through differentiated support services. Those services include male, partner, extended family engagement and peer mentoring.

4.1.3.11. Advance urgent progress towards validating HIV status knowledge for every pregnant woman including female KPs, by eliminating vertical transmission and ensuring the country is on the pathway to the elimination of HIV, viral hepatitis and syphilis.

4.1.3.12. Strengthen the integration of family planning and HIV services for improved access to quality family planning services that support the fertility desires and choices of Women Living with HIV (WLHIV) and sexually active AGYW

4.2 Core Targets and Result Framework

4.2.1 Core targets

By the end of 2027:

i. 95% of people at risk of HIV infection have access to and use appropriate, prioritized, person-centered and effective combination prevention options.

ii. 95% of women of reproductive age have their HIV and sexual and reproductive health service needs met.

iii. 95% of pregnant and breastfeeding women living with HIV have suppressed viral loads.

iv. 95% of HIV-exposed children are tested by two months of age and again after cessation of breastfeeding.

v. 95% testing and treatment targets are achieved within all subpopulations, age groups and geographic settings, including children living with HIV.

vi. 95% of people living with HIV receive preventive treatment for tuberculosis.

vii. 90% of people living with HIV and people at risk are linked to people-centred and context-specific integrated services for other communicable diseases, non-communicable diseases, sexual health and gender-based violence, mental health, drug and substance use, and other services they need for their overall health and wellbeing

Result Framework: Equitable and Equal Access to HIV Services

	Indicators	Baseline (End of 2022)	Source	Mid-Term (Mid-2025)	Assumption	End-Term, (End of 2027)	Assumption	Data Source
1	Percentage of people at risk of HIV infection have access to and use appropriate, prioritized, person-centred and effective combination prevention options.	35%	NAIIS	75%	Mid-point between baseline achievement and End term Target	95%		Spectrum Estimates
2	Percentage of women of reproductive age have their HIV and sexual and reproductive health service needs met.	67%	NDHS	75%	using ANC and Contraceptive usage	95%	Using ANC and Contraceptive usage	NDHS
3	Percentage of pregnant and breastfeeding women living with HIV have suppressed viral loads.	89%	Programme data	92%	Mid-point between baseline achievement and End term Target	95%	Using General Population suppression from Programme Data	Programme data
4	Percentage of HIV-exposed children are tested by two months of age and again after cessation of breastfeeding	89.7%	Programme data	90%	Mid-point between baseline achievement and End term Target	95%	Using General Population suppression from Programme Data	Programme data
5	Testing and treatment targets are achieved within all subpopulations, age groups and geographic settings, including children living with HIV.	95%	Programme data	95%	Mid-point between baseline achievement and End term Target	95%	Using General Population suppression from Programme Data	Programme data
6	Percentage of people living with HIV receive preventive treatment for TB.	62%	Programme data	75%	Mid-point between baseline achievement and End term Target	95%	Same as above	Programme data
7	The percentage of people living with HIV and people at risk are linked to people-centred and context-specific integrated services for other communicable diseases, non-communicable diseases, sexual health and gender-based violence, mental health, drug and substance use, and other services they need for their overall health and wellbeing	Not Available			Mid-point between baseline achievement and End term Target	90%		

5.0 STRATEGIC PRIORITY II: BREAK DOWN BARRIERS TO ACHIEVING HIV OUTCOMES

5.1 Result Areas and Major Interventions

5.1.1 Result Area 1: Community-led response

| Major interventions

5.1.1.1. Fully implement the Greater Involvement of People living with AIDS (GIPA) principle to put the leadership of PLHIV at the centre of HIV responses, ensure that networks of PLHIV and KPs are represented in decision-making bodies, empower PLHIV, AYP and KP so they can influence the decisions that affect their lives, and ensure PLHIV, AYP and KP have access to technical support for community mobilization, strengthened organizational capacities, and leadership development.

5.1.1.2. Support community-led monitoring and research and ensure that community-generated data is used to tailor responses to the needs of PLHIV and KPs, including young KPs.

5.1.1.3. Scale up community-led service delivery to the majority of HIV prevention programmes are led by PLHIV, KPs, women and young people and that all HIV testing, treatment and **co**mmu**ni**ty care programmes include community m**e**mb**er**s.

5.1.1.4. Integrate community-led HIV responses into all national HIV responses. Ensure urgent and adequate support for community-led responses at scale in all states, especially those transitioning to domestic funding, in conflict zones and during humanitarian crises.

5.1.1.5. Mobilize funding for sustainable community-led responses, ensuring financial support and equitable pay for community-led work and funding for activities led by networks of people living with HIV, Faith-based Groups and KPs, including those led by women and young people.

5.1.2 Result Area 2: Human rights

| Major interventions

5.1.2.1. End stigma and discrimination that contributes to inequalities in the HIV response and affects people living with and affected by HIV, adolescents and young people KPs, women and girls those experiencing multiple and intersecting forms of discrimination, and other vulnerable groups.

5.1.2.2. Contribute to reducing inequalities in the response by accelerating and adequately resourcing interventions to end stigma and discrimination, building on the efforts of the Global Partnership for action to eliminate all forms of HIV-related stigma and discrimination, and supporting community-led research and advocacy and implementation of the recommendation of the PLHIV Stigma Index.

5.1.2.3. Create an enabling legal environment by reviewing and reforming HIV-related punitive and discriminatory laws, policies, regulations and correctional systems to be consistent with International Human Rights Obligations to overcome human rights-related barriers to HIV services.

5.1.2.4. Introduce and enforce in collaboration with relevant MDAs, protective and enabling legislation and policies, and discourage the use of existing legislation to infringe on the rights of PLHIV, AYP and KPs.

5.1.2.5. Scale up and fund actions to reform public health and law enforcement practices to ensure they support rather than impede the HIV response including the elimination of discriminatory, arbitrary or violent practices and compulsory testing, treatment or detention in realizing equitable access to care, treatment and support

5.1.2.6. Ensure accountability for HIV-related human rights violations by increasing meaningful access to justice and accountability for people living with or affected by HIV and KPs. This includes increasing collaboration among key stakeholders, supporting legal literacy programmes, reduce barriers to access to Justice by increasing access to legal support and representation and supporting community monitoring for people living with or affected by HIV.

5.1.2.7. Prioritize advancing the rights of PLHIV, AYP, KPs and other people at risk of HIV by ensuring that all elements of the response––from the provision of HIV services to research and monitoring––are rights-affirming and that they engage PLHIV, KPs, young people and their communities. Ensure that digital health technologies and innovations advance the right to health and service access securely and without violating or undermining human rights.

5.1.3 Result Area 3: Gender equality

Major interventions

5.1.3.1. Scale up financing and implementation of gender-transformative, community-led innovations to remove social and structural barriers that block gender equality.

5.1.3.2. Transform unequal gender norms, engage women and girls and men and boys as gender equality advocates, tackle inequalities in the financing, design and delivery of health services, and increase demand and uptake of HIV prevention, treatment and care services and gender-based violence (GBV) services.

5.1.3.3. Support girls and boys so they can complete quality secondary education and acquire vocational entrepreneurial skills.

5.1.3.4. Scale up social protection interventions to enrol and retain adolescent girls and young women, boys and young men in schools and to provide pathways for economic empowerment.

5.1.3.5. Support policies and programmes that foster safe, inclusive school environments free of all forms of gender inequalities, gender-based violence, stigma and discrimination.

5.1.3.6. Prevent and respond to gender-based violence and violence towards PLHIV, KPs and other vulnerable groups in the context of HIV.

5.1.3.7. Adopt and enforce policy and legal frameworks, implement evidence-based interventions that prevent violence and HIV, integrate post-exposure prophylaxis into services for survivors of gender-based violence, and ensure that school environments are free from all forms of violence, including gender-based violence, stigma and discrimination, including through the implementation of the ILO Violence and Harassment Convention.

