Annual HIV Programme Performance Review 2024 - Report

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List of Acronyms

ANC	Antenatal care
AOP*	Annual Operational Plan
API*	Application Programming Interface
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
AYP	Adolescents and young people
CLM	Community-led monitoring
CSO*	Civil society organisation
DATIM*	Data for Accountability, Transparency, and Impact Monitoring (PEPFAR)
DBS*	Dried blood spot
DHIS2	District Health Information System 2
DQA	Data quality assessment
DTG*	Dolutegravir
EID*	Early infant diagnosis
EOC*	Emergency Operations Centre
EPI*	Expanded Programme on Immunisation
FCT	Federal Capital Territory
FSW	Female sex workers
GAM	Global AIDS Monitoring
GBV*	Gender-based violence
Gen-N	Generation Negative Strategy
GHR*	Gender and Human Rights
HIV	Human Immunodeficiency Virus
HTS*	HIV testing services
HTS_TST*	PEPFAR indicator: number of people who received HIV testing services and received results
IBBSS*	Integrated Biological and Behavioural Surveillance Survey
IDP*	Internally displaced person/people
JDQA*	Joint Data Quality Assessment
KP	Key populations
LACA*	Local Action Committee on AIDS
LAMIS*	Lafiya Management Information System (EMR)
LGA*	Local Government Area
LEA	Law enforcement agencies
MER	Monitoring, Evaluation and Reporting (PEPFAR)
MH*	Mental health
MICS	Multiple Indicator Cluster Survey
MTSS*	Medium-Term Sector Strategy
MTEF*	Medium-Term Expenditure Framework
NACA	National Agency for the Control of AIDS

NAIIS	Nigeria AIDS Indicator and Impact Survey
NASSCO	National Social Safety-Nets Coordinating Office
NCD*	Non-communicable diseases
NDARS*	National Data Analytics and Reporting System
NDR	Nigeria National Data Repository
NEMIS*	Nigeria Education Management Information System
NHIA*	National Health Insurance Authority
NHMIS*	National Health Management Information System
NHRC*	National Human Rights Commission
NOMIS*	National OVC Management Information System
NSP	National Strategic Plan
NSR*	National Social Register
OVC	Orphans and vulnerable children
OTZ	Operation Triple Zero
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PITC*	Provider-initiated testing and counselling
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PMTCT_EID*	PEPFAR indicator: early infant diagnosis under PMTCT
PoC*	Point of care
PNC*	Postnatal care
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
SACA	State Agency for the Control of AIDS
SAPC	State Action Plan Committee
SARC	Sexual Assault Referral Centres
SDS	Sustainability and Development Strategy
SLA*	Service-level agreement
SOP	Standard operating procedure
SSMPA*	Same Sex Marriage (Prohibition) Act
TB_ART*	PEPFAR indicator: ART patients who started TB treatment during the period
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAPP Act	Violence Against Persons (Prohibition) Act
VL —	Viral load

Items marked with an asterisk were not expanded verbatim in the article and are provided here using commonly accepted expansions in Nigeria's HIV programme context.*

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Executive Summary

Synthesis of Integrated Key Findings Across All Evidence Sources

Nigeria's HIV response in 2024 demonstrates a complex landscape of significant achievements alongside persistent structural and operational challenges. The triangulation of evidence from the comprehensive desk review, stakeholder interviews, and workshop group deliberations reveal a response system that has made substantial progress in treatment scale-up while facing critical gaps in prevention, domestic financing, and system integration.

Treatment and Care Achievements: Nigeria sustained strong treatment outcomes in 2024. The national cascade stands at 87-98-96, with the second and third steps remaining high and the first step still below the 95% benchmark. Paediatric outcomes continue to lag adult coverage: 83-87-88, with viral suppression among children on ART remaining high, but case-finding and linkage as the weakest points.

Prevention Performance and Q1–Q2 2025 signal: Prevention showed the clearest stress signal heading into 2025. Between Q1 and Q2 2025, KPs/VPs reached with prevention services fell by ~50.5% (70,414 → 34,819); HTS among KPs/VPs dropped by ~70.2% (115,411 → 34,389); and PrEP initiations for KPs/VPs declined by ~83% (37,442 → 6,326). Male condom distribution decreased by ~36%, female condoms increased by ~153%, and needles/syringes rose by ~12%, pointing to mixed commodity and program continuity dynamics. These quarter-over-quarter shifts underscore the need to stabilise prevention supply chains, refocus demand generation, and align partner efforts with national priorities (Q1–Q2 2025).

Furthermore, recent data from the 2023-24 Nigeria Demographic and Health Survey reveals alarming gaps in HIV knowledge and testing rates, with only 22% of men and 30% of women aged 15-24 having comprehensive HIV knowledge. Furthermore, 90.6% of men and 79% of women in this age group have never been tested for HIV, highlighting the critical need for understanding the underlying social determinants.

Data System Fragmentation: A critical cross-cutting findings across all sources is the persistent fragmentation of HIV data systems. The desk review noted an ongoing divergence between Monitoring, Evaluation, and Reporting (MER), National Data Repository Data (NDR), Nigeria National Data Repository(NDARS) and District Health Information Software 2.0 (DHIS2. 0 platforms. Stakeholders noted an ongoing challenge in data management in certain settings—such as inconsistent EMR use, variable documentation of viral load, and gaps in routine indicators. Workshop deliberations also observed that, in several programmes, donor-linked reporting streams continue to run alongside national platforms (e.g., DHIS2/NDR and MER/DATIM), which limits routine triangulation and smooth data exchange. Overall, the review frames these as interoperability and quality-assurance gaps that require steady, targeted improvement rather than signs of system failure.

Financing and Sustainability Crisis: All evidence sources point to the need to strengthen domestic resource mobilisation. The desk review, interview insights, and workshop deliberations indicate continued heavy reliance on external financing - in 2021, approximately 82% of HIV spending came from international sources. Stakeholders also highlighted that government allocations remain insufficient and uneven. The HIV Trust Fund of Nigeria launched in 2022, has yet to be fully leveraged, with fewer than one in ten states reporting integration of Trust Fund resources in their HIV budgets or activities by 2024. In addition, limited inclusion of HIV services in the National Health Insurance Authority (NHIA) scheme constrains financial protection for people living with HIV and undermines sustainability. Together, these findings signal a clear opportunity to expand domestic financing—including through health insurance mechanisms—and to improve predictability and state-level uptake.

Population-Specific Disparities: Workshop findings revealed significant gaps across target populations. Workshop participants identified state-level programs to be "largely focused on AGYW with little targeted interventions for adolescent boys and young men." Workshop group deliberations highlighted that the criminalisation of same-sex behaviour, drug use, and sex work continues to limit service uptake among key populations. The desk review confirmed that these populations face the highest HIV prevalence rates, with transgender individuals at 28.8% and MSM at 25.0%.

Summary of Cross-Cutting Challenges and Opportunities

Cross-Cutting Challenges:

1. **Structural Policy Misalignment:** Workshop groups identified policy domestication gaps across multiple domains - from AYP strategies at the state level to HIV anti-stigma laws remaining undomesticated in 19 states.
2. **Service Integration Deficits:** Evidence across all sources point to weak integration between HIV services and broader health systems. Workshop group deliberations identified limited integration with social protection programs, while interview participants noted challenges in "service integration and coordination."
3. **Human Resource Constraints:** Interview findings emphasised "serious shortage of health workers," while workshop groups consistently identified inadequate staffing as limiting service delivery across all population groups.
4. **Supply Chain Vulnerabilities:** All sources documented commodity stock-outs. Interview participants reported "frequent stock-outs of test kits," while workshop groups identified "deprioritization of HIV prevention commodities" such as condoms and PrEP and weak logistics management. .

Cross-Cutting Opportunities:

1. **Government Leadership Momentum:** Government budget momentum, community structures, digital convergence, and legal reform progress present important opportunities. These should be institutionalized by expanding digital convergence pilots (e.g., NDARS–DHIS2 interoperability led by FMoH/NACA) into national systems, building on government-owned initiatives such as the HIV Trust Fund of Nigeria and the Basic Health Care Provision Fund (BHCPF) to strengthen domestic financing, and sustaining progress through the domestication of the VAPP Act and the establishment of state Sexual Assault Referral Centres (SARCs). Leveraging political will at state levels—for example, recent increases in HIV budget allocations in Benue and Akwa Ibom will further improve resource absorption and accountability
2. **Community-Led Response Potential:** TThe desk review highlighted effective community structures like NEPWHAN's "Community iMonitor," while workshop group deliberations emphasised opportunities for empowering community-based organisations and local leaders.
3. **Digital System Convergence:** DDespite fragmentation challenges, all sources identified opportunities for interoperability of data platforms and leveraging technology for improved service delivery and monitoring.
4. **Legal and Policy Reform Progress:** TThe desk review documented Violence Against Persons (Prohibition) Act (VAPP) Act domestication in 32 states and Sexual Assault Referral Centers (SARC) establishment in 36 states, while workshop group deliberations identified pathways for expanding legal protections.

Ten Priority Recommendations by Thematic Domain

Based on consensus and triangulated evidence from workshop groups:

- **Prevention and Community-Led Response:** Drive and strengthen the country's agenda for Primary HIV Prevention (HIV test kits and testing, Condoms, and the Right information on HIV and Stigma) through investment and improved coordination. Also, focus on aligning donor and government priorities in PrEP service delivery to target populations.
- **Testing, Treatment, and Care Integration:** Prioritize scale-up of HIV testing in the community and all primary health centres by training existing ANC staff and ensuring consistent supply of test kits through improved logistics and stock monitoring.
- **Human Rights and Gender Equality:** State governments should conduct high-level advocacy programs targeted at legislative and executive arms of government seeking to domesticate the HIV anti-stigma act in the remaining 19 of Nigeria's 36 states (about 53% still pending) with the aim of raising coverage from 47% (17/36) to 100% within 12 months.
- **Adolescents and Young People:** Implement targeted interventions for adolescent boys and young men, girls and young women to address the current focus imbalance, while strengthening enforcement and domestication of the VAPP Act at state levels.
- **Key Populations:** Engage lawmakers, law enforcement agencies, and the judiciary through sensitisation sessions that lay emphasis on public health over punishment approaches, while advocating for community-led paralegal and legal aid services.
- **Leadership and Financing:** Increase domestic resource mobilization, such as budgetary allocation, access to health insurance, and linkages to corporate social responsibilities to reduce the current 82.8% dependence on international funding with immediate focus on addressing disbursement delays and bureaucratic bottlenecks.
- **Paediatric HIV and PMTCT Integration:** Strengthen community-facility linkages and tracking systems to address the gap between 90% adult ART coverage and less than 50% paediatric coverage through integrated service delivery.

- **Health and Social Protection Integration:** Leverage existing social protection policies and ensure their sustainability by making them more HIV-sensitive. Strengthen collaboration between NACA, NHIA, and NASSCO to integrate HIV services within ongoing social protection programs such as conditional cash transfers to enhance access, reduce vulnerability, and promote long-term resilience for people living with and affected by HIV.
- **Partnership and Multi-sectoral Collaboration:** Establish unified reporting frameworks to address overlapping and parallel systems with interoperability among government agencies, implementing partners, and donors.
- **Data, Research, and Innovation:** Implement state-level mini-behavioural surveillance across geopolitical zones to address current reliance on IBBSS 2020 data, while mandating states and partners to implement government governance frameworks for data reporting.

Strategic Next Steps for 2025 and Beyond

Immediate Actions (0-6 months):

- Government at national and state levels should take the lead in addressing funding disruptions from donor de-prioritization.
- Prevention and M&E coordination platforms should work on aligning government and implementing partners to align prevention service priorities
- Engage 19 states yet to domesticate HIV anti-stigma legislation to identify specific bottlenecks militating against the signing of the legislation, as well as initiate high-level advocacy visits to these states.

Short-term Priorities (6-12 months):

- Develop and implement rural health worker posting and retention policies with incentives for hard-to-reach areas
- Strengthen supply chain coordination between PHCs, LGAs, and state stores with clear timelines for commodity distribution
- Establish emergency stock buffers at LGA levels for redistribution to primary healthcare centres

Medium-term Strategic Shifts (1-3 years):

- Focus on transition from donor-dependent to domestically-funded HIV programming through graduated co-financing models
- Integrate HIV services into primary healthcare systems rather than maintaining standalone vertical programs
- Implement unified data governance frameworks that harmonize DHIS2.0, NDR, NDARS and MER reporting systems

Long-term Sustainability Measures (3-5 years):

- Achieve 50% domestic funding for HIV programming by 2027 through systematic budget line establishment, health insurance, and private sector engagement.
- Complete integration with social protection mechanisms and domestication of laws across all states with full implementation of protective laws for people living with HIV and key populations.
- Facilitate state-level capacity for independent HIV program management with minimal external technical assistance.

The evidence across all three sources demonstrates that Nigeria stands at a critical juncture where strong treatment achievements must be complemented by urgent attention to prevention gaps, domestic ownership, and system integration to achieve the 2030 goal of ending AIDS as a public health threat.

Echoes from the Journey: Lived stories Behind the Statistics

While data tells us what has changed, stories remind us who has been changed.

Behind Nigeria's HIV program numbers are real lives, young people navigating stigma, mothers making impossible choices, key populations surviving systemic exclusion, and health workers pushing through resource gaps to save lives.

As we assess the progress and performance of the 2024 HIV response, it is critical to center the experiences of those most affected. These human-interest stories reflect the impact of policies, the urgency of funding decisions, and the strength of community resilience. Their voices challenge us to design programs that do not just meet targets, but meet people where they are with empathy, equity, and urgency.

"I Was Afraid, But I Fought for My Baby" — A Pregnant Woman in Rural Nigeria

When Ada* first learned about her HIV status during her pregnancy, she was terrified. "I was very scared. Actually scared," she recalls. The diagnosis came at her antenatal care registration. She was promptly linked to PMTCT services and met Nurse Monica, whom she now calls her "guardian angel."

"I didn't even know what to think. But she assured me the drugs would protect my baby. That was all I needed to hear."

Supported by her husband and the nurse who counselled her, Ada began ART immediately. "I was not treated differently. I was supported emotionally. They made sure I understood everything."

Her baby was born HIV-negative. "The nurse came to me smiling. That smile told me everything was okay." Now, Ada reminds other women in her community to know their status and start treatment early. "It's not shameful to fight for your child's future."

"They Said No One Has to Know" — A 19-Year-Old Girl Born with HIV

Samson Konisola* found out she was HIV-positive when she was 16. "I had been taking drugs since I was four or five. But it was at 16 that my mum told me the truth." Her mother is also living with HIV and has kept it a secret to protect her daughter.

When Konisola became pregnant at 19, she feared rejection and stigma. "I was sad… but my mum told me: 'Take your drugs. Nobody has to know.'"

She enrolled in HIV care easily, she had been on ART for years, and was supported by mentor mothers and the OTZ group. "They gave us food and even helped with transport sometimes. They cared for us."

Her care experience has been smooth, but what she hopes for is economic empowerment. "I'm a hairdresser. If I can get support, I'll be okay."

"We Couldn't Wait for Help" — A Health Worker's Commitment in Rural Nigeria

In a remote facility in Taraba State, Amina*, a senior community health extension worker, has spent over 15 years serving her community. The year was unlike any year before. "The day we got the letter about funding cuts, I cried," she recalls. The donor-funded staff stopped coming, but Amina stayed.

"Three out of five HIV staff were gone in one week. Women came for ART refills and left without drugs. I couldn't sleep."

She decided to merge services. "I started attending to ANC and ART patients together. I used our ANC register to track mothers who might miss appointments." She also partnered with a volunteer peer navigator from a nearby youth group. "We went house to house for two weeks."

Despite having no formal support staff, the facility maintained over 85% retention on ART. "One mother said, 'Na you be my own NACA.' That touched me," Amina said. "We can't build health systems on foreign legs forever."

"We Built Our Own Safety Net" — A Peer Navigator's Story from FCT

In the heart of Abuja, Jude, a 28-year-old peer navigator for key populations, remembers how things changed in 2024. "The safe space we used was shut down. They said funding had shifted. For us, it felt like the ground disappeared."

Jude works with men who have sex with men, many of whom lost access to friendly services overnight. "Some were afraid to go to hospitals. Some stopped treatment entirely. But we couldn't sit back."

So Jude mobilized his network. "We started doing follow-ups with WhatsApp. I'd walk across town just to deliver one refill pack." With support from a community-led organization, he helped set up a temporary drop-in point in a barber shop.

"We didn't have a banner or a clinic sign, but people came. They trusted us."

By the end of the year, Jude had personally re-linked 74 individuals to care. "Sometimes the government forgets us. But we don't forget each other."

Signed: ***The Community***

Introduction

1.1 Background

Nigeria's HIV response has embraced a multisectoral approach, recognizing that non-health factors (such as education, justice, gender, environment, and social development) are critical to epidemic control. This coordinated approach is essential to addressing the social determinants of health and delivering effective HIV interventions across sectors. By 2023, Nigeria had made progress toward the UNAIDS 95-95-95 targets, achieving 95-90-93 progress, highlighting ongoing gaps in treatment coverage and viral suppression despite broad stakeholder engagement (GAM 2023).

95% treated

90% on treatment

93% viral supression

1.2 Rationale for the Review

The National Agency for the Control of AIDS (NACA) has the broad mandate to coordinate and implement Nigeria's response to HIV/AIDS through planning, advocating, formulating policies, supporting research, and monitoring all HIV/AIDS activities. Over the past several years, Nigeria's national HIV response has made substantial gains, driven by a clearer strategic direction and increasing implementation momentum.

The annual program review is central to assessing Nigeria's progress toward national HIV priorities across ART, PMTCT, prevention, care and support, PrEP, HIVST, gender, and human rights for priority populations. However, persistent epidemiological and programmatic gaps threaten to erode overall impact. As of 2023, while national HIV prevalence has stabilized at 1.3%, the estimated number of people living with HIV rose to over 2 million, an increase from 1.8 million in 2021 (GAM, 2023). New infections remain high, with about 75,000 cases recorded annually, and 91% of adult transmissions concentrated among four key population groups: never-married women, never-married men, female sex workers, and men who have sex with men (NACA, 2021). This underscores the urgency of evidence-based policy reform and multisectoral coordination the review process is intended to drive.

The 2024 review was conducted to assess the comprehensive performance of both health and non-health sector HIV programs, recognizing that with only six years remaining to achieve the 2030 goal of an AIDS-free Nigeria, urgent evaluation and strategic recalibration are essential.

1.3 Objectives of the Assessment

The primary objective of this review is to examine how health and non-health sector HIV programs have performed against the NSP 2024 targets. To achieve this, the assessment will pursue the following objectives:

- Assess the implementation status of health and non-health sector HIV programs relative to NSP 2024 targets.
- Evaluate progress for people living with HIV, pregnant women, key populations, and adolescents and young people, both nationally and at the state level.
- Identify emerging implementation modalities grounded in sustainability models projected for 2025.
- Evaluate coordination and collaboration between health-sector and non-health-sector actors in the HIV response.
- Review key successes, programmatic and policy gaps, challenges, and sustainable good practices in program implementation.
- Analyse the funding landscape to explore opportunities for enhancing domestic resourcing, ownership, and accountability.
- Generate evidence-based recommendations aimed at strengthening programme impact, sustainability, and alignment with national and international HIV targets.
- Identify priority areas for action in 2025, building on successes and addressing the main challenges encountered in 2024.

1.4 Scope of the Assessment

This assessment incorporates a thorough program review across both health and non-health sectors, covering thematic areas of prevention, treatment, care, and support as implemented in the period spanning 2024, and its mapped activities and performance for all priority populations, people living with HIV, pregnant women, key populations, adolescents, and young people at the national and state levels. The review captured the extent of coverage, coordination mechanisms, resource allocation, and sustainability approaches, as well as stakeholder roles and partnerships. By examining policy frameworks, operational practices, and financing models, the scope ensures a holistic understanding of how the HIV response is delivered, where gaps remain, and what strategic adjustments are needed to optimize outcomes in 2025.

1.5 Alignment with NSP 2023–2027 and Global Targets

1.5.1 Global Target Alignment

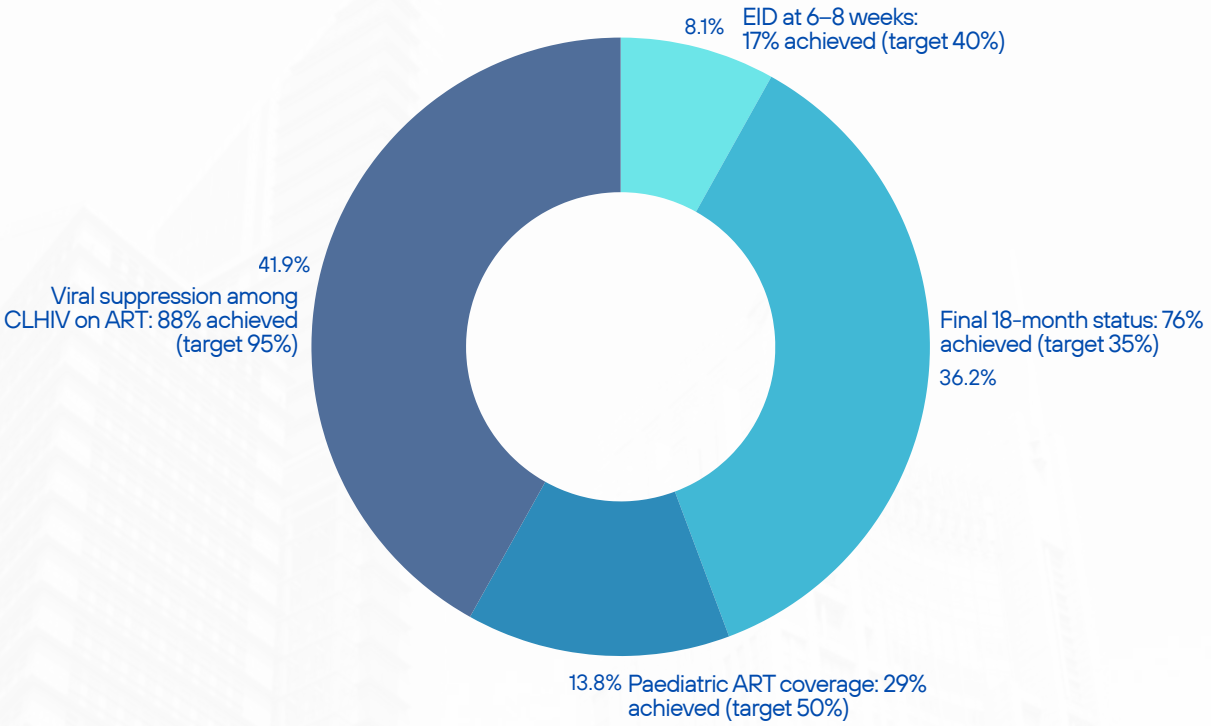
The assessment framework was explicitly aligned with key global HIV targets and commitments:

UNAIDS 95-95-95 Targets: The review evaluated Nigeria's progress toward the global targets of 95% of people living with HIV knowing their status, 95% of those diagnosed receiving sustained antiretroviral therapy, and 95% of those on treatment achieving viral suppression. Current national performance stands at 87-99-96, indicating strong treatment outcomes but persistent diagnostic gaps.

Global Alliance to End AIDS in Children by 2030: Nigeria endorsed the Alliance in February 2023 and launched its National Paediatric Alliance Plan to close the yawning gap between adult and paediatric service coverage. In addition to aiming for ≥95% of children living with HIV (CLHIV) to be on antiretroviral therapy (ART) and ≥95% viral suppression, the Alliance's four key pillars set the following targets for 2023:

- Early Infant Diagnosis (EID) coverage for infants aged 6–8 weeks: 40% target
- Final HIV-status determination at 18 months: 35% target
- Paediatric ART coverage (ages 0–14): 50% target
- Viral load suppression among children on ART: 95% target

Nigeria's performance against the 2023 HIV targets (NASCP 2024 Report)



According to NASCP's 2024 Health Sector Report, Nigeria's performance against these 2023 targets was:

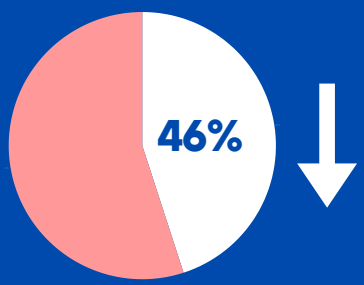
- EID at 6–8 weeks: 17% achieved (target 40%)
- Final 18-month status: 76% achieved (target 35%)
- Paediatric ART coverage: 29% achieved (target 50%)
- Viral suppression among CLHIV on ART: 88% achieved (target 95%)

In light of these shortfalls, particularly in early diagnosis and ART enrolment, Nigeria is intensifying point-of-care EID, expanding community outreach for children, and integrating paediatric HIV into routine child-health platforms to accelerate progress toward the Global Alliance goals.

Prevention Targets: According to the 2024 presentation made by NACA Nigeria, aimed for an 80% reduction in new HIV infections from 2010 levels, but recorded only a 46% decline by the end of 2023, well below the global benchmark.

In addition, the Global Alliance's Pillar 3, "preventing and detecting new HIV infections among pregnant and breastfeeding adolescents and women", sets two key targets:

- 100 % HIV retesting coverage among pregnant and breastfeeding women
- Universal adoption of WHO-recommended PrEP services for those who test negative in 2024



These shortfalls underscore the need to intensify combination prevention, scale up self-testing, broaden PrEP access, and strengthen community outreach to close the gap and align Nigeria's response with global prevention goals by 2030.

Sustainability and Development Goals: According to NASCP's 2024 Health Sector Report, the HIV assessment explicitly tracked alignment with three core SDG targets (universal health coverage (SDG 3.8), social protection (SDG 1.3), and gender equality (SDG 5.1) to ensure the response contributes to broader development goals.

SDG 3.8 Universal Health Coverage

HIV Services Driving UHC

- 85% knew their HIV status
- 98% of diagnosed on ART
- 96% on ART achieved viral suppression
- Major progress towards finaincial-risk protection and access

SDG 1.3 Social Protection Coverage

HIV Services Driving UHC

- Social protection policies for PHLIV are formally adopted nationwide
- Intergrated into cash transfer, fee waivers livelihood programs
- Formal adoption across strategies and partner platforms

SDG 5.1 Gender Equality and Women's Empowerment

Women at the center of HIV Response

- Free antenatal HIV Care
- Integration of HIV with reproductive health
- GBV mitigation protocol
- Gender-equity policies included in guidelines and monitoring

By embedding these SDG targets into the methodology, the assessment not only measured health-sector outcomes but also ensured that HIV programming strengthens Nigeria's commitments to universal coverage, social protection, and gender justice under the 2030 Agenda.

1.5.2 National Strategic Plan Framework

The National Strategic Plan (NSP) 2023-2027 provides the roadmap and framework for Nigeria's response to the HIV epidemic, acting as a blueprint for the country's response over the five-year period. The review was specifically designed to assess progress against NSP's three strategic priorities and result areas:

Strategic Priority 1: Equitable and Equal Access to HIV Services for All. The review examined progress toward ensuring that all populations, particularly those most at risk and affected by HIV, have equitable access to comprehensive HIV prevention, testing, treatment, care, and support services without discrimination or barriers.

Strategic Priority 2: Break Down Barriers to Achieving HIV Outcomes. Assessment focused on efforts to address structural, social, legal, and individual barriers that impede access to and uptake of HIV services, including stigma, discrimination, criminalization, and gender inequality.

Strategic Priority 3: Fully Resource and Sustain Efficient HIV Responses and Integrate into Health Systems. The review assessed progress toward developing sustainable, domestically owned HIV programming integrated within broader health and social protection systems, with reduced dependency on external funding.

1.5.3 Summary of key results areas, targets, and measurement parameters (NSP 2023–2027)

Why these matters: This review reports performance against the NSP. For several indicators, routine systems don't yet capture the measure exactly as phrased in the NSP; where that is the case, this report uses the closest available proxy and flags the gap for alignment.

Strategic Priority 1 — Equitable and equal access to HIV services for all

Key results areas (KRAs) & indicators (examples)

- **Person-centred combination prevention:** percentage of people at risk who have access to and use the defined prevention package (end-term target ≈ 95%).
- **TB preventive treatment for PLHIV:** percentage of eligible PLHIV who received TPT during the reporting period (end-term ≈ 95%).
- **Maternal virologic control:** percentage of pregnant and breastfeeding women living with HIV with viral suppression (end-term ≈ 95%).
- **Early infant diagnosis & final outcome:** percentage of HIV-exposed infants tested by 2 months and again post-breastfeeding, with final status recorded (end-term ≈ 95%).
- **Treatment cascade maintenance:** status knowledge / on-ART / viral suppression (maintain high levels, close paediatric gaps).

Measurement notes: prevention currently reported as "reach" for key populations; this review uses that as a proxy until "access and use" is routinely measured. HEI final outcome and PBFW suppression are being added to routine dashboards.

Strategic Priority 2 — Break down barriers to achieving HIV outcomes

KRAs & indicators (examples)

- **Legal and policy environment:** share of states with punitive provisions reduced toward <10%.
- **Stigma and discrimination:** proportion of PLHIV and KP experiencing stigma/discrimination reduced toward <10%.
- **Gender-responsive services:** coverage of gender-responsive service standards in facilities (progressive scale toward high coverage).
- **Community-led delivery:** share of services delivered by community-/women-led organisations (e.g., prevention for KPs/priority groups, testing/treatment shares).

Measurement notes: introduce a simple attribution field ("delivered by") in programme tools; use standard stigma instruments and a facility gender-readiness checklist to move from counts to rates.

Strategic Priority 3 — fully resource and sustain efficient HIV responses, integrated into health systems

KRAs & indicators (with baselines where available)

- **Total HIV investment (all sources):** baseline **US$438m (NASA 2021);** trajectory toward ~US$610m by 2027 as per NSP. 2024 total investment not yet available; keep 2021 as the reporting baseline until the next NASA release.
- **Domestic financing share:** percentage of total HIV investments from domestic sources (federal, state/LGA, Trust Fund, domestic private). Report year-on-year percentage-point gains; 2024 share pending consolidated release.
- **Government budget execution (agency example — NACA, FY2024):** Appropriation ₦8,568,068,163; releases ₦7,471,683,234.81 = 87.2% released. Track: share released, release timeliness, and alignment to planned cost lines (commodities, sample transport, last-mile distribution, and community outreach already in approved AOPs). This is an illustrative agency-level metric, not the national total.
- **Social protection linkage:** percentage of people living with/at risk/affected by HIV receiving ≥1 social-protection benefit (NHIA/NSR), with progressive targets.
- **Systems integration:** percentage of clients linked to integrated services (HIV/TB/GBV/NCD/mental health/substance use), with progressive targets.

Measurement notes: publish an annual investment series **by source** (GoN, donors, domestic private) using the NSP indicator list; maintain agency-level execution (e.g., NACA example) for transparency, but do not substitute it for national totals.

Cross-cutting enablers (applies to all three priorities)

- Data quality and governance: verification factors (e.g., TX_NEW at 100% in all sites), variance ≤10% for priority indicators, on-time/complete reporting.
- Community-led monitoring and redress: issue-to-fix time (median days), proportion of incidents resolved within SLA.
- Humanitarian continuity: coverage of essential HIV services and combination prevention in humanitarian settings (progress toward ≥90–95%).

Measurement notes: Integrate community-led monitoring into validation workflows; tag humanitarian contexts in routine data and set minimum indicator sets.

Alignment caveat: Where the NSP indicator wording and routine data fields don't yet match, this report explicitly labels the measure as a proxy and recommends the minimal field changes needed to report the NSP indicator as written.

1.6 Review Timing and Strategic Context

This comprehensive review was conducted at a critical juncture in Nigeria's HIV response. With the NSP 2023-2027 now in its second year of implementation, the assessment provides essential mid-term insights for course correction and strategic refinement. The timing is particularly urgent given emerging challenges, including donor funding shifts, the need for increased domestic resource mobilization, and the imperative to accelerate progress toward the 2030 goal of ending AIDS as a public health threat.

The review's findings and recommendations are intended to inform immediate program adjustments for 2025, while also contributing to longer-term strategic planning processes, including preparation for the NSP mid-term review and the development of the subsequent strategic framework beyond 2027.

2. Methodology

2.1 Overview of the Integrated Multi-Source Approach

The 2024 Nigeria HIV Response Review drew on three complementary phases: desk review, stakeholder consultations, and a national consensus workshop to weave together documentary evidence, frontline insights, and collective validation. By moving from the rigorous document analysis through iterative engagement with implementers to a structured group deliberation, the process ensured that findings are grounded, nuanced, and broadly owned by those who drive the HIV response.

What was done and why

- A focused **nine-day desk review** examined policy frameworks and program data to capture both strategic intent and operational realities. We prioritized the most recent editions of the National Strategic Framework (2021–2025) and National Strategic Plan (2023–2027), alongside the Nigeria HIV Prevention Strategy for Adolescents and Young People-Generation Negative Strategy, the draft Key Population Programme Review (2024), and up-to-date surveillance reports.
- **Structured interviews** with programme managers, clinicians, community leaders, and donor representatives probed real-world implementation, how services reached people living with HIV, pregnant women, key populations, and young people across all six geopolitical zones.
- A **five-day national workshop** convened ten thematic breakout groups, each charged with scrutinizing performance gaps, root causes, and practical interventions across prevention, treatment, care, and support.

When and where

- The desk review ran from 2nd to 11th July, 2025, in Abuja, drawing on electronic and hard-copy archives held by NACA and key development partners.
- Interviews took place between 11th July to 20th July 2025, both in person and by virtual link for state-level stakeholders, ensuring geographic and sectoral balance.
- The consensus workshop was held on 14th–18th July 2025 in Abuja, with eighty-plus participants representing federal and state governments, civil society, private sector partners, and donor agencies.

How the pieces fit and the criteria for inclusion

- **Document selection** followed clear criteria: recency (2021 onwards), relevance to NSP targets, representation of both health and non-health interventions, and inclusion of both policy texts and programme reports.
- **Participant selection** aimed for diversity of experience, senior decision-makers, service-level implementers, community advocates, and technical experts. Thus, voices from national policy halls to grassroots delivery sites shaped the analysis.
- **Analytical methods** combined thematic content analysis (guided by Braun & Clarke's six-step approach in ATLAS.ti v.25) with a 14-column assessment grid during the workshop, linking performance gaps to evidence, feasibility, timelines, and sustainability considerations.

By integrating documentary, qualitative, and consensus-building methods, this multi-source approach not only generated robust, triangulated evidence but also fostered shared ownership of recommendations for the next phase of Nigeria's HIV response.

Target Populations and Geographic Coverage

The review deliberately focused on the full spectrum of Nigeria's HIV response, from national coordination down to local service delivery. It examined programming for all persons living with HIV (PLHIV), with special attention on the following sub-groups:

1. Pregnant and breastfeeding women
2. Key populations: men who have sex with men, female sex workers, people who inject drugs, and transgender individuals
3. Adolescents and young people
4. Paediatric populations

At the same time, four thematic service areas were in scope:

- Prevention of mother-to-child transmission (PMTCT) and early infant diagnosis
- Adolescent and youth programming under the Generation Negative strategy
- Care for orphans and vulnerable children
- Operation Triple Zero (OTZ)

Geographically, the assessment spanned national policy and coordination platforms and probed state-level variations across Nigeria's six geopolitical zones, with particular emphasis on underperforming states and weaker health-system contexts.

2.1.1 Phase 1: Desk Review of Strategic Documents and Program Reports

Scope and Timeline: The desk review synthesised actionable insights to inform the national HIV programme review workshop, surfacing early performance signals, identifying strategic gaps, and flagging areas requiring validation across Nigeria's multisectoral HIV response and documented best practices. It was completed over a nine-day period.

Documents Reviewed and Rationale: The Documents Reviewed and Rationale: The desk review drew on strategic policies, surveillance outputs, routine information platforms, and contextual surveys that together reflect policy intent and operational delivery across the HIV response. Sources included the National Strategic Framework (2021–2025), the National Strategic Plan (2023–2027), the Generation Negative strategy, the Key Population Programme Review (2024 draft), IBBSS 2020, NAIIS 2018, GAM reports (2021–2023), the KP programmatic mapping and size estimation (20 states, 2023), and routine platforms such as DHIS2, the National Data Repository, NDARS, and MER/DATIM. Selection was pragmatic: documents needed to be current, authoritative, in active use by implementers, and taken together, offer national and state-level coverage. Findings related to inconsistent EMR use, viral-load documentation, and gaps in routine indicators are presented under Data quality assessment, not as part of document selection.

Core Document Categories Reviewed:

Strategic Policy Documents:

- The National HIV and AIDS Strategic Framework (2021-2025) and the National HIV and AIDS Strategic Plan (2023-2027), which lay out Nigeria's vision for ending AIDS as a public health threat by 2030.
- Nigeria HIV Prevention Strategy for Adolescents and Young People (2024): The Generation Negative (Gen-N) strategy, focused on adolescent and young people, aiming to embed HIV prevention within education, youth engagement, and social protection platforms.
- The Key Population Programme Review (KPPR) 2024, providing critical insight into coverage gaps, stigma-related barriers, outreach effectiveness, and community-led service delivery among key populations.

Surveillance and Epidemiological Data:

- Surveillance data from the Integrated Biological and Behavioural Surveillance Survey (IBBSS 2020) and the Nigeria AIDS Indicator and Impact Survey (NAIIS 2018), which remain central for estimating HIV prevalence, treatment coverage, and risk behaviour trends among key populations.
- Global AIDS Monitoring (GAM) Online Reporting Tool Reports (2021-2023), offering annual progress updates incorporating Spectrum modelling, civil society validation, and donor technical inputs.
- Key Population: Programmatic Mapping and Size Estimation Study in 20 States. August 2023: provided reliable data and obtained an accurate count of MSM, PWIDs, FSW, and TGs.

Monitoring and Data Systems:

- Reviews of Nigeria's routine health information platforms, including the District Health Information System 2 (DHIS2) Nigeria National Data Repository (NDR) and the Nigeria National Data Repository (NDARS)
- The PEPFAR Monitoring, Evaluation, and Reporting (MER) system and its DATIM interface, which function largely in parallel to national tools with limited cross-platform triangulation
- Joint Data Quality Assessment (JDQA) 2024. Conducted across 96 facilities in 12 states, the exercise found that 58% of facilities achieved a 100% verification factor for TX_NEW on NDARS, while larger variances (>10%) were more frequently observed for TB_ART, PMTCT_EID, and HTS_TST. Client-level checks showed strong alignment for unique ID, sex, and regimen (about 85%), with documentation improvements needed for age (about 69%) and ART start dates (about 71%).

Contextual Data Sources:

- The Multiple Indicator Cluster Survey (MICS 2021) providing broader demographic context including data on HIV awareness, maternal health access, youth schooling, and household vulnerability.

Data Quality Assessment: Data quality and interoperability remain work-in-progress rather than signs of system failure. NDARS, the DHIS2-based national reporting platform is now in nationwide use, with state-level personnel trained across 36+1 states, and routine MSF data flowing from facilities into NDARS and then to the national HMIS (DHIS2) via an interoperable API (2024 HIV Health Sector Report). At the same time, triangulation between national platforms (NDARS/NHMIS/DHIS2 and the NDR) and donor-linked streams (e.g., MER/DATIM) is still uneven in some programmes, so the review treats these as interoperability and quality-assurance gaps to be steadily fixed. GAM remains a useful synthesis tool due to multi-source validation, and its modelled estimates should be reconciled with state dashboards during subsequent phases to keep interpretation grounded in operational realities.

2.1.2 Phase 2: Key Informant Consultations

Analytical Approach:

The key informant consultations were structured to capture perspectives across multiple levels of implementation, from national coordination to facility-level service delivery. This approach enabled validation of desk review findings against operational realities experienced by implementers and beneficiaries.

Thematic content analysis was conducted following Braun and Clarke (2006). Interview recordings were transcribed verbatim and read multiple times to support immersion in the data. An inductive coding approach was used, codes were generated from what participants actually said rather than from a predefined framework. Coding and analysis were undertaken in ATLAS.ti (version 25).

Coding process. Initial, line-by-line inductive coding captured implementation experiences across prevention, testing, treatment, paediatrics/PMTCT, AYP/Gen-N, key populations, data systems, financing, governance, integration, and rights. Codes were iteratively grouped into code families and then into themes and sub-themes. The codebook evolved through successive rounds of consolidation, with decision memos documenting additions, merges, and retirements of codes.

Resulting themes. The final thematic structure reflected both service components and cross-cutting issues that recurred in the interview sessions:

- Service delivery and outcomes: case-finding and linkage; treatment, retention, and viral suppression; PMTCT/EID and paediatric care; AYP (Generation Negative); key populations.
- Systems and enablers: routine data quality and interoperability (DHIS2/NDR, NDARS, MER/DATIM), coordination and multi-sectoral integration, domestic financing and sustainability, human rights and gender equality, partnerships and community-led response, research/innovation and data for impact.

Credibility and dependability. To enhance rigour, a subset of transcripts was independently double-coded in ATLAS.ti, with discrepancies resolved through consensus meetings and documented in an audit trail (versioned codebook, meeting notes, and reflexive memos). Analyst triangulation was built into the workflow (at least two analysts reviewing theme definitions), and reflexivity was maintained throughout via brief memos on positionality and potential bias.