5.1.3.8. Conduct gender analysis and collect and effectively use age-, sex- and gender-disaggregated data, to develop, implement and monitor national gender transformative HIV policies, strategies, programmes, monitoring frameworks and budgets.

5.1.3.9. Promote gender equality through policies, programmes, results and budget allocations in the organizations and align with gender parity goals, using tools such as Global Health 50/50.

5.1.3.10. Prioritize people who are left behind due to their gender, age, sexual orientation, disability, gender identity or occupation. Ensure that women and girls who face intersecting forms of discrimination and violence (indigenous women, women with disabilities, women who use drugs, women in prison, female sex workers and transgender women) receive the tailored services and support they need and ensure that they are meaningfully engaged in HIV-related decision-making.

5.1.3.11. Ensure access to rights literacy and meaningful complaints and redress mechanisms for violations of their human rights in the context of HIV.

5.1.3.12. Promote women's economic empowerment and their access to economic resources (including their rights to land, property and inheritance) and labour markets and sustainable livelihoods. Redistribute the unpaid care work performed by women and girls in the context of HIV.

5.1.3.13. Repeal discriminatory laws and policies that increase women and girls' and boys' vulnerability to HIV and address violations of their sexual and reproductive health and rights.

5.1.3.14. Invest in women-led responses to HIV and in initiatives to support and build women's leadership—particularly networks of women and girls living with HIV, female KPs and females living with disabilities—in the design, budgeting, implementation and monitoring of the HIV response at regional, national, subnational and community levels.

5.1.4 Result Area 4: Young people

| Major interventions

5.1.4.1. Scale up the meaningful engagement and leadership of young people in all HIV-related processes and decision-making spaces.

5.1.4.2. Accelerate investments in adolescent and youth friendly healthcare facilities and services, youth leadership (particularly adolescent girls and young women and young KPs), capacity building and skills development at all levels in all aspects of the HIV response.

5.1.4.3. Foster solutions and partnerships between youth-led organizations and governments, the private sector, faith-based organizations, and other traditional and nontraditional partners to ensure sustainable investment in the financing of programmes for young people.

5.1.4.4. Strengthen access to high-quality, gender-responsive, age-appropriate comprehensive sexuality education programmes, both in-school and out-of-school, particularly for adolescent girls and young women and young KPs in settings with high HIV incidence.

5.1.4.5. Support policies and programmes focused on increasing the enrolment and retention in secondary schools for adolescent girls and young KPs and provide linkages to social protection, "cash plus" initiatives, financial incentives, pathways to employment, and interventions to transform unequal gender norms and prevention of violence against adolescent girls and young women.

5.1.4.6. Accelerate the processes regarding age of access to HIV services, hence removing legal and policy barriers, including age-of-consent laws and policies, for adolescents and youth to access HIV services, and ensure access to other health and social services, including sexual and reproductive health services, condoms and other contraceptives, and commodities and wider health and social services relating to young people's wellbeing.

5.1.4.7. Redesign HIV services to meet the needs of young people and ensure adolescents and young people (particularly adolescent girls and young women and young KPs in settings with high HIV incidence) can

access a full range of youth-centred and -led HIV services that holistically address their needs, including other health, social services and protection..

5.1.4.8. Ensure that the HIV response is integrated with COVID-19 pandemic recovery efforts as well as other emergencies and crises in humanitarian settings that benefit young people.

5.1.4.9. Strengthen age-, sex-, gender- and population-disaggregated data and real-time evidence systems, and enhance capacities to develop, monitor and analyse HIV-specific indicators across sectors.

5.1.4.10. Expand community-led outreach platforms for young people, including for young KPs and other vulnerable sub-population, by combining peer-led outreach with new media solutions that are developed in collaboration with young innovators

5.1.4.11. Fully operationalize, monitor and evaluate the performance of the Gen-N initiative, which is a national campaign designed to destigmatize HIV services and drive an increase in the uptake of HIV prevention, treatment and care services by AYP in Nigeria.

5.2 Core Targets and Result Framework

5.2.1 Core Targets

By the end of 2027:

i. 30% of testing and treatment services are to be delivered by community-led organizations.
ii. 80% of service delivery for HIV prevention programmes for KPs and women to be delivered by the community-, KP- and women-led organizations.
iii. 60% of the programmes support the achievement of societal enablers to be delivered by community-led organizations.
iv. Less than 10% of states have punitive legal and policy environments that lead to the denial or limitation of access to services.
v. Less than 10% of people living with HIV and KPs experience stigma and discrimination.
vi. Less than 10% of women, girls, and people living with HIV and KPs experience gender-based inequalities and all forms of gender-based violence (including violence from an intimate partner).
vii. Less than 10% of people support inequitable gender norms
viii. 90% of HIV services are gender responsive

Result Framework: Breakdown Barriers to Achieving HIV Service Outcomes

1	30% of testing and treatment services are to be delivered by community-led organizations.	Data not available		15%	A new indicator, the mid-point of target was utilized	30%	New	NACA
2	80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community-, key population- and women-led organizations.	Data not available		40%	New indicator, the mid-point of target was utilized	80%		NACA
3	60% of the programmes support the achievement of societal enablers to be delivered by community-led organizations.	Data not available		30%	New indicator, mid-point of target was utilized	60%		NEPWHAN NACA
4	Less than 10% of states have punitive legal and policy environments that lead to the denial or limitation of access to services.	54%	18 states (46%) have Anti-Discriminatory Acts. Stigma Index Survey	34%	Mid-point between baseline achievement and End term Target	<10%	10% reduction on the baseline year on year	NACA Stigma Index
5	Less than 10% of people living with HIV and key populations experience stigma and discrimination.	34%	Stigma index study	20%	Mid-point between baseline achievement and End term Target	<10%		Stigma Index
6	Less than 10% of women, girls, people living with HIV and key populations experience gender-based inequalities and all forms of gender-based violence.	31%	UNICEF/MWA	20%	Mid-point between baseline achievement and End term Target	<10%		UNICEF/ MWA
7	Less than 10% of people support inequitable gender norms	Data not available	UNAIDS Global AIDS Strategy 2021-2025	20%	Mid-point between baseline achievement and End term Target	<10%		UNAIDS
8	90% of HIV services are gender responsive	Data not available	UNAIDS Global AIDS Strategy 2021-2025	45%	Mid-point between baseline achievement and End term Target	90%		UNAIDS

6.0 STRATEGIC PRIORITY III: FULLY RESOURCE AND SUSTAIN EFFICIENT HIV RESPONSES AND INTEGRATE THEM INTO SYSTEMS FOR HEALTH, SOCIAL SERVICES/PROTECTION, HUMANITARIAN AND PANDEMIC RESPONSES

6.1 Result Areas and Major Interventions

6.1.1 Result Area 1: Fully-funded and efficient response

Major interventions

6.1.1.1. Enable increased efficiency, equitable and inclusive governance, policies and delivery platforms to achieve the NSP's targets and sustain the gains made to date in the HIV response and ensure affected communities including KPs and other vulnerable populations are at the forefront of the decision-making processes.

6.1.1.2. Expand partnerships to address the structural and macroeconomic barriers to increased domestic public spending on HIV and health as societal and economic priorities.

6.1.1.3. Promote and increase the volume and predictability of long-term, direct funding for community-led responses, including through establishing funding earmarks across countries and public funding of community-led responses.

6.1.1.4. Promote increased domestic and international investments in the public sector, management processes, greater transparency and accountability, and reset public-private partnerships towards equitable outcomes.

6.1.1.5. Focus resources on highly effective and efficient interventions for priority gaps and populations, including increased funding for scaling programmes for KPs and other vulnerable populations in addressing structural drivers.

6.1.1.6. Leverage appropriate technologies to reach people through differentiated approaches––tools that put services in the hands of people.

6.1.1.7. Develop and implement context-specific sustainability financing strategies (including multisectoral contributions to HIV responses) that ensure universal access and improved health outcomes.

6.1.1.8. Improve the collection and use of granular sex-, gender-, population- and age-disaggregated data to track funding for KPs, women and girls and other people underserved by the response, aiming to maximize impact and transparency, accountability and efficiency of resources and policy decisions.

6.1.2 Result Area 2: Integration of HIV into systems for health and social protection

| Major interventions

6.1.2.1. Integrate HIV into systems for health and ensure that the integrated approaches are comprehensive, people-centered (with integrated and fully resourced community-led responses and systems) and gender-transformative and that they reduce inequalities and uphold people's right to health.

6.1.2.2. Strengthen health system capacity to deliver services, including through improved human resources, procurement and supply management, monitoring and evaluation, governance and management to address the continuum of care needs of PLHIV across their life course.

6.1.2.3. Emphasize investments in community-led differentiated service delivery to ensure effective and equitable access that meets the context-specific needs of particular groups, places and individuals based on evidence of what works.

6.1.2.4. Strengthen the multi-sectorality of the HIV response, making it a whole-of-government and whole-of-society response by advocating and supporting the alignment of HIV, health and other sector strategies, policies and practices for pro-poor and pro-vulnerable social protection and essential services, including education for girls.

6.1.3 Result Area 3: Humanitarian settings and pandemics

| Major interventions

6.1.3.1. Promote policy, frameworks and legislation that ensure national emergency response plans are tailored to specific contexts and provide the initial minimum package and then expand to provide comprehensive HIV services to all people affected by humanitarian emergencies who are living with HIV or at-risk of HIV, regardless of residency or legal status.

6.1.3.2. Integrate refugees, internally displaced and other humanitarian-affected populations into national HIV policy frameworks, programmes and funding proposals, reflecting their diverse needs, including support and scale-up of community-led responses and adapted service delivery.

6.2 Core Targets and Result Framework

6.2.1 Core Targets

By the end of 2027:

i. Increase national HIV investments to USD 610 million by 2027
ii. 45% of people living with, at risk of and affected by HIV and AIDS have access to one or more social protection benefits.
iii. 95% of people within humanitarian settings at risk of HIV use appropriate, prioritized, people-centered and effective combination prevention options.
iv. 90% of people in humanitarian settings have access to integrated TB, hepatitis C and HIV services, in addition to programmes to address gender-based violence (including intimate-partner violence), which include HIV post-exposure prophylaxis, emergency contraception and psychological first aid.
v. 95% of people living with, at risk of and affected by HIV are better protected against health emergencies and pandemics such as COVID-19.

Result Framework: Fully Resourced and Sustained HIV Response

	Indicators	Baseline (End of 2022)	Source	Mid-Term (Mid-2025)	Assumption	End-Term, (End of 2027)	Assumption	Data Source
1	Increase national HIV investments to USD610,000 per year by 2027	$ 532,371,499	2019 NASA	$ 550,000,000	Mid-point between baseline achievement and End term Target	$610,000,000	The indicative cost of the NSF 2021-2025 was utilized with a year-on-year increase of $0.03 billion	NACA
2	45% of people living with, at risk of and affected by HIV and AIDS have access to one or more social protection benefits.	Data not available	NASSCO	20%	Mid-point between baseline achievement and End term Target	45%	20% to be achieved from the baseline with a 22.5% increment annually	NASSCO
3	95% of people within humanitarian settings at risk of HIV use appropriate, prioritized, people-centred and effective combination prevention options.	Data not available	Ministry of Humanitarian Affairs (FMHA)	50%	Mid-point between baseline achievement and End term Target	95%	50% to be achieved from the baseline with a 22.5% scale-up yearly	FMHA
4	90% of people in humanitarian settings have access to integrated TB, hepatitis C and HIV services, in addition to programmes to address gender-based violence (including intimate-partner violence), which include HIV post-exposure prophylaxis, emergency contraception and psychological first aid.	Data not available	FMHA	70%	Mid-point between baseline achievement and End term Target	90%	70% to be achieved from the baseline with a 10% scale-up annualy	FMHA
5	95% of people living with, at risk of and affected by HIV are better protected against health emergencies and pandemics including COVID-19	Data not available	NCDC	50%	Mid-point between baseline achievement and End term Target	95%	50% to be achieved from the baseline with a 22.5% scale-up yearly	NCDC

7.0 CROSS-CUTTING ISSUES

7.1 Leadership, Country Ownership, Governance, and Advocacy

Strengthened leadership will help reinforce and advance the principles, targets and commitments in this plan. To ensure that the country is on track to ending AIDS by 2030, leadership at the national and sub-national levels is imperative; including community leadership by PLHIV, key and priority populations, civil society organizations, the private sector, faith-based organisations, traditional leaders, the academia and international partners. Political leadership and actions in the spirit of leaving no one behind should focus on ensuring that people who are currently underserved have equitable access to acceptable, accessible and quality HIV services as well as social services and legal protection.

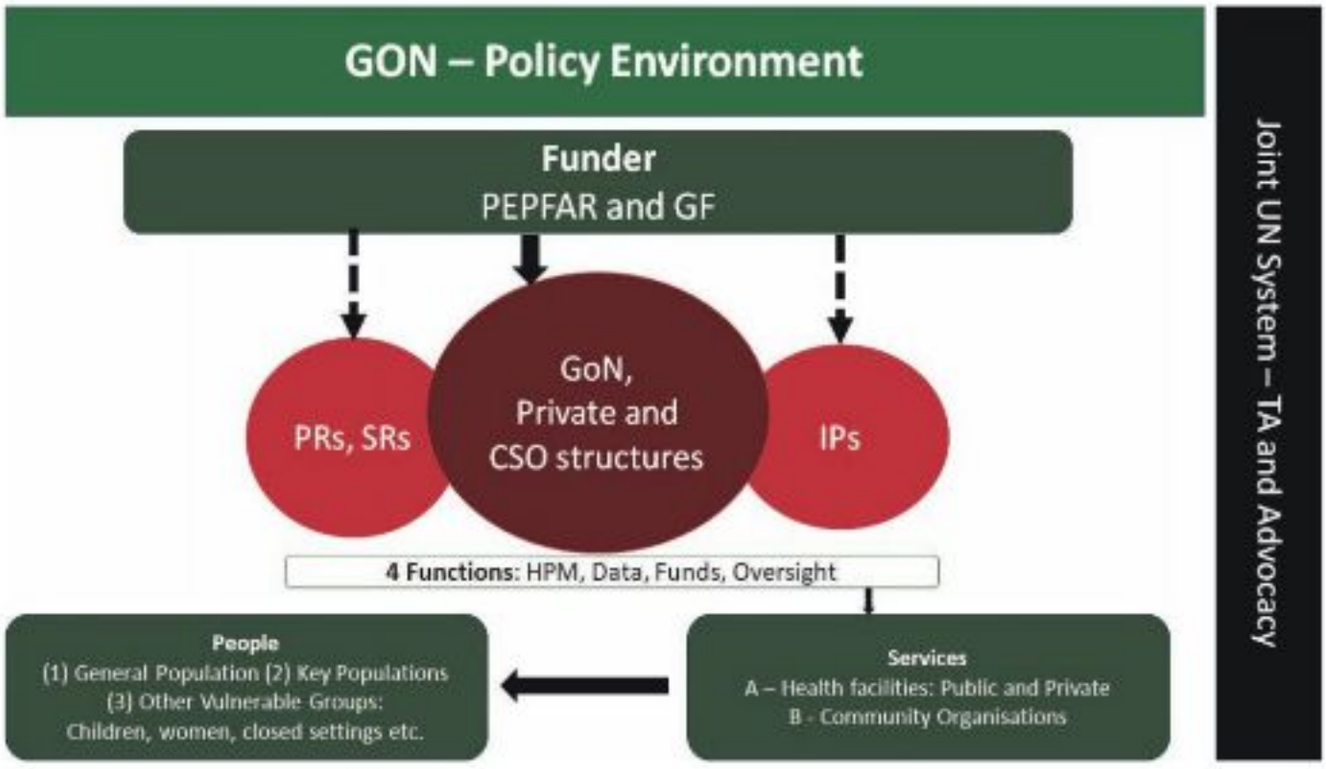


Figure 4: Sustainable delivery architecture/The New Business Model

(Source: NACA, 2022: New Business Model for the Nigerian HIV/AIDS National Response. 2023-2030)

The New Business Model is a core theme for "Alignment 2.0" and it is the national agenda which aims to strengthen Nigeria's ownership of the national HIV response as well as improve the potential for sustainability. The principles of the model were agreed to by stakeholders (GON, UNAIDS, PEPFAR, GF, and CSOs) during the National Joint Dialogue in January 2023.