Triangulation and validation. The interview themes were compared with findings from the desk review and then member-checked during the national workshop. Breakout groups used the structured 13–14 column matrix to test whether interview-derived themes aligned with observed performance gaps, root causes, feasible interventions, dependencies, evidence sources, NSP linkages, monitoring implications, and sustainability considerations. Convergence strengthened confidence in the themes; divergences were flagged for follow-up in the synthesis phase.

2.1.3 Phase 3: Stakeholder Validation Workshop with Thematic Breakout Groups

Workshop Structure and Participant Organization: The national stakeholder workshop employed a structured approach with ten thematic breakout groups, each focusing on specific components of Nigeria's HIV response:

Group 1: HIV prevention/Community Led Response

Group 2: HIV testing, treatment, care, viral suppression, and integration; and vertical HIV transmission

Group 3: Human Rights, Gender Equality, Advocacy

Group 4: Adolescents and Young People (AYP)

Group 5: Key Populations (KPs)

Group 6: Leadership, Country Ownership, Governance, Advocacy, and Funding

Group 7: Integration: HIV transmission PMTCT and Paediatric HIV

Group 8: Integration of HIV into systems for health and social protection and Humanitarian settings and pandemics

Group 9: Partnership, multi-sectoral engagement and collaboration

Group 10: Data for impact, science, research, and innovation

Structured Analytical Framework: Each thematic group employed a comprehensive 13-14 column analytical framework designed to ensure systematic analysis and actionable outputs:

Problem Identification Columns:

- **Domain:** Classification of issues as Structural/policy, Operational/Programmatic, Logistics, M&E, or Financing.
- **Performance Gaps:** Specific challenges and deficits identified.
- **Root Causes:** Underlying factors driving the identified gaps

Solution Development Columns:

- **Proposed Intervention:** Specific recommended actions
- **Feasibility:** Assessment of implementation viability
- **Levels:** Geographic or administrative levels for implementation
- **Stakeholders:** Responsible agencies and implementing partners
- **Timeline:** Implementation timeframes (immediate, short-term, medium-term, long-term)

Strategic Alignment Columns:

- **Dependencies:** Prerequisites and enabling conditions
- **Evidence Base:** Supporting documentation and data sources
- **Linked NSP Target:** Alignment with National Strategic Plan priorities
- **Cross-sectoral Integration:** Multi-ministry coordination requirements

Sustainability and Monitoring Columns:

- **Monitoring Implication:** Key indicators and measurement approaches
- **Sustainability:** Long-term viability and financing considerations

2.2 Limitations and Methodological Considerations

Data Availability versus Usability Gap: The methodology acknowledges that data availability does not necessarily equate to data usability. While many reports present headline achievements, workshop validation was crucial in testing their relevance at the facility and community levels, where many of the real implementation challenges persist. The workshop therefore offered a vital space for reconciling national narratives with local evidence and for grounding Nigeria's subsequent strategic decisions in both data and lived experience. However, due to time constraints, the desk review prioritized strategic and high-yield sources. Some sectoral implementation reviews, grey literature (donor-specific and sub-national assessments), and unaggregated datasets from Generation Negative (Nigeria HIV Prevention Strategy for Adolescent and Young People, 2024) and MER were not accessed in full but were recommended for inclusion during the workshop to support triangulation and nuance.

Surveillance Data Limitations: Several strategic and technical areas emerged as needing deeper stakeholder input, including discrepancies between modelled national cascade figures (Spectrum-based GAM reports) and state-level data housed in SACA dashboards or facility records. The operationalization of the Generation Negative strategy (Nigeria HIV Prevention Strategy for Adolescent and Young People, 2024) lacks sub-population tracking or standardized indicators across regions, making it challenging to measure reach and behavior change.

System Integration Challenges: Sustainability indicators, particularly those linked to HIV financing and integration into social protection schemes (as envisioned in the Sustainability and Development Strategy 2020-2025), were not always included in reviewed documents or routine dashboards. PMTCT scale-up remains insufficiently tracked through integrated service delivery frameworks, with coverage figures in national reports not consistently aligned with maternal and child health data.

Participant Representation Considerations: The workshop approach required balancing federal and sub-national inputs, with every session designed to feature voices from affected populations, not just those managing their programs. This was vital for ensuring a responsive, equity-driven HIV response moving toward 2030.

2.3 Analytical Framework and Synthesis Strategy

2.3.1 Triangulation Methodology

The integrated approach was designed to systematically triangulate findings across the three evidence sources:

Validation Approach:

- **Desk review findings** provided quantitative baselines and policy context
- **Key informant consultations** validated or challenged document-based assumptions through implementation experience
- **Workshop groups** resolved discrepancies and generated consensus-based recommendations

Synthesis Strategy: For each thematic area and cross-cutting issue, the analysis systematically compared findings across sources to identify:

- **Convergent evidence** where all sources aligned
- **Divergent perspectives** requiring further investigation
- **Implementation gaps** between policy intentions and operational realities
- **Stakeholder consensus o**n priority interventions and solutions

2.3.2 Quality Assurance Framework

Document Verification: All documents were reviewed in their full and final versions where available, with all materials either publicly published or shared via official channels. Additional verifiable sources were used to cross-reference key statistics and policy developments.

Stakeholder Validation: The workshop structure ensured that document and interview findings were tested against the collective experience of implementers, beneficiaries, and technical experts across Nigeria's HIV response spectrum.

Evidence Grading: Findings were categorized by strength of evidence across sources:

- **High confidence:** Confirmed across all three sources
- **Medium confidence:** Supported by two sources with no contradictory evidence
- **Emerging concern:** Identified by one source but requiring further validation

This methodological approach ensured that the review's findings and recommendations were grounded in comprehensive evidence while reflecting the practical realities of HIV program implementation across Nigeria's diverse contexts and populations.

3. Strategic context and performance overview

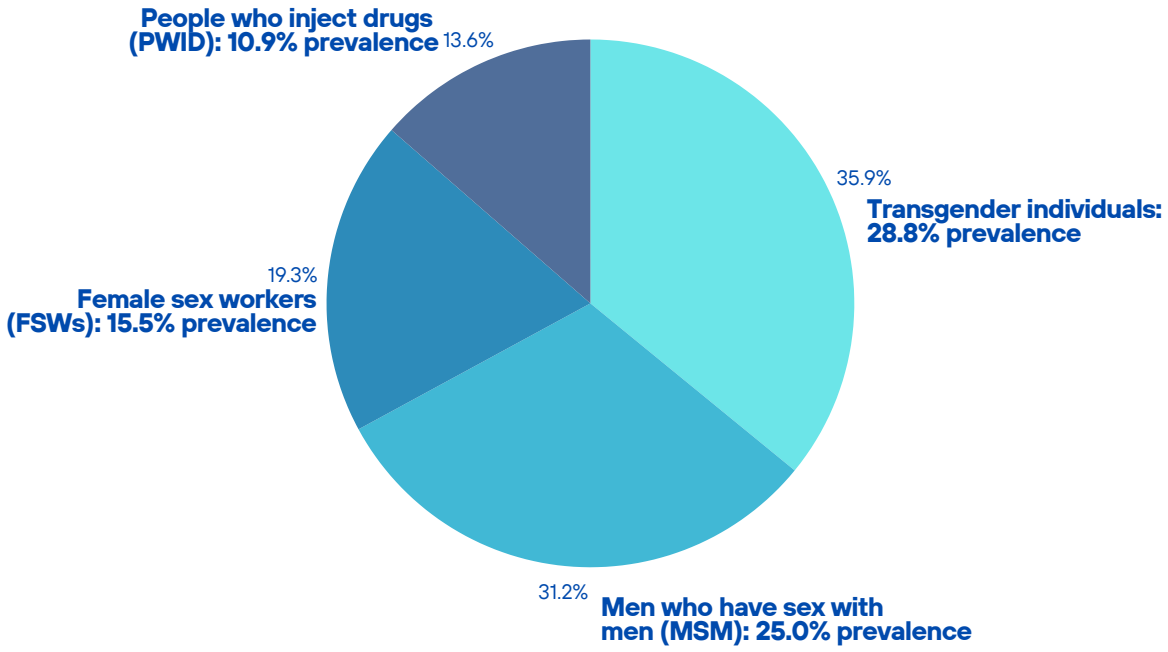
3.1 Current Epidemiological Profile

Nigeria's HIV epidemic in 2024 presents a complex landscape characterized by moderate national prevalence but significant burden in absolute numbers and concentrated risk among specific populations. As of 2023, Nigeria's estimated HIV prevalence remained stable at 1.3%, but the total number of people living with HIV has increased to 2,002,624, representing an increase from 1.8 million in 2021. This upward trend in absolute numbers despite stable prevalence reflects population growth and improved case-finding efforts.

New HIV infections continue to occur at concerning rates, with approximately 75,000 new infections annually. A critical epidemiological pattern identified through the desk review shows that 91% of adult cases are concentrated in just four high-risk groups: never-married women, never-married men, female sex workers, and men who have sex with men. This concentration underscores the continued importance of targeted prevention intervention

3.2 Key Population Burden and Disparities

HIV prevalence among key populations remains disproportionately high, with significant variations across groups:



The 2024 DHIS data reveals that 1,029,985 individuals from key populations were tested, with 26,051 testing positive, yielding a 2.53% positivity rate. Notably, people who inject drugs recorded the highest observed positivity in 2024 (3.52%), pointing to a clear opportunity for focused harm-reduction and targeted testing. Other priority groups also contributed to case-finding: among newly tested pregnant women, positivity was 0.3% (8,081 of 2,810,560); nationally, the overall HTS yield in 2023 was 1.4%, with state-level peaks up to 2.7% in FCT. In terms of testing modalities, index testing accounted for 7.8% of all positives identified in 2023, underscoring its continued value alongside community and facility-based approaches. While disaggregated yields for MSM, FSW, and transgender populations are not specified in the health-sector report, program data and targeted outreach indicate these groups typically test above the national average; integrating those figures as they are finalized will further sharpen prioritization. Overall, the pattern suggests where to intensify efforts rather than a deterioration in any one group.

3.3 Response System Performance Overview

Stakeholder interviews characterized the overall 2024 HIV program performance as "moderate," with one respondent noting that "2024 was even far better than what we are seeing ...in 2025." Treatment services for people living with HIV were described as "seamless," with approximately 198,000 people reported on antiretroviral therapy in individual state contexts.

However, significant operational challenges emerged. Interview participants consistently reported commodity stockouts, with one noting "frequent stockouts of test kits" and another describing challenges where "some of these test kits would be out of stock after its not optimal." The impact of funding disruptions became apparent, with 2025 starting "with an executive order from USG stopping funds for the HIV program (especially the KP program)."

3.4 NSP 2023–2027 Implementation Progress and Status

3.4.1 Strategic Priority Performance Assessment

The National Strategic Plan 2023-2027 established three core strategic priorities, with mixed progress evident across implementation areas:

Strategic Priority 1: Equitable and Equal Access to HIV Services. Progress has been most substantial in treatment access, with Nigeria achieving significant cascade improvements. However, Workshop participants identified that "state level programmes still largely focused on Adolescent Girls and Young Women (AGYW) with little targeted interventions for adolescent boys and young men," indicating equity gaps in prevention programming.

Strategic Priority 2: Breaking Down Barriers to HIV Outcomes. Workshop participants identified continued challenges, noting that "legal and structural barriers; including criminalization of same-sex behavior, drug use, and sex work" continue affecting service uptake. However, positive developments include the domestication of the Violence against Persons Prohibition (VAPP) Act in 32 states plus the Federal Capital Territory, and the establishment of Sexual Assault Referral Centres (SARCs) in 36 states.

Worthy of note is the deepening engagement between the National Human Right Commission and the NACA both at the state and national levels, the collaboration continues to ensure access to live saving health services are not in any way restrictive to all Nigerians.

Strategic Priority 3: Fully Resourced and Sustained Efficient HIV Responses. This remains the most challenging priority. Workshop participants emphasized the continued reliance on external support for HIV programming, consistent with Nigeria's macro-fiscal context, where interest payments absorbed ~88% of federal revenue in 2021, constraining the room for domestically financed scale-up (Nigeria Integrated National Financing Framework, pp. 25, 45). Interview participants consistently identified inadequate government funding as a primary constraint, with one noting, "funding is inadequate to provide the HIV service program in the state."

3.4.2 Policy Implementation Gaps

Workshop f findings revealed significant implementation gaps across NSP priorities. Participants identified "lack of domestication of AYP strategy at the state levels" as a key barrier. Other participants highlighted that HIV anti-stigma legislation remains undomesticated in 19 states, creating continued legal barriers to service access.

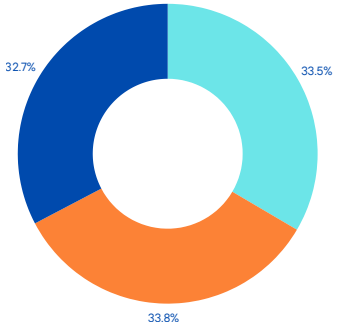
The implementation of the "Generation Negative strategy" showed mixed results, with interview participants noting support for youth programs and center provision. However, Workshop group deliberations identified a limited reach to adolescent boys and young men specifically.

3.5 National and Subnational Performance on Key Indicators

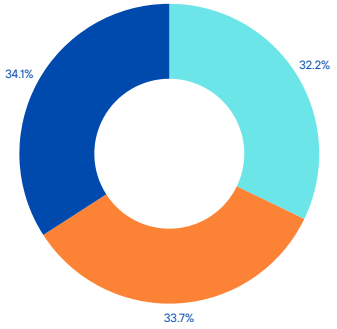
Treatment Cascade Performance

Nigeria achieved remarkable progress on the UNAIDS 95-95-95 targets. This represents a significant improvement from previous years and demonstrates the effectiveness of differentiated service delivery models and improved clinical follow-up systems.

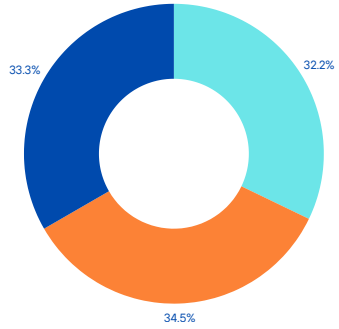
National Cascade (2024)



Paediatric Cascade (2024)



IBBSS 2020



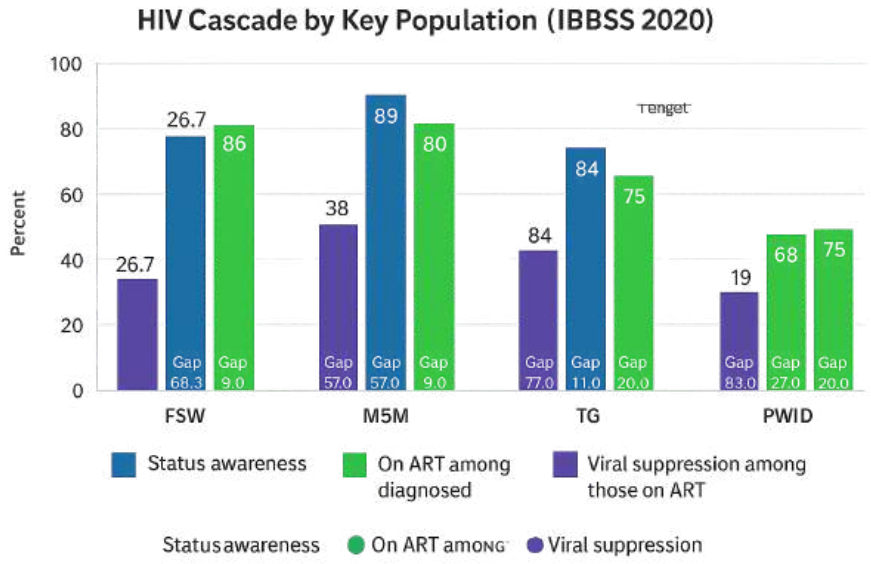
Cascade Performance by Population:

- **National cascade (2024):** The 2024 national cascade is 87-98-96, maintaining high on-ART and viral suppression rates, with the first step (status awareness) still below 95%.

- **Paediatric cascade (2024):** 83-87-88, confirming strong suppression among children on treatment but a persistent enrolment gap due to earlier steps in the paediatric case-finding pathway

UNAIDS benchmarks have shifted from the earlier 90–90–90 to 95–95–95. The IBBSS 2020 cascade below was generated in the 90–90–90 era and is survey-based; current routine programme cascades may diverge because of different denominators and timeframes.

Key Populations: IBBSS 2020 HIV cascade by typology (shown against a 95% target)



Female sex workers (FSW)

- Prevalence: 15.5%
- First step — status awareness: 26.7% (gap to 95: 68.3 percentage points)
- Second step — on ART among those diagnosed: ~89% (gap: 6 pp)
- Third step — viral suppression among those on ART: 86% (gap: 9 pp)

Implication: treatment outcomes are solid once diagnosed; the big lift is earlier diagnosis and fast linkage.

Men who have sex with men (MSM)

- Prevalence: ~25%
- First step — status awareness: 38.0% (gap: 57.0 pp)
- Second step — on ART among those diagnosed: ~90% (gap: 5 pp)
- Third step — viral suppression among those on ART: 78% (gap: 17 pp)

Implication: maintain strong initiation while expanding targeted case-finding and support for sustained suppression.

Transgender persons (TG)

- Prevalence: 29%
- First step — status awareness: 19.0% (gap: 76.0 pp)
- Second step — on ART among those diagnosed: ~84% (gap: 11 pp)
- Third step — viral suppression among those on ART: 75% (gap: 20 pp)

Implication: inclusive testing, safe access points, and continuity support can meaningfully improve all steps.

People who inject drugs (PWID)

- Prevalence: ~11% (up from 3.4% in 2014)
- First step — status awareness: 12.0% (gap: 83.0 pp)
- Second step — on ART among those diagnosed: ~68% (gap: 27 pp)
- Third step — viral suppression among those on ART: 75% (gap: 20 pp)

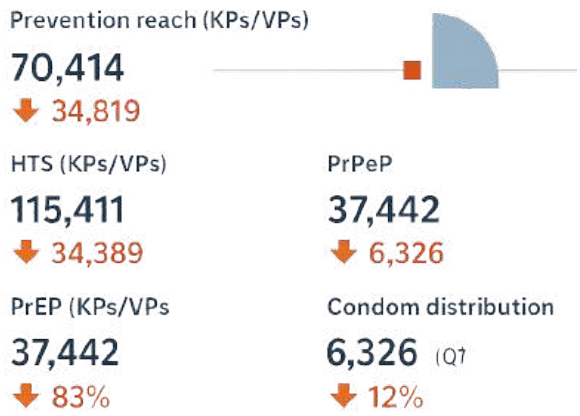
Implication: Pair low-threshold testing and harm-reduction with differentiated ART models to raise diagnosis and continuity while maintaining suppression among those on therapy.

Synthesis and performance-management notes

- The clearest opportunity across typologies is the first step (diagnosis). Where diagnosis occurs, second and third-step results are generally strong—particularly for FSW and MSM—while PWID requires additional focus at the treatment-initiation step.
- Survey vs. programme data: IBBSS 2020 is a 12-state, survey-based snapshot; routine programme cascades use service data and different denominators. For performance management, state clearly when a figure is survey vs. programme, align definitions where feasible, and update baselines with the next IBBSS while using routine KP dashboards for in-year tracking.

3.5.2 Prevention and Testing Performance

Q1–Q2 2025 prevention signal (from national slides):



- **Prevention reach (KPs/VPs):** 70,414 → 34,819 (–50.5%)
- **HTS (KPs/VPs counselled, tested, received results):** 115,411 → 34,389 (–70.2%)
- **PrEP (KPs/VPs who received PrEP):** 37,442 → 6,326 (–83%)
- **Condom distribution:** male –36%; female +153% (Q1→Q2)
- **Needles/syringes:** +12% (Q1→Q2)

Implication: performance fell sharply quarter-on-quarter and requires rapid commodity and last-mile fixes, targeted demand creation, and tighter partner alignment.

2024 Key Population Testing and Treatment Data:

- **ART Coverage:** 204,201 total key population individuals on ART, distributed as:

Sex Workers	94,969	465.%)
MSM	64,167	31.42%)
PWID	39,605	19.40%)
Transgender	2,677	1.31%)
Children of KPs	2,783	1.36%)

PrEP Performance: In 2024, 251,049 individuals enrolled in PrEP. By typology, this comprised 124,395 sex workers (49.55%), 69,880 MSM/anal sex partners (27.84%), 52,120 PWID (20.76%), and 4,654 transgender individuals (1.85%). Programme continuity can be strengthened: 31,053 discontinuations (12.37% of enrolees) and 418 seroconversions (0.17%) were recorded.