Strengthened leadership will help reinforce and advance the principles, targets and commitments in this plan.

The key element of the model is the transitioning of the management of the holistic response to HIV in Nigeria, to mandated players (government, private & community structures) at federal and state level by 2030. It redesigns the donor/partner relationships with country institutions from direct service delivery (DSD) to technical assistance (TA) to the mandated structures and it entails the assessment of the mandated structures, the building of experiential competencies in the management of the HIV response and the incremental transitioning of responsibilities to the structures.

Major interventions

7.1.1

Strengthen the engagement of the country leadership to support the effective and efficient implementation of the national HIV and AIDS response

7.1.2

Strengthen state capacity for leadership of the HIV programmes at the state level

7.1.3

Improve domestic resource mobilization and utilization for national HIV and AIDS response

7.2 Partnerships, Multi-sectorality, and Collaboration

Partnership and collaboration between global and national partners, and among the government, international development organisations, academia, the private sector, indigenous civil society organisations, faith-based organisations, community-based organisations and the media is needed to strengthen the national response. This partnership will require bold, inclusive, multisectoral approaches to HIV in order to reduce inequalities, protect human rights, strengthen collaboration, improve synergies between HIV-specific, and broader health and development initiatives at all levels.

Major interventions

7.2.1

Strengthen collaboration among all Ministries Departments and Agencies of government

7.2.2

Strengthen the multilateral governance and coordination for effective national HIV and AIDS response

7.3 Data for Impact, Science, Research, and Innovation

Data is generated through science and research to inform innovative decision-making for policy formulation, policy review and program development. The implementation of the NSP 2023-2027 will be largely data-driven to inform policy formulation, review and policy development. However, the generation and use of data, including those generated by research, monitoring and evaluation, for decision-making still needs to be strengthened and aligned with human rights principles. Financing of regular monitoring and evaluation activities, infrastructure for national and sub-national monitoring and evaluation databases, routine monitoring and evaluation of HIV programmes need to be improved and strengthened. In addition, donor-driven monitoring and evaluation sub-systems need to be integrated into the Nigeria National Response Information Management System (NNRIMS). The generation of data from the private sector, including the private-for-profit stakeholders and the informal sectors, also needs to be improved.

7.3.1

Strengthen the national HIV response through generation and use of data.

7.3.2

Support the generation of data-derived evidence to inform the national HIV programme design and implementation.

7.3.3

Facilitate regular monitoring and data-driven timely response based on evidence generated from research, programme monitoring and evaluation.

7.3.4

Facilitate the regular monitoring and evaluation of all national HIV programmes.

7.3.5

Strengthen the integration of all data information systems and structures across the country.

7.3.6

Support the alignment of multiple systems and structures to promote the collation, dissemination and utilization of research-driven evidence.

8.0 COORDINATION STRUCTURE AND PROCESS

8.1 Coordination Structure for National Response

Nigeria's national HIV and AIDS response is a multi-sectoral response that involves key actors at the Federal, State, and the local government area levels and is coordinated by NACA in line with the principle of the "Three Ones" (One National AIDS Framework, One Coordinating body and One Monitoring and Evaluation System). The State Agency for the Control of AIDS (SACA) and the Local Action Committee on AIDS (LACA) coordinate HIV activities at the State and Local Government levels respectively.

The Federal Ministry of Health coordinates the health sector response through National AIDS and STI Control Programme (NASCP) while State AIDS and STI Control Programme (SASCP) coordinates the state health sector response. Relevant Federal and State Ministries, Departments and Agencies facilitate the mainstreaming of HIV and AIDS programmes into their sectoral programmes. The National and State Technical Working Groups plan and provide technical advice on thematic areas within the national and state responses.

The State Agency for the Control of AIDS (SACA) and the Local Action Committee on AIDS (LACA) coordinate HIV activities at the State and Local Government levels respectively.

NACA interfaces with Civil Society Organizations working on HIV and AIDS through the Coalition of Civil Society Networks. The leadership of the Coalition of Civil Society Networks was drawn from the Country Coordination Entities (CCEs) a body of representatives of Civil Societies. The CCEs consist of fourteen organizations clustered into four major entities; Network of People Living with HIV/AID in Nigeria (NEPWHAN)[1], Coalition of Civil Society Organization[2], NIFCOB-AIDS[3] and Nigerian Business Coalition against AIDS (NiBUCCA)[4]. NEPWHAN is the umbrella body for PLHIV in Nigeria, Coalition of Civil Society Organization coordinates all mainline CSOs in the HIV response, NIFCOB-AIDS facilitate all faith-based response effort in the HIV/AIDS space while NiBUCCA coordinates all private/for-profit business sector.

The national response coordinated by the National Agency for the Control of AIDS (NACA) is responsible for hosting of the National AIDS Council (NCA) that meets annually with delegates from all states, FCT and representatives of other stakeholders on HIV/AIDS matters by the board in line with the stipulations of the 2007 NACA Establishment Act. The agency is situated in the Presidency and reports through the Office of the Secretary to the Government of the Federation (OSGF). There is also the Senate Committee on Primary Health and Communicable Diseases and AIDS, Tuberculosis and Malaria Committee of the House of Representatives and the national HIV/AIDS Expanded Theme Group (ETG); which is a high-level coordinating platform for all relevant MDAs, development and implementing partners in the HIV/AIDS response in Nigeria. These bodies all play coordination and accountability roles with structures for the national response.

Coordinating Structures of the National HIV/AIDS Response

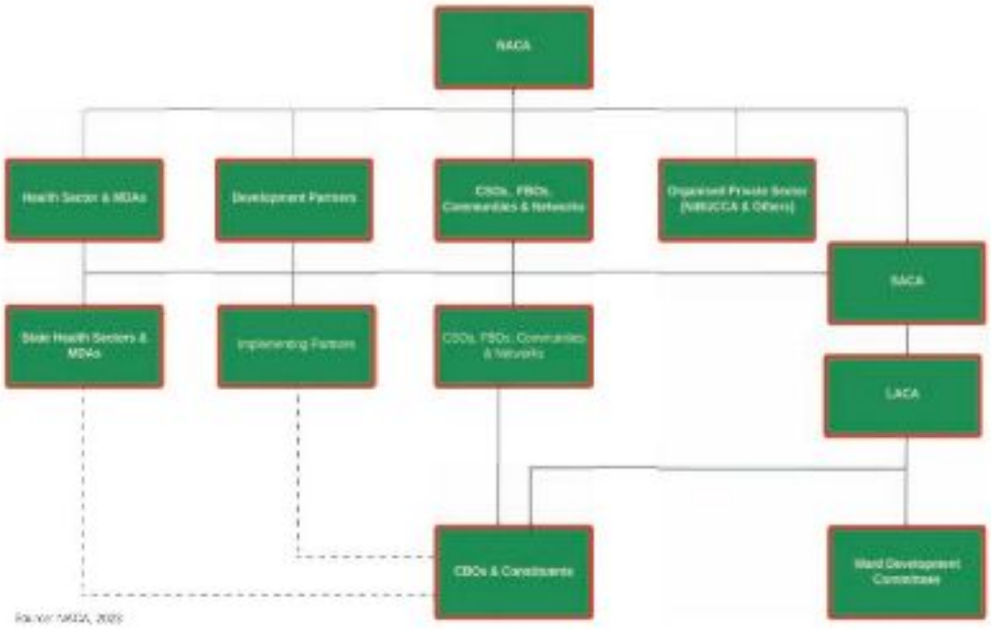


Figure 5: Coordinating Structures of the national HIV/AIDS response.

8.2 Strengthening Multi-sectoral Coordination

1. Harmonize National Operational Planning

The harmonised national multi-sectoral operational planning process should be strengthened to ensure the joint annual monitoring of the response progress is planned and conducted in line with the scheduled workplan. This will foster accountability, transparency and ensure national ownership of the response.

II. Strategic Information Management Framework

The strategic information management framework needs to be broadened to include data generated through integrated HIV responses. These data can facilitate prompt identification of gaps and inform decision-making to address these gaps.

III. Strengthen Coordinating Entities at Federal, State and LGA levels

NACA, SACAs, LACAs, Federal and State Ministries of Health and Primary Health Care Development Boards, relevant MDAs, implementing partners, community systems and service delivery structures need to be strengthened.

9.0 COSTING AND FINANCIAL RESOURCING OF THE PLAN

The National HIV/AIDS Strategic Plan 2023-2027 costs and resources available for its implementation are both vital preconditions to ensuring realistic achievement of targets and wholistic implementation of the strategy. The costing will facilitate and prioritize planned investments based on result areas with the design that appropriate measures to finance resource gaps that may emerge when all available streams of potential resources are fully explored.

9.1 Costing of the NSP

9.1.1 Overview of the Costing Approach

Financial estimates of the National HIV and AIDS Strategic Plan (2023– 2027) were costed using the One Health Tool (OHT) and excel tool. This costing approach ensures alignment with the multi-sectoral response framework for addressing the HIV epidemic. There are strategic priorities that constitute the core HIV service areas, investments proposed under each of the strategic priorities covered both the programme demands and components of health system strengthening. Health system components addressed under each priority area include infrastructure, logistics for HIV medicines and supplies, health information management, governance including community participation and human resource improvement.

The strategic priority one of the NSP has three result areas, namely **(i) HIV Prevention; (ii) HIV Testing, Treatment, Care, viral suppression and integration**; and **(iii) vertical HIV transmission and paediatric AIDS.** The OHT model estimated the cost for strategic priority one of the NSP. Strategic Priorities two and three were estimated using the excel tool. Strategic Priority two: break down barriers to achieve HIV outcomes have the following as its result areas **(i) community led responses; (ii) human rights; (iii) gender equality; and (iv) young people.** The costing for these result areas represents a percentage of total summary cost as presented by OHT after calibrating the intervention cost. Strategic Priority three has the following as its result areas: **(i) fully funded and efficient response; (ii) integration of HIV into systems for health and social protection, and (iii) humanitarian setting and pandemic response**s. The cost for these priority areas was estimated as part of the total programme management cost for the NSP 2023-2027.

> *The National HIV/AIDS Strategic Plan 2023-2027 costs and resources available for its implementation are both vital preconditions to ensuring realistic achievement of targets and wholistic implementation of the strategy.*

The limitation in this costing includes integration of priority two and three to HIV direct service demand for programming purpose under the OHT, which eventually created the justification for the use of the excel tool for costing. The new priority result focus areas such as gender equality, human rights and social discrimination could not be calibrated in the OHT which justify the use of excel based tool for its cost estimate. Though, drugs/commodities have ties to service demand, this is not so with gender and human rights as well as social discrimination. To overcome this limitation, the universal standard of allowable management financial space was deferred to. Programme management cost which was calculated outside the OHT using excel based approach was estimated per strategic priority area.

9.1.2 Indicative Costing for the National HIV and AIDS Plan 2023 - 2027

The financial estimates of this Plan are essential for mobilizing adequate resources to fast-track the national response towards ending AIDS in Nigeria by 2030. These estimates also provide an indicative cost for leveraging and prioritization of planned investments and the design of appropriate measures to finance the resource gaps that may emerge as stakeholders at federal and sub-national levels undertake to implement.

The following assumptions were considered in arriving at the financial cost of the NSP which include the population projection of 219,150,289[28] based on 2019 World Population Prospects. The official currency exchange rate used for the costing is ₦446.13 to the dollar. The assumption also posits that HIV services under the strategy will be delivered in existing health infrastructure and by the current providers. For HIV commodities, such as ART, HIV rapid test kit (RTK) and other supplies were projected towards the attainment of the 90-90-90 in 2023 and 95-95-95 targets by 2027. Human Resource cost was estimated as the share of full- time equivalent committed to HIV service delivery with each staff working for 260 days at 8 hours/ day. Annual salaries for front-line staff (doctors, nurses, including laboratory staff) was derived from the estimates applied using readjusted salary structure of health workers in Nigeria.

> *The financial estimates of this Plan are essential for mobilizing adequate resources to fast-track the national response towards ending AIDS in Nigeria by 2030.*

Health infrastructure utilization costs were estimated based on visits using the adjusted cost per out-patient visit of ($6.8USD in 2021). This amount was further adjusted for only running cost at $0.51USD in 2021. Policy-based prevention programs such as community mobilization, in-school intervention, human rights and gender were estimated at share cost of the health sector cost (28%). Treatment protocol applied in the NSP cost estimation was based on the National guidelines. Unit costs for medications and supplies were derived from the Global Fund-supported medicine and commodities database GF WAMBO Platform.

The total cost for implementing the NSP from 2023 to 2027 is estimated at the sum of ₦1.486 Trillion (One Trillion, Four Hundred and Eighty-Six billion Naira) *approximate value* (USD3,330.09 million), with HIV intervention cost accounting for 74% of the proposed investments for the five the year duration of the plan. The sum of ₦250 Billion was allocated to address HIV program management activities, including policy-based prevention intervention (Table 6). Breakdown for each of the priority areas is in the annex.

Table 6: Implementation Cost for the NSP (in Naira) by Programme Area and Year

Intervention Cost - New HIV NSP 2023 - 2027	HIV/AIDS NSP 2023 - 2027 Total Summary Cost						
	2023	2024	2025	2026	2027	Total Cost in Naira	Grand Total (in USD)
Treatment and Care	₦204.67B	₦202.02B	₦199.58B	₦196.89B	₦194.08B	₦997.23B	**$2,235.28M**
Prevention Services (KPs)	₦33.97B	₦38.91B	₦41.84B	₦48.54B	₦52.67B	₦215.93B	**$484.00M**
Other Preventive Services	₦3.91B	₦3.96B	₦4.48B	₦4.97B	₦5.61B	₦22.91B	**$51.36M**
Cross-cutting Interventions	₦20.56B	₦22.74B	₦24.66B	₦26.11B	₦27.37B	₦121.45B	**$272.23M**
Monitoring Research & Development	₦21.70B	₦23.99B	₦26.02B	₦27.55B	₦28.88B	₦128.14B	**$287.23M**
Total	**₦284.81B**	**₦291.63B**	**₦296.55B**	**₦304.06B**	**₦308.60B**	**₦1,485.66B**	**$3,330.09M**
Total costs in US$	**$638.41M**	**$653.68M**	**$664.72M**	**$681.55M**	**$691.73M**	**$3,330.09M**	

A further breakdown tables for this summary cost are presented in the annex for each of the major block of the HIV/AIDS interventions.

The year-by-year total cost resource investment requirements for the implementation of the HIV/AIDS 2023-2027 NSP are presented in Figure 5 in Naira and Figure 6 in USD.