Prevention & related services, Q1 vs Q2 2025 (national)

Indicator (KPs/VPs unless noted)	Q1 2025	Q2 2025	% change
Prevention services – people reached	70,414	34,819	–50.5%
HTS –counselled/tested/received results	115,411	34,389	–70.2%
PrEP – people who received PrEP	37,442	6,326	–83.1%
Condoms – **male** (units)	820,764	525,067	–36%
Condoms – **female** (units)	3,761	9,532	+153%
Needles & syringes (units)	131,690	147,176	+12%

3.5.3 Mother-to-Child Transmission Prevention

PMTCT coverage showed improvement but remains below optimal levels. The desk review estimated PMTCT coverage at 65% in 2024, while health sector reports indicated similar figures. Interview participants noted "PMTCT programme scale-up was a continuous success" with efforts involving "mapping over 1,100 sites, including TBAs."

However, Workshop participants identified significant gaps, noting that "a large number of children missed during family or index testing" and "parents/guardians' refusal to bring their wards to the health facility, either due to stigma or being overprotective."

3.5.4 Paediatric HIV Performance Gap

A critical disparity emerged between adult and paediatric HIV outcomes. Workshop participants identified "Low Paediatric ART Coverage (adult coverage is on 90% while paediatric is less than 50%)" as a major performance gap, highlighting the urgent need for improved paediatric case-finding and treatment linkage.

3.5.5 Geographic and Subnational Variations

The desk review identified persistent geopolitical disparities in HIV prevalence, service uptake, and health system performance. Prevalence exceeds 5% in states such as Akwa Ibom and Benue, and several Northern states currently report coverage below 60% on key indicators, indicating priority areas for targeted scale-up.

Interview participants highlighted state-level variations in government support. In Benue State, increased HIV budget allocation under new gubernatorial leadership resulted in "funds reached LGA levels," while other contexts showed minimal government financial support.

3.6 Policy, Legal, and Programmatic Milestones

3.6.1 Legal Framework Developments

Violence against Persons Prohibition Act (VAPP): Significant progress occurred with VAPP Act domestication in 32 states and the Federal Capital Territory by 2023, representing expansion from previous years. This legal framework provides critical protections against gender-based violence and supports HIV prevention efforts.

Sexual Assault Referral Centres (SARCs): Operational SARCs were established in 36 states, providing essential services for survivors of sexual and gender-based violence. Interview participants noted these centers as achievements in the response infrastructure.

HIV Anti-Stigma Legislation Gaps: Workshop participants identified a critical gap with HIV anti-stigma laws remaining undomesticated in 19 states, perpetuating "continuous stigma and discrimination" and limiting service access for people living with HIV and key populations.

3.6.2 Programmatic Innovation Milestones

Harm Reduction Program Implementation: A significant programmatic milestone was the "full implementation of harm reduction programme interventions." Previously, only six of nine harm reduction interventions were implemented, lacking needle syringe programs, opioid substitution therapy, and naloxone for overdose management. Plans for the rollout of medication-assisted treatment (MAT) was finalized in 2024, with implementation set to begin in 2025.

Early Infant Diagnosis Expansion: Significant achievements included improved early infant diagnosis capabilities. In Anambra State, five point-of-care facilities were established using the "m-PIMA machine and the GeneXpert site," substantially improving turnaround times for infant diagnosis.

Operation Triple Zero (OTZ) Success: Interview participants highlighted OTZ as a major achievement, with one noting "the level of support received through initiatives like Operation Triple Zero" and describing how "youths gather up to help their fellow youths" in peer support networks.

3.6.3 Data and Surveillance Milestones

Data Quality Improvements: A significant milestone was the resolution of data discrepancies that had prevented international reporting. One interview participant noted: "For the first time ever, we went digging into what exactly is happening, cleaning up the data and all, and were able to publish on the international platform, the country's data."

Community Monitoring Institutionalization: The "Community iMonitor" platform, used by NEPWHAN has gained recognition as an effective tool for real-time accountability and treatment monitoring although integration into national systems remain incomplete.

3.7 Data Availability, Quality, and Systems Integration Issues

3.7.1 System Fragmentation Challenges

critical cross-cutting issue identified across all evidence sources is persistent data system fragmentation. The desk review noted that "integration between the NDR, DHIS2.0, NDRS and donor-facing systems like MER remain limited, resulting in a fragmented monitoring environment."

Workshop participants emphasized that "donor-linked program reporting function largely parallel to national tools, with limited cross-platform triangulation." This fragmentation creates multiple problems:

- Redundant reporting burdens at facility and SACA levels
- Conflicting definitions and inconsistent indicator alignment
- Limited ability to validate data across platforms

3.7.2 Data Quality and Verification Issues

Historical Data Quality Challenges: A national joint DQA conducted in November 2024 across 96 facilities in 12 states found generally good concordance for key treatment indicators: 58% of facilities achieved a 100% verification factor for TX_NEW on NDARS, while variance greater than 10% was more common for TB_ART, PMTCT_EID, and HTS_TST in some sites (JDQA 2024). Client-level checks revealed high concurrence for unique identifiers, sex, and regimen (approximately 85%), with opportunities to improve documentation for age (approximately 69%) and ART start dates (approximately 71%). Data-systems criteria (staffing, tools, indicator definitions, data use) ranged roughly from the low 60s to mid-70s percent, indicating steady progress with specific areas requiring continued support. In light of these 2024 findings, the review addresses data quality issues as targeted improvements in interoperability, documentation, and supervision—rather than as signals of system failure.

Electronic Medical Records Integration: The desk review revealed inconsistent electronic medical record (EMR) usage and variable documentation of viral load across facilities. Despite the existence of electronic medical records and audit systems like NDR, facility-level data discrepancies and overreporting persist.

3.7.3 Surveillance Data Limitations

Outdated Bio-behavioral Data: A significant limitation is Nigeria's reliance on IBBSS 2020 and NAIIS 2018 data for key epidemiological indicators. Workshop participants identified "gaps remain in behavioural surveillance and state-level granularity" due to "high cost and complexity of national bio-behavioural surveys" and "infrequent behavioural survey" implementation.

State-Level Data Granularity: The desk review noted that "national-level dashboards often mask inequalities by presenting aggregated metrics. Without disaggregation by age, sex, geographic zone, and risk category, program planning cannot adequately address disparities."

3.74 Integration and Interoperability Issues

Cross-Platform Data Alignment: Despite improvements in GAM data alignment with EMRIMS-DHIS2.0, MER, and Spectrum outputs post-2022, significant challenges remain. Workshop group deliberations identified "overlapping and parallel reporting systems with limited interoperability amongst government agencies, IPs, and donors" as a persistent barrier.

Community Data Exclusion: Workshop group deliberations highlighted that existing M&E systems "fail to fully capture the contributions of non-health sector or community-led interventions," despite their significant impact on service delivery and community engagement.

Decision-Making Data Utilization: Workshop Participants identified "poor use of data for decision making," noting that "available data not fully analysed and used for decision making" and "lack of harmonization across multiple data platforms and reporting tools."

This strategic context reveals the HIV response system achieving significant treatment successes, while facing persistent challenges in prevention, data integration, domestic financing, and equity across populations and geographic areas. The convergence of evidence across desk review, stakeholder interviews, and workshop deliberations confirms both areas of progress and urgent priorities requiring immediate attention.

4. Thematic analysis and synthesis of findings

Each subsection integrates data from desk review, interviews, and workshop outputs under one theme

4.1 HIV Prevention and Community-Led Response

4.1.1 Status of Prevention Programming and Impact

2024 prevention outcomes remained below target, and Q1–Q2 2025 showed a marked downturn: prevention reach –50.5%, HTS –70.2%, and PrEP –83% from Q1 to Q2 among KPs/VPs, while commodity trends were mixed (male condoms –36%, female condoms +153%, needles/syringes +12%). These signals, together with reported reporting-rate declines in Q2, point to both supply and implementation continuity gaps needing immediate correction to protect gains.

Current Performance Assessment: The triangulated evidence indicates that prevention is the least effective component of Nigeria's HIV response. The desk review documented approximately 75,000 new infections annually, with a 46% decline in new infections from 2010 to 2023, falling short of the 95% % reduction target in the NSP 2023–2027. Interview participants described 2024 prevention performance as "moderate," noting that the policy framework (NSP 2023–2027 (prevention pillar), the Generation Negative strategy for adolescents and young people, and guidance emerging from the Key Population Programme Review (2024 draft)) is "very good" and "quite successful," while implementation continues to face resource and systems constraints. Overall, prevention targets were underachieved across several population groups.

PrEP Programming Challenges: A key gap identified during the workshop was the misalignment between government and donor priorities in the delivery of PrEP services. Government programs prioritized high-risk adolescents and young people, sero-discordant couples, KP and their partners, while donor-supported programs (PEPFAR) focused primarily on KP and, more recently, PBFW. According to 2024 eNNRIMS DHIS data specific to KP, 218,747 individuals received PrEP, representing 54.6% of the annual target of 400,357. However, retention remains a significant challenge, with 31,053 individuals (14.2%) discontinuing PrEP and 418 seroconversions recorded. Interview participants highlighted that a major issue with PrEP is adherence, noting that many individuals do not complete the full regimen and discontinue treatment prematurely.

Prevention Service Disruptions: "The workshop highlighted that PrEP and condom service delivery has been severely disrupted, with participants noting that "services are no longer functional" due to restricted or limited donor funding. Interview findings confirmed this disruption, revealing that in early 2025, the U.S. Government (KP) prevention services and repurposed funding toward life-saving and humanitarian interventions, significantly affecting the availability and continuity of HIV prevention services for KPs.

4.1.2 Role and Sustainability of Community-Based Actors

Community Organization Contributions: The desk review noted that community organizations remain vital to Nigeria's HIV response with NEPWHAN continuing to lead community-based treatment monitoring through platforms like Community iMonitor. KP-led CSOs demonstrated sustained engagement in reaching hard-to-reach and criminalized populations, while faith-based and youth-led initiatives contributed significantly to stigma reduction and behavioural change communication.

Financial Sustainability Challenges: "Persistent challenges related to financial sustainability emerged across all sources of evidence. The desk review noted that "the majority of community-led organizations remain excluded from domestic funding pipelines and face prolonged underfunding despite their high impact." In response, workshop participants recommended leveraging existing government structures and funding mechanisms to empower community-based organizations (CBOs), networks of key and vulnerable populations, and local leaders to lead outreach and service delivery efforts.

Integration into Formal Systems:" Interview participants highlighted successful community engagement, citing the "cooperation of support groups" and how "youths gather up to help their fellow youths." Despite these successes, workshop participants emphasized the need to integrate community-led services into government health facilities and to strengthen the capacity of health workers to deliver community-friendly services.

4.1.3 Challenges in Uptake and Reach of Preventive Services

Awareness and Knowledge Gaps: Workshop participants identified "low awareness and limited knowledge among the target population about prevention services," with "KP and GP not knowing where to access PrEP" due to "change in donor priorities." The desk review now draws on NDHS 2023–24, which confirms that comprehensive HIV prevention knowledge among youth aged 15–24 is 30% for women and 22% for men, indicating that overall knowledge remains low.

Structural and Supply Chain Barriers: Multiple evidence sources identified commodity availability as a critical constraint. Interview participants consistently reported "frequent stockouts of test kits" and challenges where "some of these test kits would be out of stock." Workshop participants noted "de-prioritization of HIV prevention commodities from the National led last-mile distribution, leading to shortage/stock out."

Root Cause Analysis: Workshop participants identified several interconnected root causes:

- "Over-reliance on donor funding"
- "Global financial challenges"
- "Parallel implementation of intervention by donors (deviation from the national guideline)"
- "Lack of political will"

4.2Testing, Treatment, and Continuity of Care

4.2.1 HIV Testing Coverage and Yield

Testing Performance Overview: The desk review documented that: 1,029,985 individuals from key populations were tested in 2024, with 26,051 testing positive (2.53% positivity rate). However, significant testing gaps persist, particularly among underserved populations. Workshop participants identified "unbooked pregnancies" as a critical concern, noting women who "did not register for antenatal care until late or delivery time, without knowing their HIV status." Quarter-over-quarter (Q1→Q2 2025), KP/VP HTS volumes fell ~70.2% nationally, reinforcing the need to stabilise test kit supply and protect PITC/index testing across high-yield points of care.

Key Population Testing Variations: Testing yields varied significantly across populations, with people who inject drugs showing the highest positivity rate at 3.52%, indicating this population remains most at risk. Interview participants noted that mobile testing was hindered by frequent stock-outs of HIV test kits, limiting reach and effectiveness.

Facility-Level Testing Challenges: Workshop participants identified multiple barriers, including "lack of awareness and health education at the community level," "stigma and fear of HIV," and "financial and access barriers." Interview participants confirmed these challenges, noting that not "everybody would agree with what you are doing" and some clients "don't want to come" for testing services.

4.2.2 ART Coverage, Retention, and Viral Suppression

2024 national cascade: 87-98-96, , with continued high viral suppression among those on ART. In 2024, 204,201 individuals from key populations were receiving ART, with high rates of viral suppression among those retained in care. Interview participants described treatment services as "seamless," noting that approximately 198,000 individuals were on ART within specific state contexts.

Population-Specific Performance Variations:
Key Population ART Coverage (2024):

- Sex Workers: 94,969 on ART
- MSM: 64,167 on ART
- PWID: 39,605 on ART
- Transgender: 2,677 on ART

Viral suppression data (≥6 months on ART):

- Sex Workers: 58,704 virally suppressed
- MSM: 38,894 virally suppressed
- PWID: 25,506 virally suppressed
- Transgender: 1,859 virally suppressed

Paediatrics: 83-87-88 cascade confirms strong suppression among children on therapy but continued gaps in early diagnosis and timely ART initiation.

4.2.3 Integration of Services, Differentiated Care, and PMTCT Gaps

Differentiated Service Delivery Success: The desk review identified that differentiated service delivery (DSD) models were "instrumental in sustaining treatment continuity, especially in hard-to-reach areas and during post-COVID-19 recovery." Interview participants confirmed that "OSS was well-utilised and integrated with other services. It was well-stocked and functioned efficiently."

PMTCT Coverage and Integration Challenges: Workshop participants identified that "only 60-70% of pregnant women living with HIV are identified and enrolled in care." The desk review estimated PMTCT coverage at 65% in 2024, while interview participants noted "PMTCT programme scale-up was a continuous success," involving "mapping over 1,100 service delivery points (sites), including TBAs."

Service Integration Disruptions:

In the context of the 2025 global aid policy shifts, interview participants highlighted worrying reductions in service integration. They noted that One-Stop Shops (OSS), which had previously ensured adherence support and provided integrated services such as TB and hepatitis testing, are no longer functioning at the same capacity. Workshop participants emphasized the urgent need to strengthen the integration of HIV services within public health facilities and to ensure that all related programs are embedded at the primary care (PC) level to mitigate the impact of reduced external support.

Linkage to Care Gaps: Workshop participants highlighted "weak linkage to care, especially between ANC, delivery services, and HIV treatment" with "significant drop-off between maternal diagnosis and EID testing for infants." Root causes include "frequent stock-outs of test-kits, condoms, and DBS kits for EID," "health worker shortage and poor task clarity," and lack of tools such as referral registers, follow-up mechanisms (e.g., phone calls), and designated linkage officers.

4.3 Human Rights, Gender, and Equity Dimensions

4.3.1 Legal and Social Barriers to Access

Legal Framework Progress and Gaps: The triangulated evidence reveals mixed progress on legal protections. The desk review documented that the Violence Against Persons Prohibition (VAPP) Act has been domesticated in 32 states and the FCT, with Sexual Assault Referral Centres (SARCs) operational in 36 states. However, workshop participants highlighted a critical gap: HIV anti-stigma laws remain undomesticated in 19 states, perpetuating "continuous stigma and discrimination."

Criminalization Impact on Key Populations: Workshop participants observed that "legal and structural barriers—including criminalization of same-sex behaviour, drug use, and sex work" continues to affect service uptake. The root causes were identified as "social norms, religious orientation and legal frameworks which are not supportive. (Same sex marriage prohibition Act, (SSMPA) 2013)

Enforcement and Implementation Challenges: Workshop participants identified "delayed justice/enforcement of gender-related laws and policies" due to "gender stereotypes at the decision-making levels." Interview participants noted ongoing challenges where "KP communities face stigma and avoid public facilities."

4.3.2 Gender-Responsive Programming and Inclusion Gaps

Gender-Based Violence Response Infrastructure: The desk review confirmed significant infrastructure development with SARCs now operational across 36 states. Interview participants noted these as achievements in the response framework. However, Workshop participants identified "inadequate GHR funding at the state levels" due to "low-level prioritization of gender activities/interventions at the state level."

Women's Participation in Decision-Making: Workshop participants highlighted "gender stereotype at the decision-making levels" as a barrier to effective policy implementation. The workshop recommended advocating "for more safe space for women's involvement in politics, policy, and decision-making at all levels."

Adolescent Girls and Young Women Focus Imbalance: Workshop participants identified that "state level programmes still largely focused on AGYW with little targeted interventions for adolescent boys and young men," indicating a gender imbalance in youth programming that requires correction.

4.3.3 Protection, Stigma, and Enforcement Issues

Persistent Stigma and Discrimination: All evidence sources confirmed persistent stigma as a major barrier. Workshop participants noted "continuous stigma and discrimination" persists despite policy frameworks. Interview participants reported that "KP community members face heightened risks of GBV, stigma, and discrimination."

Community-Level Barriers: participants highlighted multiple stigma-related challenges, including "cultural silence around sexual and reproductive health," "fear of discrimination and social rejection," and "lack of confidentiality at health facilities." Interview participants confirmed that "not everybody would agree with what you are doing," and some clients avoid services due to stigma concerns.

Law Enforcement Sensitization Needs: Participants highlighted recommended engaging "law makers, law enforcement, and judiciary through sensitization sessions on public health over punishment" and advocating for "community-led paralegal and legal aid services for KPs experiencing rights violations."

Media and Community Awareness Gaps: participants highlighted "absence of media sensitization (radio jingles, sensitization/awareness outreaches)" as contributing to limited public awareness of protective laws. The workshop recommended "collaboration with media houses (government and private) to promote awareness of gender and human rights laws, policies as part of their corporate social responsibilities."

4.4 Adolescents and Young People

4.4.1 Barriers to Access and Service Gaps

Knowledge and Awareness Deficits: According to NDHS 2023–24, comprehensive HIV prevention knowledge among young people aged 15–24 is 30% for women and 22% for men. Knowledge rises sharply with education (56% of women and 43% of men with more than secondary education vs. 15% of women and 9% of men with no education), underscoring the value of targeted, age-appropriate messaging and school-to-community outreach.

Workshop deliberations also flagged youth treatment outcomes as a priority for closer tracking. The workshop further noted that new HIV infections have fallen more slowly than desired (2010–2023), reinforcing the need to intensify prevention for adolescents and young people alongside improved linkage and continuity of care.

Structural and Policy Implementation Barriers: Group participants highlighted key structural challenges, including "lack of domestication of AYP strategy at the state levels" and "lack of enforcement and domestication of the Violence Against Persons Prohibition Act (VAPP)." The root causes include "weak collaboration between SACA, SASCP, NHRC, LEAs, and the Judiciary at the state level."

Service Access and Psychological Barriers: Multiple barriers affect young people's engagement with HIV services. Workshop participants highlighted "psychological effects of taking medications," "unemployment status of some indigent AYP," and "workplace fatigue (mental health issues PATA 64%)" as significant challenges. Additionally, "lack of compliance to health care ethics among some health workers" and "judgmental attitude of some health workers" create service environment barriers.

4.4.2 Youth-Specific Interventions (e.g., Generation Negative)

Generation Negative Strategy Implementation: The desk review revealed that the Generation Negative (Gen-N) Strategy aimed to integrate HIV prevention into education, youth engagement, and social protection platforms. However, implementation tracking remains insufficient with "the operationalization of the Gen-N strategy lacking sub-population tracking or standardized indicators across regions, and so, making it difficult to measure reach and behaviour change."

Programming Focus Imbalance: Groupparticipants highlighted a critical gap where "state level programmes still focused largely on AGYW with little targeted interventions for adolescent boys and young men." This gender imbalance in youth programming requires immediate correction to ensure comprehensive coverage.

Support Group Effectiveness: Interview participants highlighted successful youth engagement models, particularly noting Operation Triple Zero (OTZ) as "the biggest achievement," where "youths come together to help their fellow youths." One participant described how peer support works: "There are times that one person might not have food or money to come to the facility. You find out that most of these peers find a way to give you food or send you money for you to come to the facility."

4.4.3 Demand Generation and Youth Participation

High Viral Suppression Among Engaged Youth: Interview participants noted positive outcomes where young people were successfully engaged, reporting "high suppression rate among AYPs" with "about 88% of all those adolescents actually achieving viral suppression, which is a huge success."

Skill Development and Economic Empowerment: Interview findings highlighted "skill acquisition for AYPs" as a significant achievement, providing "opportunities for self-dependence" through programs that gave "sewing machines, kneading and the rest." This economic empowerment approach addresses unemployment-related barriers to service engagement.