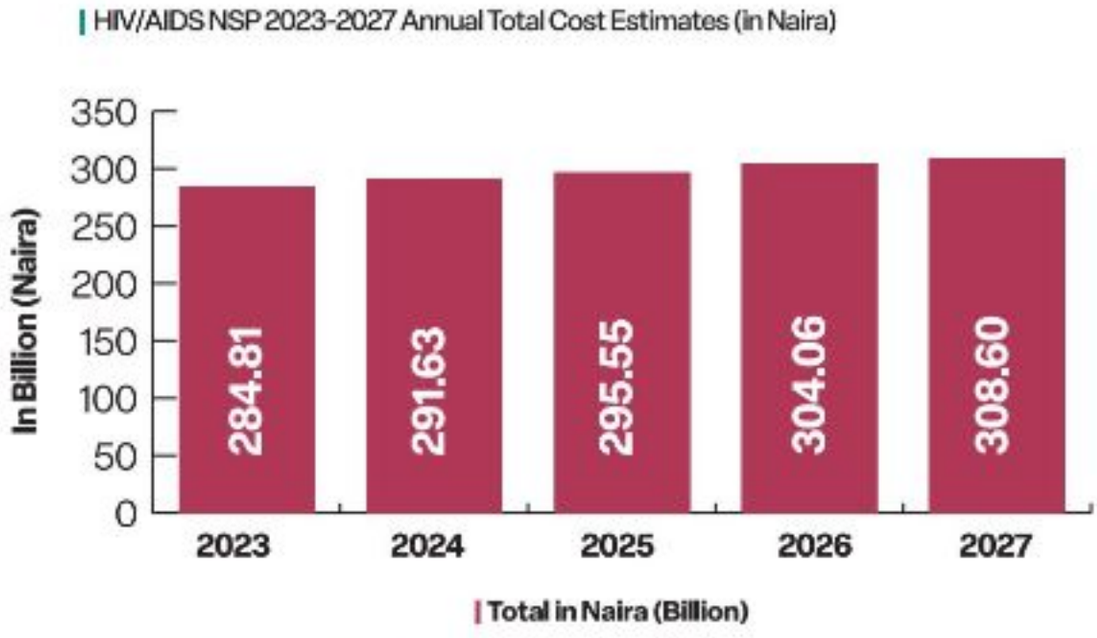


Figure 6: Annual Total Cost for NSP 2023-2027 (Naira)

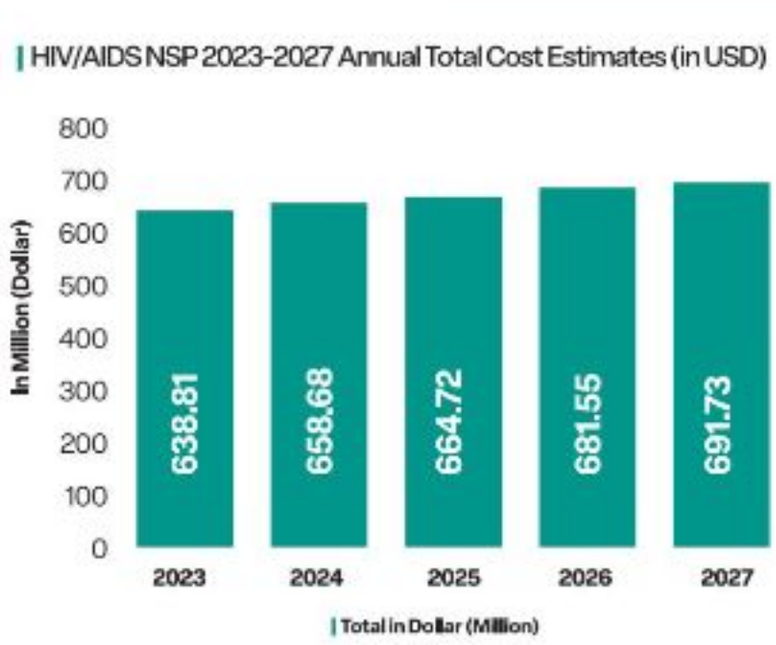


Figure 7: Annual and Total Cost for NSP 2023-2027 (USD)

9.1.3 Risks and Assumptions for the Costing of the NSP

Increased donor fatigue and fund withdrawal. The fatigue is evident, even from the resource gap analysis. 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 *National Domestic Resource Mobilization and Sustainability Strategy for HIV 2021-2025* to generate increased domestic funding from public, private, non-profit and development focused foundations for sustainability is essential.

Increased new infections due to negative behaviour modification as a result of perceived low vulnerability. Promotion of behaviour 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 (MPPI), developing targeted and appropriate HIV prevention communication plan and promoting workplace programmes to support workers in all sectors to access HIV prevention services are key.

Inadequate political will in the fight against HIV. Strong political leadership of government and with the Civil Society Organisations role as government watchdog will help mitigate the fight against HIV.

Reduction of key technical expertise to other programme areas and brain drain. An emerging issue (e.g., a global pandemic or geopolitical conflict) could significantly divert the attention of technical experts 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. This brain drain may adversely affect the 2030 agenda to end AIDS in Nigeria if not addressed.

Reduced access to HIV services. Map and increase community-based care and support service sites to improve the coverage of targeted social and behaviour 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 services into routine health services. Government to come up with legislation to integrate HIV services into routine health services that will ensure availability, accessibility, and affordability of HIV services and removal of all bottlenecks around accessing HIV services.

9.2 Mechanism for Financing the National HIV and AIDS Strategic Plan 2023-2027

9.2.1 Public sector resources

In the light of the global economy, Nigeria has the potential to increase her spending on HIV/AIDS as the share of the health sector to GDP stand at 2.99% (2019) and 3.38% (2020). The fact that Nigeria allocated 826.9 27 billion to health sector in 2022 should increase more resources to HIV/AIDS, but this was not so. Further evidence in previous years of low spending on HIV/AIDS is public sector contribution as reported relating to HIV as a sub-sector of the health sector which stands at 1% as at 2018 28 as a percentage of health sector spending. This is clear evidence that there is room to accommodate financial space for HIV/AIDS. It is in line with this that Federal Government of Nigeria has given space for increase allocations over the year to HIV response. The mainstream of public sector-financing for HIV in Nigeria in 2022 are: (i) Basic Minimum Package of Health Services (this is consolidated revenue fund); (ii) Health Insurance Scheme; and government budgetary allocations.

Basic Minimum Package of Health Services: The National Health Act that established the Basic Health Care Provision Fund (BHCPF) as part of commitment to developing Universal Health Coverage for all Nigerians was signed into law in Nigeria in October 2014. Source of finance for the BHCPF is the Federal Government annual grant of at least 1% of the Consolidated Revenue fund. The BHCPF covers 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 paediatric treatment into the Basic Minimum Package of Health Services as part of the post-natal mother and baby care interventions.

Health Insurance Scheme: Integrating HIV services into state insurance schemes will help increase financial protection for people living with HIV, who will be able to avoid or reduce the economic burden imposed by user fees they sometimes must pay to see a healthcare provider or access ART.

Government Budgetary Allocation: The federal government of Nigeria has continued to fund the HIV response through its MDAs some of which include the National Agency for the Control of AIDS, Federal Ministry of Health, Federal Ministry of Women Affairs, Federal Ministry for Youths and Social Development, Ministry of Education and Federal Ministry of Defense. National AIDS Spending Assessment (NASA) 2019 estimates public contribution to the HIV response as USD91,477,782. Government expenditure is largely funded by budgetary allocation.

9.2.2 Private Sector Resources

HIV/AIDS Trust Fund: The Government of Nigeria has worked 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 on closing the commodities gap. It is envisaged that this will result in significantly increased 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 paediatric HIV treatment and contributing HIV commodities to the national pool. The contributions of CoCSHAN, NEPHWAN, NIFCOB-AIDS in proposal development that eventually lead to service delivery should be quantified as part of resources and investment profile for HIV/AIDS in Nigeria. Overall, the HIV/AIDS trust fund is an important mechanism to ensure sustainable financing for treatment of PLHIV.

9.2.3 International Development Partners

The HIV response in Nigeria has so far been heavily dependent on external resources, with more than 80% of the resources for interventions being provided by Global Fund, PEPFAR and other international partners. More than $10 billion has been expended on HIV response in Nigeria between 2004 and 2022, and the funding from the United States government accounted for about 75% of that. While the proportion of fund contributed by the Nigerian government has hitherto been low, the country is highly determined to increase its level of resourcing for HIV response significantly as well as mobilise more domestic funding. This promising step notwithstanding, Nigeria will continue to require the support of international development partners for its HIV response, at least in the short- and medium-term, given the current state of its national economy and the HIV burden.

9.2.4 Domestic Production of ARVs and other HIV Commodities

This is a potential avenue for improving the level of domestic funding available for HIV programming. With the estimated population of PLHIV as 1.9million, Nigeria has a huge market for HIV-related commodities. With the right policies and incentives, Nigeria's growing pharmaceutical market has the potential to successfully venture into greater production of HIV-related commodities. All necessary protocol including formulation and packaging essential medicines can be regulated to meet international standards. Locally produced condoms will account for most of the condoms marketed in Nigeria.

> *Almost all antiretroviral drugs used in Nigeria in 2022 were imported with no local value-added, as treatment costs currently account for about 65% of HIV funding requirements*

Almost all antiretroviral drugs used in Nigeria in 2022 were imported with no local value-added, as treatment costs currently account for about 65% of HIV funding requirements. It is therefore important for the Government of Nigeria to lay the necessary policy, fiscal and regulatory environment for cost-competitive domestic production of antiretroviral drugs meeting WHO prequalification requirements. The local consumption should be satisfied first before consideration to other surrounding nations. Large-scale industrial development initiative that will take time to have return on investment, but the long run curve is definitely good for economy and human capital development. Simple packaging and local formulation are unlikely to bring competitiveness vis-a-vis integrated volume suppliers producing their own Active Pharmaceutical Ingredients (APIs). A critical element in the development of local production is the promotion of brands consumers can trust. To this end, the Federal Ministry of Health through NAFDAC will facilitate the setting up of a bioequivalence studies laboratory to ensure that all essential medicines produced locally in Nigeria will be quality assured for their desired pharmacological efficacy.

9.3 Financial Strategy for NSP 2023-2027

The financial strategy proposed for a feasible and fundable National HIV and AIDS Strategic Plan is hinged on constant mapping of all available resources annually to find equilibrium of planned estimate with available funding. During implementation, there is flexibility to scale up or down should the need arise. In this financial analysis, development assistance is aimed at improving quality and coverage of HIV/AIDS specific services like interventions empowering community systems and non-state actors targeted PLHIV services.

All mapped resources that have direct relationship with HIV programming are Federal and State Government subvention to NACA, SACA, NASCP and other line ministries. On the international HIV resource support mapped are USG PEPFAR, GF, UN system and other development partners.

Table 7: Annual funding gap analysis (in USD)

Funding Source in USD (Million)	2023	2024	2025	2026	2027	Total
Government of Nigeria (NACA) in million	$18.3m	$18.3m	$18.3m	$18.3m	$18.3m	$81.3m
Government of Nigeria (NASCP)	TBD	TBD	TBD	TBD	TBD	$ -
Government of Nigeria (State Budget)	TBD	TBD	TBD	TBD	TBD	$ -
HIV Trust Fund (in million)	$26.9m	$33.6m	$47.1m	$73.0m	$116.8m	$297.3m
USG PEPFER (in million)	$510.9m	$510.9m	$510.9m	$510.9m	$510.9m	$2,554.3m
World Bank	-	-	-	-	-	$ -
Global Fund (in million)	$191.2m	$185.9m	$156.1m	TBD	TBD	$503.2m
Private Sector	-	-	-	-	-	$ -
Faith Based (in million)	$4.5m	$5.4m	$6.5m	$7.7m	$9.3m	$33.3m
Health Insurance (in million)	$4.5m	$5.4m	$6.4m	$7.5m	$8.7m	$32.4m
Total Available (in million)	**$744.2m**	**$737.4m**	**$743.1m**	**$615.3m**	**$661.8m**	**$3,501.8m**
National HIV/AIDS Strategic 2023-2027 (Cost in Dollar) in million	$638.4m	$653.7m	$664.7m	$681.6m	$691.7m	$3,330.1m
Funding Gap (in million)	$105.8m	$83.7m	$78.4m	$(66.3m)	$(29.9m)	
Funding Gap Percentage	**17%**	**13%**	**12%**	**-10%**	**-4%**	

The magnitude of support for HIV/AIDS has drastically reduced, which now necessitate unavoidable expansion of fiscal space for HIV programs in Nigeria. It is proposed that about 97% of current resources will be made available for HIV beyond 2024 to further reduce the funding gap estimated at 10% in 2026 and 4% in 2027 and this will hold if there is sustainable performance of the planned resource mapped at 100% investment in the HIV/AIDS space. This is on the assumption that there are consistent national resource commitments to HIV response as well as international assistance to HIV programs. The funding gap will be bridged if more investments crowd-in within the life span of this NSP. The cost driver for this NSP is the ART services as identified in the summary cost table at 73%. A shift in government policy to mobilize resources into HIV space is more desirable and important in this cycle of NSP. In addition to government policy shift, annual allocation to HIV programs at ₦150 billion will eliminate the funding at the end of the 2023-2027 NSP.

Locally produced Anti-Retroviral Drugs have the potential of cost reduction by 27%. One critical strategy is for NACA to coordinate development assistance by avoiding double effort of resources for same HIV interventions. Transparency and accountability of resources will free more resources for HIV interventions.

10.0 APPENDIXES

Appendix I: Details of Costing of the NSP

Appendix I-A: Cost of interventions relating to NSP Strategic Priority I, 2023-2027

Intervention Cost for NSP 2023-2027	Strategic Priority I: Equitable & equal access to HIV services for all					Total (in ₦Billion Naira)	Total In USD (in Million $)
Priority I: Result Areas	2023	2024	2025	2026	2027		
4.1.1. HIV Prevention	₦29.81B	₦33.74B	₦36.44B	₦42.11B	₦45.86B	**₦187.97B**	**$421.33M**
4.1.2. HIV Testing, Treatment, Care, Viral Suppression and Integration	₦116.47B	₦115.27B	₦114.20B	₦113.04B	₦112.56B	**₦571.54B**	**$1,281.10M**
4.1.3. Vertical HIV Transmission, paediatric AIDS	₦15.95B	₦15.59B	₦15.04B	₦14.44B	₦13.80B	**₦74.82B**	**$167.70M**
Total for Strategic Priority 1	₦162.23B	₦164.60B	₦165.68B	₦169.59B	₦172.21B	₦834.32B	**$1,870.13M**
Cost in USD	**$363.64M**	**$368.95M**	**$371.36M**	**$380.14M**	**$386.05M**	**$1,870.13M**	
Programme Management Cost	₦24.50B	₦24.85B	₦25.02B	₦25.61B	₦26.01B	₦125.98B	**$282.39M**
Grand Total for Strategic Priority 1	₦186.73B	₦189.45B	₦190.69B	₦195.20B	₦198.23B	**₦960.31B**	**$2,152.52M**
Grand Total Cost in USD	**$418.55M**	**$424.66M**	**$427.44M**	**$437.54M**	**$444.34M**	**$2,152.52M**	

Appendix I-B: Cost of interventions relating to NSP Strategic Priority II, 2023-2027