Funding and Resource Challenges: Sustainable youth engagement faced resource constraints. Interview participants noted that "the youths were engaged but faced funding gaps since Benue was not part of the Global Fund AYP-supported states." This highlights geographic disparities in youth programming support.

Community and Facility Integration Needs: Workshop participants recommended strengthening "community-facility linkages and tracking systems" while addressing "judgmental attitude of some health workers" through improved training and sensitization.

4.5 Key Populations

4.5.1 Structural and Legal Challenges

Criminalization and Legal Barriers: "legal and structural barriers, including criminalization of same-sex behaviour, drug use, and sex work" as fundamentally affecting service uptake. The root cause was traced to "social norms, religious orientation, legal frameworks that are not supportive and were based on our social norms and religion," (Same Sex Marriage Prohibition Act, (SSMPA) 2013).

Service Environment Challenges: Interview participants confirmed ongoing difficulties, noting that "KP communities face stigma and avoid public facilities" and "KP community members face heightened risks of GBV, stigma, and discrimination." Workshop participants identified "low HIV awareness of testing options among key populations (facility testing, self-testing)" due to "targeted awareness campaign on testing options is not optimal due to poor financing, poor collaborations."

Law Enforcement and Judicial System Barriers: The structural challenges extend beyond healthcare settings. Participants highlighted the recommendation to engage "lawmakers, law enforcement agencies, and the judiciary through sensitization sessions on public health over punishment" to address systemic discrimination within justice systems.

4.5.2 Community-Led Innovations and Service Access

One-Stop-Shop Model Effectiveness: Interview participants highlighted the success of KP-friendly service models, noting that "KP-friendly one-stop shop clinic offered better services" and facilities were "on top of the game and provided KP-friendly HIV services." The OSS model provided integrated services and was "well-utilised and integrated with other services."

Peer Navigation and Support Systems: The desk review confirmed that KP-led community organizations and peer navigation systems improved reach, trust, and linkage to services through tailored testing, prevention, and ART delivery models deployed through safe spaces and mobile outreach teams.

2024 Service Performance: Despite challenges, key population services showed strong performance metrics:

- Over 1 million KP individuals accessed HIV testing
- 204,201 were on ART
- 127,105 were virally suppressed
- Strong retention rates among those successfully linked to care

4.5.3 Peer-Driven Approaches and Gaps in Program Reach

Network Strengthening Achievements: Interview participants noted "strengthening of NKPRHN, " including " state leadership capacity building and stakeholders' engagement," leading to the "development of a 5-year strategic plan and accountability framework for NKPRHN," and providing "life-saving intervention at the community level for KPs."

Geographic and Population Reach Variations: Workshop group deliberations identified significant gaps in program reach, noting that in some states, the OSS was the "only facility" providing KP-friendly services. Additionally, "high mobility and security issues (e.g., the death of a KP coordinator), which led many to flee," created access challenges in conflict-affected areas.

Harm Reduction Implementation Gaps: Interview respondent noted that "needle & syringe programs for PWID are skeletal in the NSP states, and harm reduction intervention wasn't sure of." However, progress was made with "full implementation of harm reduction programme interventions" being planned, including previously unavailable needle syringe programs, opioid substitution therapy, and naloxone for overdose management.

Service Disruption Challenges: Sustainability challenges emerged prominently. Interview participants reported that "with OSS centers closed in 2025 due to President Trump's order, tracking KP adherence would be difficult." This highlights the vulnerability of KP services to disruptions in external funding.

4.6 Leadership, Governance, and Financing

4.6.1 Domestic Ownership and Political Commitment

Government Leadership Variations: The evidence suggests significant differences in state commitment and follow-through. Stakeholders described gains in some settings, more substantial ownership, clearer direction, and more predictable funding. For instance, in Benue State, interviewees highlighted an increase in the HIV budget under the new administration, with funds flowing down to LGA-level structures to support delivery. NACA's 2024 assessment of government spending on human resources for HIV also shows variation in state financing and reporting. On average, estimated government HR expenditure per state increased from ₦1.64 billion in 2019 to ₦2.01 billion in 2021 (national totals: ₦60.82 billion, ₦69.27 billion, and ₦74.39 billion, respectively), indicating gradual increases in public outlays for the workforce delivering HIV services. At the same time, several states (Kwara, Edo, Akwa Ibom, and Lagos) could not be included in the state-level analysis due to the unavailability of financial data at the time, underscoring uneven documentation and release-tracking across the federation. Service footprints also differ: in the five facilities sampled per state, 46.23% of Edo's and 44.80% of Sokoto's state ART cohorts were captured, suggesting comparatively concentrated service organization in those locations.

Political Will Challenges: Workshop participants identified persistent challenges with "lack of implementation, misalignment, and enforcement of national and state policies" due to "inadequate funding from federal and state governments" and "non-compliance of policies." Interview participants emphasized that "political will is paramount to ensuring that our leaders understand the importance" of HIV programming.

Coordination Gaps

National gaps. The health sector response has formal coordination channels, including partner coordination meetings, national task teams, performance reviews with all 36+1 states, and joint policy development with stakeholders, all aligned with NACA for a "one national response." Even so, workshop discussions highlighted the need to broaden the consistent participation of CSOs and affected-population networks in high-level deliberations to strengthen the relevance and ownership of policies.

Sub-national gaps. The non-health sector M&E assessment (2024) highlights practical coordination shortfalls at the state level: low advocacy support for M&E and weak feedback loops; weak communication between SACAs and NHS entities; irregular reporting cycles that complicate alignment with health-sector data; and underutilisation of national guidelines. States were also advised to formalize DHIS2 governance teams, standardize processes, and strengthen interoperability with other platforms (e.g., the health sector, NOMIS, NEMIS). Together, these point to coordination gaps that are solvable with clearer roles, routine engagement, and predictable reporting.

4.6.2 Budget Allocation, Absorptive Capacity, and Partner Alignment

Donor Dependency Crisis: Multiple evidence streams show Nigeria's HIV response is critically reliant on external funding. At the national level, NASA reports that international sources financed approximately 93%, 96%, and 96% of total HIV spending from 2019 to 2021, respectively. In 2021 specifically, PEPFAR contributed ~76% and the Global Fund ~19% of all HIV expenditures. These national figures align with the workshop and desk-review findings that flagged donor dependence (e.g., 82.8% / 81%); any differences likely reflect sub-national scopes or differing denominators, while NASA's country-wide accounting shows even higher reliance. Interviewees' concern— "funding is inadequate to provide the HIV service program in the state"—is consistent with this documented structural dependence.

Budget Allocation and Release Challenges: Workshop participants identified "Disbursement delays by the Government" due to "budget inefficiencies, lack of transparency, and bureaucratic bottlenecks hindering timely resource allocation." Interview participants confirmed these challenges, noting that "access to funds remain a major challenge, approvals take too long" and "the challenge we have is government resource, not that it has not been approved for release by government."

HIV Trust Fund Underperformance: The desk review noted that the HIV Trust Fund of Nigeria launched in February 2022, "remains underutilized with limited evidence of scaled disbursements, transparency in fund flows, or systematic integration into national HIV budgeting." No public progress report has been issued since the fund's inception.

Partner Alignment Challenges: Workshop participants identified "weak collaboration and synergy in terms of programming amongst implementing partners and government agencies" due to "no counterpart funding by government." Interview participants noted that "the program is funded and implemented mainly by partners. Government support is minimal to moderate."

4.6.3 Accountability and Oversight Structures

State-Level Accountability Mechanisms: Interviewed participants highlighted efforts to strengthen local accountability structures, including *"reactivation of Local Government Agency for the Control of AIDS (LACA) structures"* with capacity building on *"how to mobilize resources and also how to be active in the budget and AOP process in their various LGAs." Additionally, "letters were circulated to LGA chairmen promoting "LGAs taking ownership" of HIV programming,"* R1.

Data-Driven Decision Making: Workshop participants emphasized the importance of evidence-based governance, with participants noting "the data we go through helps to inform these strategies, the decisions we take," and "we use our data for any decision that we want to take at the state level."

Sustainability Planning Gaps: Workshop participants identified that "Nigeria is looking at using the already developed sustainability plan that NACA has worked on," but implementation remains inconsistent. The desk review noted that "no state currently operates with a costed HIV sustainability plan tied to routine budget cycles."

4.7 Pediatric HIV and PMTCT Integration

4.7.1 Service Coverage and Missed Opportunities

Pediatric Coverage Gap: Workshop participants identified a critical disparity: "Low Paediatric ART Coverage (adult coverage is over 90%, while paediatric is less than 50%)." This represents one of the most significant gaps in Nigeria's HIV response, despite overall strong cascade performance for adults.

PMTCT Coverage Status: The desk review estimated PMTCT coverage at 65% in 2024, while the interviewed participants described the "PMTCT programme scale-up as a continuous success," involving "mapping over 1,100 sites, including TBAs." However, Workshop participants noted that "only 60-70% of pregnant women living with HIV are identified and enrolled in care."

Case-Finding Challenges: Workshop participants identified that "a large number of children missed during family or index testing" due to multiple factors, including "parents/guardians' refusal to bring their wards to the health facility, either due to stigma or being overprotective."

4.7.2 Mother-Child Pair Tracking and Continuity

Linkage to Care Gaps: Workshopparticipants identified "weak linkage to care, especially between ANC, delivery services, and HIV treatment" with "significant drop-off between maternal diagnosis and EID testing for infants." The root causes include "frequent stockouts of ARVs or DBS kits for EID demotivate clients and delay critical steps in the care cascade."

Early Infant Diagnosis Improvements: Despite challenges, significant achievements were noted. Interview participants highlighted improved early infant diagnosis in some states: "for instance, in Anambra State we have five PoCs, point of care for early infant diagnosis, the m-PIMA analyzer and the Gene-Xpert site that was activated for the testing and early infant diagnosis, which ensures that our infant's diagnosis comes out early, as well as decreasing the turnaround time."

Community Engagement Strategies: Workshop participants recommended strengthening community involvement through "regular engagement meetings with TBAs to encourage early referrals to PHCs" and "provide TBAs with basic incentives for every pregnant woman referred for ANC/PMTCT."

4.7.3 Coordination Across Maternal and Child Health Systems

Integration Challenges: Workshop participants identified "lack of integration between immunization clinics, outpatient services, and HIV services" as a fundamental barrier. The recommendation emphasized the need to "integrate HIV, immunization, outpatient, and nutrition services."

Cultural and Social Barriers: Workshop participants identified multiple social determinants affecting PMTCT success, including "cultural beliefs against early disclosure of pregnancy," "male dominance," and "preference for Traditional Birth Attendants (TBAs)." Interviewed Participants noted that due to late presentation, some HIV-positive women remain undiagnosed during pregnancy, and their babies' HIV status is only determined much later, often well after birth.

Health System Strengthening Needs: Workshop participants emphasized the need to "scale up HIV testing in all PHCs by training existing ANC staff on HIV counselling and testing" and "ensure consistent supply of HIV test kits through improved logistics and stock monitoring."

4.8.1 Systems Integration and Social Protection

4.8.1 Multisectoral Collaboration

Integration Policy Framework: The desk review noted that while multisectoral collaboration is a stated priority in all major policy frameworks, including the NSP 2023-2027 and SDS 2020-2025, "operational tools for cross-sector delivery remain lacking. No central system currently tracks HIV service overlap with education, justice, or social welfare programs."

Cross-Sector Coordination Challenges: Workshop participants identified limited integration of HIV services into social protection programs (e.g., NHIA, NASSCO, Conditional Cash Transfers) due to the absence of an HIV-sensitive policy, weak inter-agency collaboration, and lack of HIV data linkage with the social registry.

Ministry Coordination Gaps: Interviewed participants noted that "service integration and coordination has actually been a challenge several times" and "coordination is realistically very, difficult." The desk review confirmed minimal evidence of performance tracking from linked social protection platforms, insurance schemes, or state-level health integration efforts.

4.8.2 HIV in Humanitarian Contexts

Emergency Response Gaps: Workshop participants identified "inadequate HIV service delivery in humanitarian settings (IDP camps)" due to "no available SOPs for HIV in emergencies," "weak NACA–NEMA, National refugees commission, and other relevant humanitarian agencies collaboration," and "periodic ARV/test kit stock-outs across SDPs areas."

Pandemic Preparedness Deficits: A critical gap identified was the exclusion of HIV from pandemic preparedness and response. This is due to HIV not being classified as an essential service in the National Pandemic Response Plan (NPRP), the absence of NACA representation in Emergency Operations Centre (EOC) coordination, and the lack of a continuity plan for HIV services during pandemics.

Humanitarian Population Tracking: Workshop participants noted that "displaced persons were not reflected in HIV data systems," creating invisibility of vulnerable populations in emergency settings and limiting targeted response capacity.

4.8.3 Social Protection and Social Determinants

Health Insurance Integration Gaps: The desk review noted that "Nigeria's National Health Insurance Agency (NHIA) has yet to formally and consistently incorporate comprehensive HIV services, particularly for the informal sector, youth, and key populations." Workshop participants emphasized the need for "HIV-sensitive social protection policies" and strengthened collaboration frameworks.

Domestic Funding for Non-Health Sectors: Workshop participants highlighted "weak domestic funding for HIV in non-health sectors" because "HIV-related activities outside health are heavily donor-funded" and "line ministries lack HIV budget lines."

Social Registry Linkage Needs: Theworkshop participants recommended developing systems where "HIV data linked with social registry" to enable coordinated social protection responses for people living with HIV and their families.

4.9 Partnerships and Coordination Mechanisms

4.9.1 Coordination Platforms and Effectiveness

Coordination System Fragmentation: Workshop participants identified "weak collaboration and synergy in terms of programming amongst implementing partners and government agencies" as a fundamental challenge. The root cause was identified as "no counterpart funding by government," creating asymmetric partnership dynamics.

Data System Coordination Challenges: A persistent issue across all evidence sources is coordination around data systems. Workshop participants highlighted "overlapping and parallel reporting systems with limited interoperability amongst government agencies, IPs, and donors" due to "unsynchronized data reporting systems."

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Decision-Making Coordination Gaps: Workshopparticipants identified two key gaps in decision-making coordination: the "poor use of data for decision making" stemming from the "available data not fully analysed and used for decision making" and the "lack of harmonization across multiple data platforms and reporting tools."

4.9.2 Partner Roles, Alignment, and Harmonization

Donor-Government Alignment Issues: Interviewed participants noted varying levels of government-partner collaboration. While some reported "strong collaboration with UNHCR and minimized duplication of efforts," others highlighted challenges where "the program is funded and implemented mainly by partners. Government support is minimal to moderate."

Implementing Partner Coordination: The desk review confirmed that "donor-side systems such as EMR and DATIM still underrepresents critical components like primary prevention, mental health integration, and psychosocial support," creating narrow assessments of program quality.

Technical Working Group Effectiveness: Workshop participants referenced "ATM Technical Working Group" as providing evidence for gap assessments, indicating functional technical coordination mechanisms in specific thematic areas.

4.9.3 Government-Donor-NGO-Private Sector Synergy

Private Sector Engagement Limitations: The desk review noted that "private sector engagement" has moved "beyond corporate social responsibility to define structured private sector roles in logistics, diagnostics, and demand creation," but implementation remains limited. Interviewed participants noted the success of "working with PPMVs [Patent and Proprietary Medicine Vendors" for community-level service delivery.

NGO-Government Integration: Interviewed participants highlighted positive examples of NGO-government collaboration with private health facilities, noting partnerships with medical directors to ensure that women receive the necessary services.

Coordination Platform Functionality: The desk review noted that while national coordination mechanisms claim multisectoral reach, there is little evidence of performance tracking from social protection platforms, insurance schemes, or state-level health integration efforts.

4.10 Data, Research, and Innovation

4.10.1 Performance of Routine Data Systems (DHIS2, NDR, LAMIS)

System Fragmentation and Interoperability: The triangulated evidence consistently identifies data system fragmentation as a critical challenge. The desk review noted that "platforms like DHIS2, NDR, and EMR/DATIM now captures large volumes of near-real-time HIV program data. However, these systems operate in silos using different governance structures, data formats, and reporting timelines."

Data Quality and Verification Issues: Workshop participants highlighted that "donor-linked program reporting operates largely in parallel to national systems, with limited cross-platform data triangulation." The desk review confirmed that "data from EMR and NDR frequently differ from DHIS2-based reports, particularly at sub-national levels, limiting the reliability of aggregate progress statements."

State-Level Data Capacity Challenges: Interviewed participants reported significant challenges: "Our data system, if healthcare workers are partner-based, that means that our data is in the hands of the partners," and "data management has collapsed" in some contexts. Workshop participants identified that "surveillance is not institutionalized in state-level budgets; donor funds prioritize treatment and commodities."

4.10.2 Research-to-Practice Gaps

Surveillance Data Currency Issues: Workshop participants identified "gaps in behavioural surveillance and state-level granularity" due to "high cost and complexity of national bio-behavioural surveys" and "infrequent behavioural survey" implementation. The desk review confirmed continued reliance on outdated sources, "IBBSS 2020 and NAIIS 2018, for key epidemiological indicators" despite being over four years old.

Evidence Generation Challenges: The desk review noted that "most reports rely on numeric indicators, leaving out community voices and frontline realities. Issues such as stigma, provider discrimination, legal fear, and system fatigue are underreported, despite their impact on service uptake and retention."

Research Utilization Gaps: To avoid duplicating the general "data-for-decision" points, this domain focuses on how evidence moves into policy and practice. The materials indicate four practical gaps: (1) most states do not yet have a formal Evaluation and Research Agenda, (2) dissemination is not consistently built into M&E plans (e.g., policy briefs for policymakers, youth-friendly summaries, routine learning bulletins), (3) limited, documented pathways for converting operational research/pilots into guideline updates, budgets, and supervision tools, and (4) weak tracking of how study findings inform annual workplans. Interview notes echo this pattern—capacity-building initiatives exist (e.g., e-learning), but structured channels for translating findings into directives are uneven.

4.10.3 Innovation in Program Delivery and Analytics

Digital Platform Innovations: Interviewed participants highlighted successful innovations, including "NACA e-learning platform to build capacity of all in HIV service provision" and "client case management apps anything about that client will pop up, you will not miss this opportunity."

Community-Led Monitoring Innovation: The desk review emphasized that "community-led tools such as 'Community iMonitor' (used by NEPWHAN) have shown promise for real-time accountability but are yet to be institutionalized." Participants recommended exploring "inclusion of non-health sector (community-led) reporting into the National Data Repository (NDR)."

Data Integration and Harmonization Needs: Workshop participants recommended that "states and partners are mandated to implement the government governance framework" for data reporting. Interviewed participants emphasized the need to "integrate various systems and platforms to have a single source for all related data."

Innovation Implementation Challenges: Despite progress in deploying national digital systems, the ability to leverage them consistently for program innovation remains uneven. NDARS (DHIS2-based) and the client-level NDR are operational at scale with 38,035 PMTCT service points onboarded and state teams trained across 36+1 states yet gaps in IT equipment, connectivity, and dedicated data staff still limit routine use and data-to-action workflows. Interviews also highlighted practical opportunities to deepen uptake, such as the NACA e-learning platform and client case-management apps, which, if paired with reliable connectivity and on-the-job mentoring, can translate technology into everyday implementation gains.

4.11 Sustainability and Response to Funding Landscape Changes

4.11.1 Current Sustainability Framework and Performance

Official Sustainability Roadmap and New Business Model: The sustainability presentation outlined Nigeria's formal roadmap to HIV program sustainability, anchored by the New Business Model (NBM) adopted through management consensus in January 2023. The roadmap defines three phases: the Current HIV Program (2024), characterized by NGO-led implementation and donor-dominant funding; the NBM phase (2026), with government-led implementation but continued donor-dominant funding; and the Sustainable HIV Response phase (2030), marked by both government-led implementation and government-dominant funding.

The desk review confirmed that the Sustainability and Development Strategy (SDS) 2020-2025 established a vision for transitioning to domestically financed and locally owned systems. However, the sustainability presentation reveals a more structured approach through the NBM, which focuses on "transition of management of the holistic response to HIV, to mandated structures (government, private & community structures)" and "redesign of the donor/partner relationships with host country institutions from direct service delivery (DSD) to technical assistance (TA) to mandated structures."

Donor Dependency Crisis: Workshop participants documented that 82.8% of HIV funds in Nigeria came from international/external sources, consistent with desk review findings of 81% from external sources. The sustainability presentation confirms this challenge, noting that the current implementation arrangement is "donor-dependent and unsustainable." While acknowledging that "Nigeria is on track to achieve epidemic control of HIV before 2030" "Donor support is expected to be restructured after epidemic control is achieved" to strengthen local ownership and build a more sustainable GON-led HIV program.

HIV Trust Fund Underperformance: The desk review identified that the HIV Trust Fund of Nigeria, launched in February 2022, "marked a significant milestone in public-private collaboration" but "remains underutilized with limited evidence of scaled disbursements, transparency in fund flows, or systematic integration into national HIV budgeting." The sustainability presentation emphasizes the need for diversified financing, including "health insurance (NHIA), statutory appropriation, and other domestic resourcing opportunities."

4.11.2 Impact of Recent Funding Landscape Changes

Immediate Funding Disruptions: Interview and workshop notes indicate that the USG directive did not halt HIV services; instead, it repurposed portions of HIV program funds toward life-saving and humanitarian efforts. Services for key populations continued. The primary near-term effect was a temporary suspension of disaggregating KP types in PEPFAR reporting, which affected routine performance tracking. Some partners also reported short-lived operational knock-ons—such as delayed payments to ad-hoc staff and brief pauses in selected community activities—until guidance and budgets were realigned. Overall, the issue is best framed as a shift in reporting and prioritization, not a cessation of services.

Service Delivery Disruptions: The funding disruptions had immediate service delivery consequences. Interviewed participants reported that "OSS centers closed in 2025 due to the Trump order, tracking KP adherence is difficult." Workshop group deliberations confirmed that "SDPs for the delivery of PrEP and condom services are no longer functional" due to "restricted/limited donor funding." Workshop participants noted the "inability to collect non-health sector data from across all the OSS and CBOs at the community levels."

Geographic and Population-Specific Impacts: The impacts varied across populations and geographic areas. Interview participants noted that key population services were most severely affected, while some areas were able to maintain services through government support. The workshop participants documented that "there are currently no funds from the government to implement gender and human rights activities in almost all states," highlighting a significant gap in gender and human rights programming.

4.11.3 Government Response and Ownership Variations

State-Level Government Support Variations: The Workshop participants revealed specific examples of government adaptation to funding crises. Niger State "absorbed about 130 ad-hoc staff to temporarily continue service delivery at the facility," while the Benue Governor "temporarily allocated One Hundred thousand Naira to each local government in 23 LGA to boost coordination and support for HIV." Plateau State "allocated 1% of the LGA allocation of funds to some LGAs in the state." These concrete examples demonstrate varying levels of state government commitment and adaptive capacity.

Innovative State-Level Approaches: The workshop documented innovative approaches, including Gombe state "investment in primary healthcare systems, while ensuring that facilities are up to standards, services optimized and integrity ensured instead of treating it as a fragmented facet." The state developed "Go health that seeks to use a system of contributory healthcare systems to help families in situations of medical emergencies," as well as demonstrating integration of HIV services into strengthening broader healthcare systems.

Political Commitment Inconsistencies: Challenges persist in many contexts. The Workshop participants confirmed that in almost all the states "there are currently no funds from the government to implement gender and human rights activities." Workshop participantsidentified "lack of implementation, misalignment, and enforcement of national and state policies" due to "inadequate funding from federal and state governments" and "non-compliance of policies."

Institutional Capacity Limitations: Interviewed participants noted systematic capacity limitations affecting sustainability readiness: "The program is funded and implemented mainly by partners. Government support is minimal to moderate." The workshop participants noted ongoing "consultations and meetings for domestic resource mobilization are currently ongoing," and that "the government has employed more workforce in some states," indicating emerging but uneven HR development.

4.11.4 Community and Civil Society Adaptation Strategies

Community-Led Organization Resilience: Despite funding disruption, community organizations adapted to maintain essential services. The desk review noted that community-led organizations demonstrated continued engagement despite being "chronically underfunded" and "excluded from domestic funding pipelines." Interviewed participants highlighted community solidarity, noting how "youths gather up to help their fellow youths" and provide mutual support during resource constraints.

Community Monitoring and Accountability: Community organizations strengthened monitoring roles during funding disruptions. The desk review identified that platforms like "Community iMonitor" provided real-time accountability and treatment monitoring, while workshop groups consistently recommended integrating community-generated data into national validation mechanisms as sustainability measures.

Civil Society Advocacy Response: Workshop participants identified intensified advocacy needs, recommending "continuous high-level advocacy" for domestic resource mobilization and legal framework completion. Civil society organizations adapted by increasing advocacy focus on government accountability and domestic ownership.

4.11.5 Health System Integration as Sustainability Strategy

Integration Progress and Challenges: Workshop groups consistently identified health system integration as essential for sustainability. Workshop participants recommended to "integrate all programs down to the PHC [primary health care] level. The HIV program should stop being a standalone program." Furthermore, the desk review noted that "operational tools for cross-sector delivery remain lacking" despite policy commitments.

Primary Health Care Integration Opportunities: Interviewed participants cited examples of successful integration where "PMTCT services have improved due to collaboration with the Ministry of Health." Workshop participants identified systematic opportunities to "integrate HIV services in public health facilities" and "harmonization of HIV indicators into the HMIS [Health Management Information System]."

Social Protection Integration Potential: Workshop participants identified that "limited integration of HIV services into Social Protection Programs" represent missed sustainability opportunities. The desk review confirmed that "linkages between HIV care and broader social protection mechanisms, such as cash transfers, school feeding, or nutrition schemes, remain largely aspirational."

4.11.6 Innovation and Efficiency Measures

Cost-Effective Service Delivery Models: In response to funding constraints, stakeholders developed innovative approaches. Interviewed participants noted successful "working with PPMVs [Patent and Proprietary Medicine Vendors]" for community-level service delivery. Workshop groups consistently recommended leveraging existing government infrastructure rather than creating parallel systems.

Technology and Digital Solutions: Interviewed participants highlighted technology innovations supporting efficiency, including "client case management apps" and "situation room" approaches for data-driven decision making. The desk review noted that "community-led tools such as 'Community iMonitor' have shown promise for real-time accountability," requiring institutionalization for sustainability.

Differentiated Service Delivery Sustainability: The desk review confirmed that differentiated service delivery models "were instrumental to sustaining treatment continuity, especially in hard-to-reach areas and during post-COVID-19 recovery." Interviewed participants noted these approaches remained effective during funding disruptions, indicating their sustainability potential .

4.11.7 Long-Term Sustainability Planning Requirements

New Business Model and Mandated Structures Framework: The sustainability presentation outlines a comprehensive framework of mandated structures to assume HIV program management. These include Health, Women's Affairs, Human Rights Commission, National Social Safety Nets, Education, Labour and Productivity, and FBOs/CSOs for various intervention areas (Treatment, GHR, Social Protection, and Prevention). The framework specifies that "mandated structures may engage in line with country needs, the private sector and civil society to help the country achieve its expected programme outcomes."

State-Level Capacity Development Process: The sustainability presentation defines a systematic three-step state process: 1) "Understand day-to-day operations & cost inputs (human resources, materials and funding)," 2) "Engage IPs & other stakeholders and identify a more efficient HIV program that can be situated within mandated structures and is sustainable for government," and 3) "Make the transition from IP management to management by government mandated structures while IPs provide technical support as long as they are available."

Cost of Doing Business Assessment Implementation: The sustainability presentation documents an ongoing Cost of Doing Business (CODB) Assessment commencing with seven states across 6 geopolitical zones (Anambra, Ebonyi, Gombe, Kwara, Lagos, Akwa-Ibom and Kaduna) to "facilitate and fast track state level engagements towards the sustainability agenda" and "develop a sustainability program, as well asroll-out toolkits based on these engagements that other states can use."

Institutional Development Priorities: Workshop participants identified systematic requirements for state-level sustainability preparation, including "costed sustainability plans with embedded accountability and co-financing targets" and "minimum criteria for state readiness to assume program ownership." The Workshop participants noted that"Consultations and meetings for domestic resource mobilization are currently ongoing," indicating active preparation for transition.

Legal and Policy Framework Completion: Workshop participants identified legal framework completion as essential for sustainability particularly the "domestication of HIV anti-stigma act in the remaining 19 states" of Nigeria, and establishing functional enforcement mechanisms. This provides necessary protection for continued programming regardless of changes in funding sources.

4.11.8 Strategic Recommendations for Sustainability

Immediate Sustainability Actions: Based on triangulated evidence, immediate actions include operationalizing the HIV Trust Fund with transparent reporting mechanisms, establishing emergency government funding protocols for service continuity, and strengthening state-level capacity for program management during funding transitions.

Medium-Term Sustainability Framework: Workshop groups consistently recommended graduated co-financing models, where states progressively assume greater financial responsibility, the integration of HIV services into routine health and social protection systems, and the establishment of domestic accountability frameworks independent of donor requirements.

Long-Term Sustainability Vision: The evidence supports a vision where Nigeria achieves 50% domestic funding by 2027, maintains epidemic control achievements through integrated service delivery, and establishes community-led accountability mechanisms with sustainable domestic financing.

Evidence base: *This analysis consolidates sustainability challenges documented throughout the desk review (SDS implementation gaps, HIV Trust Fund underperformance), interview findings (funding disruptions, government support variations), workshop group recommendations (graduated co-financing, system integration, domestic capacity building), Workshop participants (specific state adaptations to funding crises, concrete examples of government investment), and the official sustainability presentation (New Business Model framework, mandated structures, Cost of Doing Business Assessment, three-phase transition timeline).*

5. Strategic recommendations

5.1 Recommendations by Thematic Area

5.1.1 HIV Prevention and Community-Led Response

Major Recommendation: Place prevention under clear country ownership, encompassing a single government-led package, a unified coordination table, and a single financing track. Define who to reach, where, and with what (HTS, condoms/lubricants, PrEP/PEP, SBCC, and where policy allows harm reduction), and align all partner work plans and reports to that state-owned plan with quarterly dashboards.

Sub-actions

- **Immediate (0–6 months):**
  - Leverage Existing Prevention Technical Working Group co-chaired by MoH/NACA and a CSO representative; publish a national target-population matrix (AGYW, ABYM, KP typologies, in-/out-of-school AYP, PBFW) with state allocations for PrEP initiations, HIV self-tests, and condom distribution.
  - Issue a budget-call addendum and partner guidance requiring alignment to the matrix; approve site-readiness standards for PrEP (same-day initiation, MMD, follow-up).
  - Review Nigeria's current PrEP programming and performance data to assess effectiveness, identify gaps, and determine the most feasible and impactful implementation approach. This should include evaluating uptake trends, coverage among key populations, service delivery models, and barriers to access. Findings from this review will guide evidence-based strategies for scaling up PrEP in alignment with the realities of Nigeria's health system and policy environment.
  - Kick off quick supply-chain wins: harmonise LMIS forms across HIV/TB/malaria for condoms, self-tests, and PrEP; set min/max stock levels, emergency redistribution SOPs, and a monthly stock-out log.

- **Short term (6–12 months):**
  - Integrate quantification and last-mile delivery for HIV commodities with TB/malaria runs to cut duplication and transport costs.
  - Launch a small-grants window for community networks (PLHIV, KP-led, youth/women's groups) with output-based payments (e.g., self-tests distributed, PrEP initiations, return-for-results rates).
  - Standardise the prevention service package and tariffs; include eligible services (PrEP consults, labs, follow-up) in NHIS/State SHI where applicable.

- **Medium term (1–2 years):**
  - Medium term (1–2 years):
  - Expand differentiated prevention models: community PrEP pick-up, pharmacy-based refills, tele-follow-up; pilot harm-reduction elements for PWID (needle/syringe services, OST where policy allows).
  - Embed community-led monitoring with a concise indicator set (PrEP continuation at 3/6 months, STI screening coverage, stockout days) and publish state dashboards.
  - Establish an evidence-to-policy loop: quarterly prevention learning briefs, with allocations re-weighted by yield and continuation performance.

- **Long term (3+ years):**
  - Create a domestic-resource framework for prevention with annual domestic-share milestones; ring-fence budget lines for condoms, self-tests, PrEP demand creation, and supervision; crowd in private sector beyond CSR through matching windows.
  - Institutionalise prevention governance in MTSS/MTEF cycles and hold annual state reviews to rebalance targets and sites based on results.

Evidence based recommendation identified misaligning donor and government priorities in PrEP services delivery" as the primary structural gap with interview participants noting prevention performance as "moderate" due to resource constraints.

5.1.2 Testing, Treatment, and Continuity of Care

Major Recommendation: Put primary health centres at the centre of case-finding and same-day linkage, closing the PMTCT coverage gap and lifting paediatric treatment coverage while protecting the adult cascade (87–99–96). Do this by making routine, risk-screened provider-initiated testing the norm; re-testing in ANC/PNC; early infant diagnosis at birth and 6–8 weeks; index testing for biological children and partners; immediate ART initiation; and reliable commodity and laboratory support.

sub-actions

- **Immediate (0–6 months):** Retrain ANC, child-welfare, OPD, and paediatric ward staff on HTS, informed consent/assent, index testing, and same-day linkage to ART, supported with simple job aids. Stand up LGA emergency buffers and weekly stockout reviews; set min/max stock levels and rapid redistribution SOPs. Line-list mother–baby pairs and previously untested children; run weekly "find-and-link" huddles with facilities/OVC partners. Start birth testing in high-volume sites and deploy point-of-care EID where turnaround is long. Activate a defaulter-tracing SOP (48-hour phone outreach, 7-day community follow-up) and align unique IDs across NDARS and NDR.

- **Short term (6–12 months):** Lock in a PHC–LGA–state logistics calendar (requisition, delivery, redistribution) and quarterly quantification. Fix sample transport for VL/EID with scheduled pickups and basic e-tracking/SMS results. Expand same-day ART start, multi-month dispensing (3–6 months), and differentiated service delivery; optimise DTG-based regimens. Integrate HIV services into EPI, OPD, nutrition, TB clinics, and emergency paediatrics; prioritise PITC for malnourished children, TB presumptives, and inpatients. Link OVC/community cadres to appointment reminders and caregiver counselling.

- **Medium term (1–2 years):** Establish monthly cohort reviews at facility level (testing→linkage→retention→VL suppression) with simple dashboards and root-cause actions. Strengthen the lab network: hub-and-spoke sample transport contracts, equipment uptime SLAs, and targeted pilots of point-of-care VL/EID. Deepen the paediatric focus with age-banded testing algorithms (0–4, 5–9, 10–14), child-friendly clinic hours/spaces, and adolescent-responsive follow-up.

- **Long term (3+ years):** Fund digital tracking of mother–baby pairs and paediatric cohorts within NDARS/NDR, including automated alerts for missed appointments and overdue VL. Institutionalise continuous quality improvement for the HTS→ART→VL cascade and embed budgets for commodities, sample transport, and supervision in MTSS/MTEF cycles. Sustain adult cascade performance (87–99–96) and move paediatric coverage toward adult levels, reporting progress annually with age-disaggregated indicators.

Evidence base: Workshop participants identified weak linkage between ANC, delivery services, and HIV treatment, while interview participants noted "seamless" treatment services but testing gaps due to commodity stockouts.

5.1.3 Human Rights, Gender Equality, and Advocacy

Major Recommendation: Within 12 months, fast-track domestication and operationalisation of the HIV Anti-Discrimination Act in the remaining 19 states by using the Global Alliance Pillar 4 platform as the coordination spine. Pair a Ministry of Justice–led model-bill pack with Conference of Speakers/Attorney-Generals' Forum engagement, a public passage-tracking dashboard, timely gazetting, implementation guidelines (SOPs for health, education, and law enforcement), provider sensitisation, and funded complaint/redress pathways via NHRC and CSO legal-aid networks.

sub-actions

- **Immediate (0–6 months):** Minister of Health and DG NACA conduct advocacy visits to state governors on HIV anti-stigma law domestication and fund release for gender and human-rights activities. In parallel, constitute a MoJ-led task team (MoH/NACA/NHRC/CSOs) to issue a model-bill package, agree a 12-month domestication calendar, and stand up a public dashboard to track first/second readings, passage, and gazette dates.

- **Short-term (6–12 months):** Work with community stakeholders (PLHIV networks, KP-led groups, women's/youth associations, and faith/traditional leaders) and collaborate with government and private media houses to run a coordinated awareness drive on gender and human-rights protections (e.g., HIV Anti-Discrimination Act, VAPP, Child Rights). Frame placements as corporate social responsibility. Deliverables: co-branded PSAs across radio/TV/social (English plus major local languages per zone), monthly call-in segments with legal-aid/GBV services, media pledges for a minimum number of free airtime slots, and simple monitoring (audience reach, referrals to legal/GBV services, and documented discrimination cases). This leverages existing CSO participation mechanisms while expanding practical, public-facing outreach.

- **Medium-term (1–2 years):** Move from laws-on-paper to practice: (i) publish sector SOPs and patient-rights charters in facilities; (ii) train prosecutors, magistrates, police, and health providers on enforcement and non-discrimination; (iii) operationalise 35% affirmative action with concrete measures—minimum representation in health/HIV committees, leadership pipelines for women and young women, and gender-responsive budgeting in state MTSS—while expanding safe spaces (legal-aid desks, survivor-friendly services) for participation and redress.

- **Long-term (3+ years):** Institutionalise a standing Rights & Gender Steering Group (MoJ/MoH/NACA/NHRC/CSOs) with annual targets, budget lines, and public scorecards (e.g., number of states enforcing the Act, cases resolved by NHRC/legal-aid, facility compliance audits, provider refresher coverage). Embed these commitments in MTEF/MTSS cycles so protections and accountability outlive project funding.

Evidence base: Workshop participants identified "continuous stigma and discrimination" due to undomesticated anti-stigma laws in 19 states, while the desk review confirmed VAPP Act progress in 32 states.

5.1.4 Adolescents and Young People

Major Recommendation: Deliver a gender-responsive, age-banded (10–14, 15–19, 20–24) AYP package that serve adolescent girls and young women and adolescent boys and young men equally. Make prevention and care easy to start and easy to stay with: male-friendly entry points (schools, apprenticeships, sports, social/digital platforms), strengthened AGYW platforms, routine offer of PrEP to eligible youth, condoms and self-testing at convenient pick-up points, youth-friendly clinic hours, GBV prevention/response, consent and SRH education, safe referral pathways, and Generation Negative embedded in state plans. Track delivery with age- and sex-disaggregated indicators and youth-led feedback.

sub-actions

- Immediate (0–6 months): Stand up youth-friendly corners at high-volume PHCs and secondary facilities with extended hours; deploy peer navigators (female and male) for testing, PrEP initiation/continuation, and linkage; run school/out-of-school outreach (including apprenticeships and sports venues) with on-site self-testing and same-day PrEP/ART where eligible. Issue a short HR directive introducing rural-posting/retention incentives for facilities serving hard-to-reach youth, and add simple digital reminders (SMS/WhatsApp) for appointments and refills.

- Short-term (6–12 months): Domesticate AYP strategies at state level with a standard indicator set to track reach, initiation, and behaviour change across gender and age groups; publish quarterly AYP dashboards. Align service packages with Generation Negative (in-school and out-of-school tracks) and ensure PrEP, condoms, HTS, and GBV services are budgeted in state MTSS.

- **Medium-term (1–2 years):** Establish supportive supervision and mentorship that tackles judgmental attitudes and provider fatigue—quarterly coaching, adolescent-responsive service checklists, on-the-job role-plays, and simple staff well-being measures. Expand differentiated delivery for youth (community PrEP refills, pharmacy pick-ups, tele-follow-up) and strengthen referral loops with OVC and social-welfare platforms.

- **Long-term (3+ years):** Institutionalise youth-led programming (youth advisory groups, micro-grants for demand creation, skill-building linked to health outreach) and sustain adolescent treatment outcomes—maintaining and improving viral suppression among adolescents (e.g., from ~88% toward 95%) through consistent VL monitoring, adherence support, and age-friendly clinics.

Evidence base: Workshop group deliberations identified "state-level programmes still largely focused on AGYW with little targeted interventions for adolescent boys and young men," while interview participants noted high suppression rates among engaged youth.

5.1.5 Key Populations

Major Recommendation: Build a rights-and-public-health compact with lawmakers, law enforcement, and the judiciary, while resourcing community-led paralegal and legal-aid services so access to prevention, testing, and treatment is protected and improved for all KP typologies.

sub-actions

- **Immediate (0–6 months):**
  1. Run joint sensitisation for health providers, police, and relevant judiciary officers on non-discrimination and confidentiality in health settings;
  2. Co-sign simple non-interference protocols (health–police–CSO) for outreach sites and facilities, with named focal officers and a rapid-response hotline;
  3. Issue outreach permissions/letters of introduction for KP community teams to minimise disruption during field activities;
  4. Start on-the-job mentoring for clinic staff on respectful services and incident documentation.

- **Short term (6–12 months):**
  1. Establish or scale community-led paralegal networks with a small grants window for case support;
  2. Launch a basic case-tracking system (time-to-resolution, type of incident, referral outcome) and review it quarterly with police/legal-aid focal points;
  3. Use joint awareness platforms (health authorities, CSOs, media) to clarify legal protections and service entitlements, improving uptake and continuity.