Intervention Cost for NSP 2023-2027	Strategic Priority II: Break down barriers to achieving HIV outcomes					Total (in 'Billion Naira)	Total In USD (in Million $)
Priority 2 Result Areas	**2023**	**2024**	**2025**	**2026**	**2027**		
5.1.1. Community led response	₦5.31B	₦5.87B	₦6.37B	₦6.74B	₦7.06B	**₦31.35B**	**$70.26M**
5.1.2 Human rights	₦7.18B	₦7.94B	₦8.61B	₦9.11B	₦9.55B	**₦42.39B**	**$95.03M**
5.1.3. Gender Equality	₦8.92B	₦9.86B	₦10.70B	₦11.32B	₦11.87B	**₦52.67B**	**$118.06M**
5.1.4 Young People	₦11.31B	₦12.51B	₦13.57B	₦14.36B	₦15.06B	**₦66.80B**	**$149.74M**
Grand Total for Result Area II	₦32.72B	₦36.18B	₦39.24B	₦41.54B	₦43.54B	**₦193.21B**	**$433.09M**
Cost in USD	**$73.34M**	**$81.09M**	**$87.95M**	**$93.11M**	**$97.61M**	**$433.09M**	
Programme Management Cost	₦4.94B	₦5.46B	₦5.92B	₦6.27B	₦6.58B	₦29.18B	**$65.40M**
Grand Total for Strategic Priority II	₦37.66B	₦41.64B	₦45.16B	₦47.81B	₦50.12B	₦222.39B	**$498.49M**
Grand Total Cost in USD	**$84.41M**	**$93.34M**	**$101.23M**	**$107.17M**	**$112.34M**	**$498.49M**	

Appendix I-C: Cost of interventions relating to NSP Strategic Priority III, 2023-2027

Coordination Cost for NSP 2023-2027	Strategic Priority 3: Fully funded and efficient HIV response					Total (in 'Billion Naira)	Total In USD (in Million $)
Priority 3 Result Areas	**2023**	**2024**	**2025**	**2026**	**2027**		
6.1.1. Fully funded & efficient response	₦10.66B	₦11.79B	₦12.78B	₦13.53B	₦17.55B	₦66.31B	**$148.63M**
6.1.2. Integration of HIV into systems for health and social protection	₦28.82B	₦31.87B	₦34.57B	₦36.59B	₦38.36B	₦170.22B	**$381.55M**
6.1.3. Humanitarian Settings and Pandemics	₦4.57B	₦5.05B	₦5.48B	₦5.80B	₦6.08B	₦26.98B	**$60.47M**
Grand Total for Result Area 3	₦44.05B	₦48.71B	₦52.83B	₦55.93B	₦61.99B	₦263.50B	**$590.64M**

Coordination Cost for NSP 2023-2027	Strategic Priority 3: Fully funded and efficient HIV response					Total (in 'Billion Naira)	Total In USD (in Million $)
Priority 3 Result Areas	2023	2024	2025	2026	2027		
Cost in USD	$98.74M	$109.18M	$118.42M	$125.36M	$138.94M	$590.64M	
Programme Management Cost	₦6.65B	₦7.36B	₦7.98B	₦8.44B	₦9.36B	₦39.53B	$88.60M
Grand Total for Strategic Priority 3	₦50.70B	₦56.07B	₦60.81B	₦64.37B	₦71.35B	₦303.29B	$679.83M
Grand Total Cost in USD	$113.65M	$125.67M	$136.30M	$144.29M	$159.93M	$679.83M	

Appendix I-D: Programme Management Cost Per Strategic Priority Area of NSP 2023-2027

Coordination Cost for NSP 2023-2027	Programme Management					Total (in 'Billion Naira)	Total In USD (in Million $)
Per Strategic Priority	2023	2024	2025	2026	2027		
Programme Management Cost for strategic Priority I	₦24.50B	₦24.85B	₦25.02B	₦25.61B	₦26.01B	₦125.98B	$282.39M
Programme Management Cost for strategic Priority II	₦4.94B	₦5.46B	₦5.92B	₦6.27B	₦6.58B	₦29.18B	$65.40M
Programme Management Cost for strategic Priority III	₦6.65B	₦7.36B	₦7.98B	₦8.44B	₦9.36B	₦39.79B	$89.19M
Grand Total Cost In Naira	₦36.09B	₦37.67B	₦38.92B	₦40.33B	₦41.94B	₦194.95B	$436.97M
Grand Total Cost in USD	$80.89M	$84.44M	$87.24M	$90.39M	$94.01M	$436.97M	

Appendix I-F: Annual intervention coverages (%) for the NSP costing (2023-2027)

HIV Prevention Services	2023	2024	2025	2026	2027	Total Number of Services 2023 -2027
PWID: Outreach	25	35	45	55	65	**1,491,941**
PWID: Needle and Syringe Programme	12	16	19	22	25	**339,297.10**
PWID: Drug Substitution	0.0	01	0.3	0.4	0.5	**4,675.57**

HIV Prevention Services	2023	2024	2025	2026	2027	Total Number of Services 2023 -2027
Interventions focused on female sex workers	25	35	45	55	65	**1,491,941**
Interventions focused on men who have sex with men	45	55	65	70	80	**343,696**
Youth Focused Interventions - Out-of-School & AGYW	94	88	83	79	74	**359,994,542**
HIV Testing Services Including Self-Testing	100	100	100	100	100	**57,038,795.29**
Condoms	57	64	70	75	80	**96,191,061.61**
PMTCT	100	100	100	100	100	**289,872.46**
Management of STI for key population	34	35	36	37	38	**3,257,147.30**

Appendix I-G: Average annual cost per case, 2023-2027

Prevention Services Package	Average Cost in NGN	Average Cost in US$	% of Prevention Service Cost
PWID: Outreach	₦17,271.98	$38.72	0.0%
PWID: Needle and Syringe Programme	₦59,998.46	$134.49	0.3%
PWID: Drug Substitution	₦2,996,396.37	$6,716.42	94.5%
Interventions focused on female sex workers	₦40,373.21	$90.50	1.2%
Interventions focused on men who have sex with men	₦14,860.06	$33.31	0.4%
Youth Focused Interventions - Out-of-School & AGYW	₦665.13	$1.49	0.0%
HIV Testing Services Including Self-Testing	₦981.59	$2.20	0.0%
Condoms	₦1,404.50	$3.15	0.0%
PMTCT	₦114,546.58	$256.76	3.0%
Management of STI for key population	₦5,689.28	$12.75	0.1%

Appendix I-H: Intervention coverages in percentages, 2023-2027

Care and treatment Services	2023	2024	2025	2026	2027	Total Number of Services 2023 -2027
ART for men	70	80	90	93	95	**2,715,053**
ART for women	86	88	90	93	95	**5,232,532**
Proportion of adults on ART using Second-Line ART	5	5	5	5	5	**418,294**
Cotrimoxazole for children	100	100	100	100	100	**764,756**
Pediatric ART	100	100	100	100	100	**512,092**
Diagnostics/lab costs for HIV+ in care	80	85	90	93	95	**7,203,090**
Management of Opportunistic Infections associated with HIV/AIDS (including TPT Provision)	80	85	90	93	95	**1,255,931**
Screen HIV+ cases for TB	100	100	100	100	100	**9,534,409**
HIV prevention for TB patients	100	100	100	100	100	**592,231**

Appendix I-J: Average annual cost per case, 2023-2027

Care and treatment Services	Average Cost in NGN	Average Cost in US$	% of Treatment & Care Service Cost
ART for men	₦43,628.30	$97.79	12.5%
ART for women	₦43,628.30	$97.79	12.5%
Proportion of adults on ART using Second-Line ART	₦123,756.43	$277.40	38.5%
Cotrimoxazole for children	₦12,675.48	$28.41	1.7%
Pediatric ART	₦73,177.00	$164.03	22.7%
Diagnostics/lab costs for HIV+ in care	₦24,182.11	$54.20	7.9%
Management of Opportunistic Infections associated with HIV/AIDS (including TPT Provision)	₦13,397.27	$30.03	2.3%
Screen HIV+ cases for TB	₦7,074.70	$15.86	1.8%
HIV prevention for TB patients	₦459.18	$1.03	0.1%

Appendix II: List of NSP 2023-2027 Development Consultants

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