- **Medium term (1–2 years):**
  1. Create predictable funding lines for KP-led organisations (peer navigation, outreach, legal aid) in state sustainability plans and the HIV Trust Fund window;
  2. Formalise diversion and referral pathways (e.g., harm-reduction and treatment referral for PWID; health and social-support referral for sex workers) so operational practice prioritises public health over punishment;
  3. Embed community-led monitoring so real-time service barriers trigger rapid fixes at site and LGA levels.

- **Long term (3+ years):**
  1. Convene a structured legal-policy review to address punitive provisions and administrative practices that impede service access (e.g., operationalisation of same-sex, drug-use, and sex-work statutes/by-laws), paired with judicial training and clear SOPs;
  2. Maintain and build on current service achievements (201,301 KPs on ART; 127,105 virally suppressed) by tracking KP-disaggregated linkage, retention, and suppression and tying results to co-financing and performance agreements.

This sequence keeps services running safely now, funds community leadership, and creates the policy environment that sustains equitable access over time.

Evidence base: Workshop group deliberations identified criminalization and structural barriers as primary challenges, while interview participants noted successful KP-friendly OSS models that faced closure due to funding cuts.

5.1.6 Leadership, Governance, and Financing

Major Recommendation: Shift from general calls to "raise funding" to a concrete, year-on-year increase in the domestic share of HIV spending, anchored in costed federal/state sustainability plans, activated HIV budget lines with predictable releases, and an operationalised HIV Trust Fund of Nigeria. Use NASA's recent baseline (high external share in 2019–2021) to set annual percentage-point targets and publish progress each year.

sub-actions

- **Immediate (0–6 months):** Activate/standardise HIV budget lines across MDAs and all states; issue a budget-call addendum that specifies eligible HIV expenditures, GL codes, and a quarterly cash-release calendar. Require monthly release dashboards (allocation vs. cash released vs. spent) and sign simple co-financing MoUs with states/LGAs to clarify roles and deliverables.

- **Short term (6–12 months):** Require every state to submit a costed sustainability plan with explicit domestic co-financing targets and timelines (e.g., counterpart funds for commodities, supervision, M&E). Tie federal grants/technical support to meeting those targets. Begin publishing an annual domestic-share metric: _domestic (FGN + states/LGAs + Trust Fund + public insurance) ÷ total HIV spend_.

- **Medium term (1–2 years):** Operationalise the HIV Trust Fund at scale: publish governance rules, disbursement criteria, quarterly pipelines, and project dashboards; introduce matching-grant windows that crowd in private sector contributions beyond CSR (payroll giving, pooled procurement, performance-based matching). Pilot pooled state procurement to lower unit costs for paediatric commodities, EID, VL testing, and last-mile distribution.

- **Long term (3+ years):** Embed HIV financing in the MTEF and state MTSS cycles; set incremental domestic-share milestones (e.g., steady percentage-point gains each fiscal year) and progressively shift selected budget lines (supervision, transport, minor equipment, community engagement) to domestic sources. Maintain transparent reporting so that external funds increasingly complement, rather than substitute for, federal and state financing.

Evidence base: Workshop group deliberations documented an 82.8% dependence on international funding, while interview participants consistently identified government funding inadequacy and approval delays as primary constraints.

5.1.7 Pediatric HIV and PMTCT Implementation

Major Recommendation: Prioritise the scale-up of HIV testing among children to close the paediatric case-finding gap (the most significant current bottleneck) while tightening community–facility linkages and ensuring rapid, same-day linkage to ART.

sub-actions

- **Immediate (0–6 months):** Operationalise routine, risk-screened provider-initiated testing and counselling (PITC) across paediatric outpatient/inpatient departments, immunisation (EPI) clinics, nutrition services, TB clinics, and emergency units. Activate index testing for the biological children of known PLHIV with clear consent/assent procedures. Line-list all HIV-exposed infants and previously untested children, run weekly "find-and-link" reviews with facilities/OVC partners, and ensure same-day enrolment for positives. Collaborate with trained TBAs to notify, refer, and follow up HEIs for timely testing and EID.

- **Short-term (6–12 months):** Integrate paediatric testing with high-traffic service points (immunisation, outpatient, and nutrition, emergency) and expand point-of-care EID where DBS turnaround times are long. Introduce birth testing for HIV-exposed infants in high-volume sites and standardise maternal re-testing during pregnancy and breastfeeding. Set facility-level paediatric testing and yield targets with monthly dashboards, and stabilise test-kit supply and sample transport.

- **Medium-term (1–2 years):** Deploy caregiver-focused IEC to address stigma, consent/assent, and myths that delay testing; extend targeted community outreach through OVC platforms and community health workers to reach never-tested or lost-to-follow-up children. Strengthen cohort tracking for mother–baby pairs to prevent missed EID and post-EID testing.

- **Long-term (3+ years):** Institutionalise paediatric case-finding quality-improvement cycles; digitise mother–baby pair and paediatric treatment tracking; and align NDARS/NDR indicators to monitor volumes, yields, and suppression by age bands (0–4, 5–9, 10–14). Sustain gains through dedicated budget lines and routine supervision/mentorship tied to Global Alliance paediatric targets (EID, final 18-month status, paediatric ART coverage, and viral suppression).

Evidence base: Workshop group deliberations identified the critical coverage gap and need for community-facility linkages, while interview participants noted early infant diagnosis improvements in states with enhanced capacity.

5.1.8 Systems Integration and Social Protection

Major Recommendation: Build a single, practical integration plan that links HIV services with social safety nets and insurance—anchored by FMoH, NACA, NHIA, and NASSCO—so eligible clients and households can move seamlessly between care, financial protection, and social support. Deliver three things: (i) HIV-sensitive benefit packages under NHIA, (ii) referral pathways to and from the National Social Register (NSR) and state social registers, and (iii) clear operating roles in emergencies and humanitarian settings.

sub-actions

- **Immediate (0–6 months):** Integrate agencies responsible for coordinating multi-sectoral relief into NACA's existing coordination structures to ensure the needs of displaced persons are adequately addressed. This alignment will strengthen multi-sectoral response mechanisms, improve service delivery, and guarantee that vulnerable populations, including displaced persons living with HIV, are not left behind

- **Short-term (6–12 months):** Develop SOPs for HIV in emergency and humanitarian settings and formalise collaboration with NEMA and the refugee/IDP commissions (activation triggers, continuity-of-treatment packs, ARV/TB/PrEP continuity, rapid VL/EID access, referral back to routine care). Align state social protection units and SACAs on monthly referral reviews; add NHIA benefit verification at the facility level so eligible clients can use entitlements without out-of-pocket payments.

- **Medium-term (1–2 years):** Include HIV as an essential service in the National Pandemic Response Plan and secure NACA representation in Emergency Operations Centre coordination. Expand integrated case management (social workers/OVC partners embedded in clinic flows), scale the NSR linkage nationally, and introduce NHIA coverage for defined HIV-related services (e.g., clinic visits, selected labs, transport top-ups for hard-to-reach clients) where policy allows. Track uptake with a concise indicator set: proportion of ART clients enrolled in NHIA; proportion of eligible households on the NSR; number receiving transport/nutrition support; time-to-resumption of treatment after displacement.

  Establish a joint working group (FMoH/NACA/NHIA/NASSCO, with state reps). Sign a light data-sharing and governance MoU that protects privacy while enabling referrals (unique-ID crosswalk, minimum data set). Publish simple bidirectional referral SOPs (facility ↔ social registry; OVC/social welfare ↔ clinics). Pilot automatic National Social Register (NSR) screening/enrolment for vulnerable PLHIV households at high-volume ART and PMTCT sites; test small transport/nutrition voucher pilots for linkage and retention

- **Long-term (3+ years):** Achieve routine, nationwide integration of HIV with health insurance and social protection—dedicated domestic budget lines for non-health-sector supports (legal aid, GBV response, transport/nutrition where targeted), annual performance reviews with public dashboards, and periodic impact evaluations to show effects on linkage, retention, and viral suppression. Embed these commitments in MTEF/MTSS cycles so they persist beyond project funding.

Evidence base: Workshop group deliberations identified limited integration and weak collaboration, while the desk review noted minimal evidence of multisectoral performance tracking despite policy commitments.

5.1.9 Partnership and Multi-Sectoral Collaboration

Major Recommendation: Move to a practical one plan, one budget, one report compact. Government sets a single results framework and indicator dictionary; partners align reporting to the agreed system(s) of record to end overlap and parallel submissions, with clear counterpart-funding commitments.

sub-actions

- **Immediate (0–6 months):** Convene a quarterly Partnership Compact meeting co-chaired by Health/NACA and Budget/Planning. Sign a light compact that (i) adopts a unified results framework and reporting calendar, (ii) maps all platforms and names a system of record per domain (e.g., NDARS/DHIS2 for routine services; NDR for client-level; NOMIS for OVC; NEMIS for school-based inputs), and (iii) freezes new bespoke partner templates. Issue a budget-call addendum that creates counterpart lines (supervision, data, last-mile delivery) with quarterly release tracking.

- **Short term (6–12 months):** Implement joint planning matrices for Education, Women Affairs, Health, and Youth to coordinate targets, sites, and populations by state; add Justice, Social Welfare, and Interior where relevant. Publish quarterly partnership scorecards (targets, spend, outputs, outcomes). Stand up a helpdesk/sandbox so partners can integrate via APIs to the named systems of record and train state M&E teams on the unified framework.

- **Medium term (1–2 years):** Approve a data-governance policy covering roles, single-source-of-truth rules, privacy, API standards, de-duplication, and change control. Pilot automated data exchange (e.g., NDARS↔NDR; NDARS↔NOMIS/NEMIS where applicable) in six states and retire duplicative spreadsheets. Introduce joint budget tagging for HIV-related spend across ministries to enable NASA-aligned tracking.

- **Long term (3+ years):** Institutionalise an annual partnership review where analysis drives resource shifts and target rebalancing; embed compact commitments in MTSS/MTEF cycles and require new projects to align with the unified framework. Maintain public dashboards and a focused learning agenda, with biennial independent data-quality audits across platforms.

Evidence base: Workshop group deliberations identified weak collaboration due to no counterpart funding and unsynchronized reporting systems, while interview participants noted coordination as "realistically very, very difficult."

5.1.10 Data, Research, and Innovation

Major Recommendation: Move to a single, practical evidence system—one governance framework, one validation workflow, and one surveillance plan. Pair routine programme data (NDARS/DHIS2 and the client-level NDR) with regular, state-supported behavioural surveillance (a rotating, zonal "mini-BSS") and a new national IBBSS round, then turn outputs into quarterly, decision-ready dashboards and short policy briefs that feed directly into planning and budgeting.

sub-actions

- **Immediate (0–6 months):** Stand up joint dashboards that pull from NDARS/DHIS2, NDR, and (where relevant) MER/DATIM; publish a short indicator dictionary naming a system of record per metric and a monthly validation workflow (source registers ↔ NDARS exports ↔ facility summaries). Run a "data-validation sprint" using JDQA 2024 priorities (keep TX_NEW at 100% verification, and reduce >10% variances seen for TB_ART, PMTCT_EID, and HTS_TST) with site sign-offs and a simple corrective-action log. Establish a national "data room" for quarterly reviews and state deep-dives.

- **Short term (6–12 months):** Budget and plan a rotating, state-led behavioural surveillance module (zonal cadence) to complement the next IBBSS; include AYP and KP modules (with disaggregation where permissible), stigma/GBV items, PrEP and self-testing indicators, and ethical safeguards. Build lightweight APIs to reduce double entry; pilot automated de-duplication between NDR and NDARS; and roll out a templated data-to-action brief for each state (what changed, where, when).

- **Medium term (1–2 years):** Integrate community-led monitoring (e.g., Community iMonitor) into national validation, define a minimal dataset, metadata standards, and an escalation path into site QI action trackers. Institutionalise annual JDQA-style audits, expand analyst training/e-learning, and publish method notes so states can replicate analyses consistently.

- **Long term (3+ years):** Adopt a national data-governance policy (roles, privacy, API standards, de-duplication, change control) and require all partners to use government systems as the primary reporting mechanism. Retire parallel spreadsheets, maintain public dashboards, commission independent data-quality audits, and formalise a research-uptake loop (policy briefs + implementation notes + documented changes in guidelines, budgets, and supervision tools). This delivers real-time, evidence-informed decision-making that is durable beyond project cycles.

Evidence base: Workshop group participants identified surveillance gaps and parallel reporting challenges, while interview participants noted data management collapse in some contexts despite technological advances.

5.2 Cross-cutting delivery framework (how 5.1 gets executed)

This section avoids repeating the interventions in 5.1. Instead, it sets the architecture, cadence, and accountability to deliver them. Think of it as the operating system behind the programmes.

- National Delivery Board (quarterly): sets one results framework and approves annual targets, budgets, and dashboards.
- State Delivery Teams (monthly): convert 5.1 targets into site lists, micro-plans, and weekly tasking.
- LGA Huddles (weekly): short, problem-solving meetings on commodities, linkage, and missed appointments.
- Practical RACI: who leads, who supports, who signs off, and by when published once, used by all.

- Budget-call addendum: names eligible HIV expenditures, GL codes, and a quarterly cash-release calendar.
- Release tracking: simple public dashboard allocation → release → spend for federal, state, and Trust Fund flows.
- Co-financing compacts: short MoUs with states/LGAs that pair federal technical support with time-bound domestic contributions.
- Procurement levers: pooled state buys for agreed items; matching windows in the Trust Fund to crowd in private capital beyond CSR.

3. Data-to-action loop
   - One system of record per metric (NDARS/DHIS2 for routine; NDR for client-level; named social/education systems where relevant).
   - Monthly validation workflow (source registers ↔ NDARS exports ↔ facility summaries) with a one-page corrective-action log.
   - Minimum viable dashboard: five tiles—testing yield and linkage, ART continuity, paediatric case-finding, VL coverage/suppression, stockout days.
   - Learning cadence: quarterly "what changed, where, when" briefs that feed planning and budget re-weights.

4. People and capability
   - Supportive supervision network: quarterly coaching visits with checklists aligned to 5.1 priorities (PITC, EID, PrEP continuation, CLM).
   - State data fellows and pharmacy/logistics mentors embedded for 6–12 months where gaps are largest.
   - Simple well-being measures to reduce provider fatigue and keep adolescent-friendly services responsive.

5. Community partnership and accountability
   - Community-led monitoring integrated into the national validation process (minimal dataset, escalation path, time-to-fix tracked).
   - Grievance-redress routes: paralegal/legal-aid links, facility incident logs, and feedback loops to police/judiciary focal points.
   - Media as amplifier: co-branded PSAs and monthly call-ins (in major local languages) tied to legal-aid and GBV services.

6. Supply-chain resilience
   - Integrated quantification with TB/malaria where feasible; standard min/max levels at facility and LGA stores.
   - Emergency redistribution SOPs, weekly stockout reviews, and scheduled sample transport with simple e-tracking.
   - Service-level agreements for equipment uptime and last-mile delivery; retire duplicative spreadsheets as eLMIS/API links mature.

7. Social protection and emergencies linkages
   - Referral SOPs between facilities and the social registry; privacy-protecting data-sharing to unlock targeted support.
   - Continuity-of-care playbook for emergencies (activation triggers, ARV/PrEP continuity, rapid VL/EID access) aligned with national EOC roles.
   - NHIA benefit verification at facility level so eligible clients use entitlements without out-of-pocket payments.

8. Sequencing that keeps momentum

- First 90 days: stand up the Delivery Board and State Teams, issue the budget-call addendum, publish the indicator dictionary, launch the validation workflow, and emergency stock SOPs.
- Months 6–12: first public release dashboard, co-financing MoUs signed, pooled procurement pilots live, state AYP/KP/prevention matrices in use, CLM data visible in dashboards.
- Year 2: institutionalise quarterly learning briefs and annual data-quality audits; scale pooled procurement; embed social-protection referrals; expand state data fellowships where results lag.
- Year 3+: lock into MTSS/MTEF cycles; automate more data exchange; commission independent reviews every two years.

9. Scorecard (lead indicators that drive the rest)

a. Testing: linkage within 7 days (percent of positives initiated).
b. Paediatric case-finding yield and same-day enrolment.
c. VL coverage and suppression (age-banded).
d. PrEP continuation at 3 and 6 months.
e. Commodity stockout days (HIVST, test kits, EID/VL).
f. Release timeliness (share of planned cash released on schedule).
g. Fix velocity (median days from CLM/validation issue to resolution).
h. Data verification (share of sites at 100% TX_NEW verification).

The figure below gives a graphical overview of how this part of the recommendations work.

FOUNDATION

- **Governance & cadence**
- Key mechanism: National Delivery Board (quarterly); State Delivery Teams (monthly); LGA huddles (weekly); single RACI for who does what by when.
- Success metric: 36+1 states hold monthly delivery meetings; ≥90% of LGAs hold weekly huddles; ≥80% of action items closed within 30 days.

- **Financing mechanics**
- Key mechanism: Budget-call addendum with GL codes and a quarterly release calendar; public release-tracking dashboard; state/LGA co-financing MoUs; Trust Fund matching windows; pooled procurement.
- •Success metric: ≥95% on-time releases; domestic share of HIV spend rises by ≥5 percentage points per year; 100% of states have active HIV budget lines.

ASSURANCE & INCLUSION

- **Community accountability**
- Key mechanism: Community-led monitoring integrated into national validation (minimal dataset, escalation path, time-to-fix tracked); non-interference protocols; paralegal/legal-aid referral links.
- Success metric: ≥80% of incidents resolved within 30 days; ≥90% of agreed fixes implemented within 60 days.

- **Social protection & emergencies**
- Key mechanism: Referral SOPs with NASSCO/NSR and NHIA; facility-level entitlement verification; continuity-of-care playbook for emergencies; NACA representation in EOC.
- Success metric: ≥40% of ART clients enrolled in NHIA by Year 2; ≥70% of eligible households linked to social support; ≤7-day median treatment interruption during emergencies.

ENGINES

- **Data-to-action**
- Key mechanism: One system of record per metric (NDARS/DHIS2 for routine; NDR for client-level); monthly validation workflow (registers ↔ NDARS exports ↔ facility summaries); minimum dashboard (yield/linkage, ART continuity, paediatric case-finding, VL coverage/suppression, stockout days).
- Success metric: 100% TX_NEW verification in all sites; ≤10% variance on TB_ART, PMTCT_EID, HTS_TST in ≥90% of sites; dashboards published quarterly.

- **People & capability**
- Key mechanism: Supportive supervision network (quarterly coaching); embedded state data/pharmacy fellows (6–12 months); on-the-job mentoring; simple staff well-being actions.
- Success metric: ≥90% of facilities meet service-readiness checklist; adolescent-friendly service score improves by ≥20% within 12 months.

- **Supply-chain resilience**
- Key mechanism: Integrated quantification with TB/malaria where feasible; facility/LGA min–max stock levels; emergency redistribution SOPs; scheduled sample transport with basic e-tracking; SLAs for equipment uptime.
- Success metric: ≤5 stockout days per quarter (HIVST, test kits, EID/VL); ≥95% samples transported on schedule; ≥95% equipment uptime.

6. Implementation roadmap

6.1 Short term (0–12 months): priority actions and quick wins

1. Immediate service and financing stabilisation (0–6 months)
    - Emergency commodity and logistics fix: Work with the National Product Supply Chain Management Program (NPSCMP) to activate and manage LGA buffer stocks for emergency commodities.
    - Targeted fund releases (purpose clarified): fast-track cash specifically for (i) HIVST/test kits and EID/VL supplies, (ii) sample transport contracts, (iii) last-mile distribution to PHCs and (iv) short, time-bound support for community/outreach sessions already in approved AOPs.
    - Rapid linkage continuity: same-day ART starts; 48-hour defaulter tracing; weekly "find-and-link" huddles at facility/LGA.
2. Governance and coordination quick wins (0–6 months)
    - Use existing platforms: convene rapid action meetings through the existing State TWGs and LACA structures—no new committees.
    - Align prevention targets: apply the 5.2 population matrix to partner work-plans; minute decisions and assign owners/dates.
    - One-page action logs: who does what by when; track closure every week at LGA, monthly at state.
3. System stabilisation (6–12 months)
    - Data harmonisation start: publish the "system of record" list (NDARS/DHIS2 for routine, NDR for client-level) and run the monthly validation workflow; produce a minimum dashboard (yield/linkage, ART continuity, paediatric case-finding, VL coverage/suppression, stock-out days).
    - Workforce refresh: on-the-job refreshers for ANC/OPD/paediatric units on PITC, index testing, consent/assent, and same-day linkage; light mentoring for site data clerks.
    - Service integration touchpoints: operationalise HIV services at high-traffic points (EPI, OPD, nutrition, emergency paediatrics) using existing staff and rooms.

6.2 Medium term (1–3 years): system improvement and coordinated scale

1. Health-service integration and paediatric focus (12–24 months)
    - Routine, risk-screened PITC as the norm; birth testing in high-volume sites; point-of-care EID where DBS turnaround is long.
    - Age-banded paediatric testing (0–4, 5–9, 10–14) with cohort tracking for mother–baby pairs; quarterly facility cohort reviews.

2.. Multi-sectoral operating links (18–36 months)
    - Practical SOPs with NASSCO/NHIA for bidirectional referrals (facility ↔ social register/benefits); entitlement checks at the facility level.
    - Emergency playbook with EOC/NEMA/Refugee Commissions for continuity of ARV/PrEP, rapid VL/EID access, and tracked return to routine care.

3. Institutional capacity and human resources (12–30 months)
    - Rural posting/retention incentives within HR rules; periodic rotations; supportive supervision every quarter; simple staff well-being actions.
    - Strengthen State TWGs to run data-to-action reviews, not just meetings; publish brief "what changed, where, when" notes each quarter.

4. State-level implementation capacity (24–36 months)
    - Develop costed state sustainability plans that include clear sustainable financing milestones, dedicated counterpart budget lines, and strategies for strengthening human resources. Facilitate state-level linkage to the national pooled procurement mechanism for priority commodities to enhance efficiency, reduce costs, and ensure long-term program viability.
    - Readiness benchmarks to assume greater ownership (budget share, staffing ratios, verification scores, reporting timeliness).

6.3 Long term (3–5 years): institutional sustainability and domestic transition

1. Domestic financing trajectory (36–60 months)
    - Year-on-year increases in the domestic share of HIV spend (publish percentage-point gains annually); operational HIV Trust Fund windows with matching grants; transparent release dashboards.
    - Predictable public financing for supervision, sample transport, site connectivity, and community engagement embedded in MTSS/MTEF.

2. Institutional ownership and governance (48–60 months)
    - Government systems as the single coordination/reporting backbone; partners align via APIs—not spreadsheets.
    - Community-led monitoring embedded in validation; incident-to-fix times tracked and reported.

3. System maturity and universal coverage (36–60 months)
    - Full embedding of HIV services within PHC/UHC platforms (including benefits where policy allows); streamlined reporting that retires parallel templates while maintaining quality.
    - Periodic independent data-quality audits and biennial reviews to rebalance resources by results.

Notes on scope and fit

- The purpose of fund release is now explicit (commodities, sample transport, last-mile distribution, time-bound outreach already budgeted).
- State TWGs already exist—the roadmap uses and strengthens them; no duplication.
- HIV anti-stigma law domestication sits in Section 5.1 (rights/legal). Here, Section 6 sticks to operational execution.

This implementation roadmap reflects the evidence-based priorities and realistic timelines identified through stakeholder consultation, ensuring that Nigeria's HIV response can transition from donor-dependent programming to sustainable, domestically-owned epidemic control by 2030.

7. Monitoring, performance, and accountability (NSP-aligned)

This section reports performance against the NSP 2023–2027 results framework using the two NSP indicator files. Where the exact NSP indicator isn't yet recorded as phrased, we show the closest proxy, the gap, and the fix to align reporting.

7.1 Result Framework A — Equitable and equal access to HIV services

Person-centred combination prevention (all people at risk)

- Target (2027): 95%
- Baseline: 35% (end-2022)
- Latest (2024 cum.): 65%
- Gap: –30 pp to end-term
- Fix: lock the NSP numerator/denominator into routine tools; keep KP typology as a disaggregation.

KP prevention reach (proxy for the above)

- MSM 72.5% • PWID 63.4% • FSW 58.6% • TG 11.8%
- Gap: this is "reach" for KPs, not "access & use" for all at-risk groups.
- Fix: keep using as a proxy tile until the person-centred prevention indicator is fully measurable.

TPT among PLHIV (eligible)

- Target (2027): 95%
- Baseline: 62% (end-2022)
- Latest (2024 cum.): 70%
- Gap: –25 pp
- Fix: confirm "eligible PLHIV" denominator; publish state cohorts quarterly.

PBFW viral suppression

- Target (2027): 95%
- Baseline: 89%
- Latest (2024 cum.): 91%
- Gap: –4 pp
- Fix: add a routine PBFW VL-suppression line to dashboards, disaggregated (antenatal vs. breastfeeding).

HEI testing completion (by 2 months + post-breastfeeding final status)

- Target (2027): 95%
- Baseline: 89.7%
- Latest (2024 cum.): 90%
- Gap: –5 pp
- Fix: track both events per HEI and report completion as per NSP wording.

Prevention access is climbing (65%), but still 30 points off the 2027 target; PBFW suppression and HEI completion are close to the finish line, tighten routine tracking to close the last mile.

7.2 Result Framework B — Break down barriers to achieving service outcomes

Punitive legal/policy environment

- Target (2027): <10% of states with punitive provisions
- Baseline: 54% of states punitive (≈46% with anti-discrimination law)
- Latest: not yet quantified as a state share in routine tracking
- Gap: state-level quantification missing
- Fix: maintain a simple state legal tracker (Yes/No per provision) and report the share quarterly.

Stigma and discrimination (experiencing stigma)

- Target (2027): <10%
- Latest proxies: PLHIV 19.4% • MSM 30.8% • FSW 22% • PWID 14.3% • TG 21.8%
- Gap: KP rates exceed target; methods vary
- Fix: standardise the instrument and cadence; publish a combined programme survey trend line.

Gender-responsive services

- Target (2027): 90% of services gender-responsive
- Latest (2024): 30% (coverage proxy)
- Mid-term (2025): 45%
- Gap: –60 pp to end-term
- Fix: implement a facility gender-readiness checklist and aggregate coverage quarterly.

GBV and rights protection (programme counts)

- 2024 counts: MSM 1,574 • PWID 644 • FSW 2,064 • TG 79
- Gap: counts ≠ population-based rates
- Fix: convert to rates using service denominators; track timeliness of redress (median days to resolve).

Legal and gender barriers remain the limiting factor. Hence, measure them consistently (state legal score, gender-readiness score, stigma trend) and tie fixes to supervision and advocacy calendars.

7.3 Result Framework C — Fully resourced and sustained HIV response

Total HIV investment (all sources)

- Target (2027): ≈ US$610m/year
- Baseline: US$438m (NASA 2021)
- Latest (2024): not yet available in the files
- Gap: missing annual series (and source breakdown)
- Fix: publish a yearly series by source and track domestic share percentage-point gains.

Government budget execution (illustrative agency metric)

- NACA FY2024: Appropriation ₦8,568,068,163; Releases ₦7,471,683,234.81 → 87.2% released
- Use: transparency tile; do not substitute for national total.

Social protection linkage

- Target (2027): 45% of PLHIV/at-risk/affected receiving ≥1 benefit
- Latest: not populated
- Fix: add NHIA/NSR verification fields to routine tools.

Integrated service linkages (HIV/TB/GBV/NCD/MH/substance use)

- Target (2027): 90%
- Baseline: 18%
- Latest (2024 cum.): 36%
- Gap: –54 pp
- Fix: operationalise referral SOPs and capture linkages in NDARS; publish state dashboards.

Money visibility is improving (agency execution shown), but the national financing picture needs a simple, annual, by-source series; integration linkages are moving (18%→36%) but still far from 90%.

7.4 One-page performance tiles (what to show on the dashboard)

1. **Person-centred prevention** — 65% (target 95%)
2. **KP prevention (proxy)** — MSM 72.5% | PWID 63.4% | FSW 58.6% | TG 11.8%
3. **TPT among PLHIV** — 70% (target 95%)
4. **PBFW VL suppression** — 91% (target 95%)
5. **HEI completion** — 90% (target 95%)
6. **Stigma** — PLHIV 19.4% | MSM 30.8% | FSW 22% | PWID 14.3% | TG 21.8%
7. **Integration linkages** — 36% (target 90%)
8. **Financing (illustrative)** — NACA release rate 87.2% (FY2024)

7.5 Immediate indicator fixes (to keep the numbers flowing)

- Publish an NSP indicator dictionary (numerator, denominator, frequency, system of record, disaggregation).
- Keep proxy bridges clearly labelled (e.g., KP prevention reach) until the NSP-phrased indicator is implemented.
- Add three data fields across tools: "delivered by" (community-led attribution), humanitarian flag, NHIA/NSR verification.
- Convert counts to rates (e.g., GBV) using service/population denominators.
- Run a short quarterly dashboard with the eight tiles above and a one-page "what changed, where, when" brief.

8. Resource needs and financing strategy

The following table focuses on what to finance, why, through which channel, and how to track it, sequenced across near-term stabilisation, medium-term system building, and long-term sustainability. It maintains the purpose of fund releases explicitly and utilizes existing platforms (e.g., State TWGs).

Timeframe	Financing topic	Purpose of funds (what this pays for)	Key cost lines (examples)	Primary channel(s)	Activation mechanism	Accountability / KPI
0–6 months	Commodity stabilisation	Restore uninterrupted services	HIVST/HTS kits, PrEP, ARVs; EID/VL reagents & consumables; packaging	Federal/state budgets; emergency requirement	Fast-track release; LGA buffer stocks with min/max levels	Stockout days per quarter ≤5; % facilities with uninterrupted testing in the last 30 days
0–6 months	Sample transport & lab flow	Clear EID/VL backlogs and maintain turnaround	Scheduled courier runs; hub-and-spoke pickups; basic e-tracking	State budgets; partner co-funding where mapped	Call-off transport contracts; weekly run calendars	% samples picked up on schedule ≥95; median VL/EID TAT within threshold
0–6 months	Targeted operating support	Keep *approved* outreach/defaulter tracing running during cash gaps	Transport/airtime; session venues; short gaps for critical ad-hoc staff	State/LGA; small Trust Fund window	Time-bound micro-releases tied to approved AOPs	Linkage within 7 days; return-to-care rate; spend vs plan dashboard
6–24 months	Workforce upskilling & retention	Make frontline teams competent and retained	PITC/index/PrEP refreshers; KP/AYP/youth-friendly care; hardship/rotation incentives	State HR budgets; training votes; partner TA	Annual training plan; HR circular on incentives	% facilities meeting service-readiness checklist; retention in hard-to-serve sites
6–24 months	Data interoperability & kit	Move data into one usable stream	NDARS⇔NDR⇔LIMS APIs; basic IT kits; connectivity/power backup	Federal/state ICT; partner in-kind	Framework APIs; device roll-out via state data units	TX_NEW 100% verification; ≤10% variance for TB_ART/PMTCT_EID/HTS_TST
6–24 months	Community capacity & CLM	Fund community-led delivery and accountability	Peer navigation; CLM micro-grants; demand creation	State budgets; Trust Fund community window	Output-based micro-contracts	Fix velocity (median days issue→resolved); outreach outputs achieved
6–24 months	Service integration touchpoints	Embed HIV across PHC flows	Minor refurb; patient flow changes at EPI/OPD/nutrition/emergency paeds	State PHC budgets; small capex	Works orders through PHC agency	Paediatric case-finding yield; integration coverage (% sites offering combo)
3–5 years	State programme management	Run domestically led programmes	Planning/M&E posts; pooled procurement pilots; analytics fellows	State MoH/SACA budgets	Costed sustainability plans with GL codes	% states with costed plans & on-time releases; pooled buys live
3–5 years	Legal/rights implementation	Translate laws into practice	Gazetting; SOPs; provider sensitisation; complaint/redress systems	MoJ/MoH/NHRC; state votes	Model pack; passage-to-practice checklist	% states enforcing; cases resolved within SLA
3–5 years	PHC/UHC & social protection integration	Financial protection and continuity	NHIA reimbursements (defined set); referral rails to NSR; emergency continuity	NHIA; NASSCO; state schemes	MOUs; entitlement verification at facilities	% PLHIV enrolled in NHIA; % eligible households on NSR
3–5 years	HIV Trust Fund—operations	Predictable, transparent co-financing	Matching windows; quarterly pipelines; public reporting	Trust Fund + private	Board rules; disbursement criteria; matching ratios	Share of domestic HIV funding from Trust Fund; on-time disbursements
3–5 years	Domestic share glide path	Reduce volatility; grow local spend	Year-on-year %-point gains in domestic share	Federal/state budgets; Trust Fund; earmarked levies (where approved)	Annual budget-call addendum; compact with states	Domestic share ↑ annually; release timeliness ≥95%

Financing levers and coordination (how money moves without duplication)

Lever	What it does	How to activate	Success check
Budget line integration	Makes HIV spend visible and releasable	GL codes + quarterly cash-plan calendars	% states with active lines; % on-time releases
Performance-linked budgeting	Rewards delivery and equity	Flex small share of state allocations by results	Targets met in under-served LGAs; paeds/EID gains
Trust Fund matching	Crowds in domestic spend	1:1 (or set) match on verified outputs	Matched ₦ vs outputs; public pipeline reports
NHIA/State schemes	Adds financial protection	Define reimbursable set; verify at facility	% eligible clients using benefits
Joint resource plan	Aligns asks across NACA/MoF/partners/ private	Annual plan + public release/spend dashboard	Fewer parallel projects; spend vs plan on track

This financing layout keeps releases purposeful (commodities, transport, last-mile, approved outreach), moves medium-term funds into people, data, and integration, and builds long-term ownership via state plans, NHIA/social protection links, and an operational Trust Fund. Progress is judged by a small set of money-to-results metrics: domestic share rising each year, on-time releases, fewer stockout days, stronger verification, and better paediatric case-finding, and quicker fixes from community feedback.

9. Annexes

Annex A: List of Documents Reviewed

1. Desk Review Document

- **Title:** "Desk Review of Nigeria's Non-Health Sector HIV/AIDS Programs: 2024 Performance Analysis"
- **Subtitle:** Pre-Workshop Assessment for NACA Annual Review
- **Content:** Comprehensive desk review conducted over a nine-day period synthesizing strategic documents, surveillance data, M&E system assessments, and donor-side programmatic reports
- **Key Components:** Executive summary, methodology, performance analysis, document analysis, thematic findings, sustainability assessment, best practices, implementation strategies

2. Interview Consultation Report

- **Title:** Review Report documenting stakeholder consultation findings
- **Content:** Qualitative analysis using thematic content analysis technique (Braun & Clarke 2006)
- **Analysis Tool:** ATLAS.ti version 25
- **Key Components:** Study objectives, methodology, findings on 2024 HIV performance, achievements, challenges, recommended solutions

3. Workshop Group Outputs

- **Title:** "Final Group Work.xlsx"
- **Content:** Structured outputs from 10 thematic breakout groups using standardized analytical framework
- **Structure:** 13-14 column analytical framework covering performance gaps, root causes, proposed interventions, feasibility, stakeholders, timelines, dependencies, evidence base, NSP linkages, monitoring implications, and sustainability considerations

Annex B: Key Informants Consulted (by Category)

Interview Participant Categories

Based on the interview report, key informants were consulted across 7 states, with representation from Nigeria's geopolitical zones and the FCT. Fully involving both national and state-level actors of Nigeria's HIV response as well as the target beneficiaries:

Government Representatives:

- State Agency for the Control of AIDS (SACA) officials
- State AIDS and STI Control Programme (SASCP) representatives
- Local Government Area (LGA) coordinators
- Primary Health Care (PHC) facility managers

Implementing Partners and Civil Society:

- Non-governmental organization representatives
- Community-based organization leaders
- Faith-based organization coordinators
- Key population network representatives

Technical and Program Staff:

- M&E specialists and data managers
- Prevention program coordinators
- Treatment and care program managers
- Community health workers and volunteers

Note: The interview report referenced respondents as R1 through R12, indicating at least 12 key informants were consulted, but specific names and complete institutional affiliations are not detailed in the available documentation.

Annex C: Workshop Methodology and Participant List

Workshop Structure and Methodology

Thematic Breakout Group Organization: The national stakeholder workshop employed a structured approach with 10 thematic breakout groups:

1. **Group 1:** HIV prevention/Community Led Response
2. **Group 2:** HIV testing, treatment, care, viral suppression, and integration; and vertical HIV transmission
3. **Group 3:** Human Rights, Gender Equality, Advocacy
4. **Group 4:** Adolescents and Young People (AYP)
5. **Group 5:** Key Populations (KPs)
6. **Group 6:** Leadership, Country Ownership, Governance, Advocacy and Funding
7. **Group 7:** Integration: HIV transmission PMTCT and Paediatric HIV
8. **Group 8:** Integration of HIV into systems for health and social protection and Humanitarian settings and pandemics
9. **Group 9: P**artnership, multi-sect orality and collaboration
10. **Group 10:** Data for impact, science, research and innovation

Analytical Framework Used: Each group employed a standardized 13-14 column framework:

- Domain classification
- Performance gaps identification
- Root causes analysis
- Proposed interventions
- Feasibility assessment
- Implementation levels
- Stakeholder identification
- Timeline specification
- Dependencies analysis
- Evidence base documentation
- NSP target linkages
- Cross-sectoral integration requirements
- Monitoring implications
- Sustainability considerations

Workshop Participant Categories

[Placeholder: Detailed participant list by institution and thematic group assignment need to be provided.]

Annex D: Detailed Data Tables and Performance Graphs

Table D.1: HIV Prevalence by Population Group

Population Group	HIV Prevalence (%)	Source	Year
Transgender (TG)	28.8	IBBSS	2020
Men who have Sex with Men	25	IBBSS	2020
Female Sex Workers (FSW)	15.5	IBBSS	2020
People Who Inject Drugs	10.9	IBBSS	2020
Adults (15-49, national)	1.3	UNAIDS GAM	2023
Children (0-14, national)	0.2	NAIIS	2018

Table D.2: 95-95-95 Cascade Performance

Group	% Know Status	% on ART (of those who know)	% Virally Suppressed (on	Source	Year
FSW	26.7	89	86	IBBSS	2020
MSM	38	90	78	IBBSS	2020
TG	19	84	75	IBBSS	2020
PWID	12	68	75	IBBSS	2020
National (PLHIV)	87	99	96	UNAIDS GAM	2023

Table D.3: 2024 Key Population Service Performance

Indicator	Value	Source
Total KP tested for HIV	1,029,985	DHIS2 2024
KP testing positive	26,051 (2.53% positivity)	DHIS2 2024
KP on ART (total)	201,301	DHIS2 2024
- Sex Workers on ART	94,969	DHIS2 2024
- MSM on ART	64,167	DHIS2 2024
- PWID on ART	39,605	DHIS2 2024
- Transgender on ART	2,677	DHIS2 2024
KP Virally Suppressed (≥6 months)	127,105	DHIS2 2024

Table D.4: PrEP Performance 2024

Indicator	Value	Source
PrEP Enrolment (new in 2024)	252,069	DHIS2 2024
- Sex Workers	124,395	DHIS2 2024
- MSM/anal sex partners	69,880	DHIS2 2024
- PWID	52,120	DHIS2 2024
- Transgender	4,654	DHIS2 2024
PrEP Discontinuations	31,053	DHIS2 2024
PrEP Seroconversions	418	DHIS2 2024

Table D.5: HIV Burden and Mortality Estimates

Indicator	Value	Source	Year
Estimated PLHIV	2,002,624	UNAIDS GAM	2023
New HIV Infections	78,000	UNAIDS GAM	2022
AIDS-Related Deaths	48,000	UNAIDS GAM	2022
PMTCT Coverage (estimated)	65%	DHIS2/NACA	2024

Annex E: Thematic Gap Matrix

Summary of Performance Gaps by Thematic Area

Thematic Area	Primary Performance Gaps	Root Causes	Priority Interventions
Prevention/Community-Led Response	Misaligning donor and government priorities in PrEP delivery; Non-functional SDPs for PrEP	Over-reliance on donor funding; Change in donor priorities; Lack of political will	Government coordination strengthening; Community engagement and outreach; Leverage existing government
Testing, Treatment, Care	Unbooked pregnancies; Low PMTCT coverage (60-70%); Weak linkage to care	Lack of awareness; Stigma and fear; Inconsistent commodity supply	Scale up HIV testing in PHCs; Train existing ANC staff; Strengthen logistics coordination
Human Rights, Gender	Continuous stigma and discrimination; HIV anti-stigma laws not domesticated in 19 states	Lack of political will; Low prioritization of gender activities	High-level advocacy to legislative/executive arms; Stakeholder engagement and advocacy visits
Adolescents and Young People	Low viral suppression (15-49 age); Focus imbalance toward AGYW only	Lack of AYP strategy domestication; Psychological effects of medications;	Targeted interventions for boys/young men; Strengthen state-level collaboration
Key Populations	Legal and structural barriers; Criminalization effects; Low HIV awareness of testing	Social norms; Religious orientation; Poor financing and collaboration	Engage lawmakers, law enforcement, judiciary; Train health providers on KP sensitivity
Leadership, Governance, Financing	82.8% dependence on international funding; Disbursement delays; Limited CSO involvement	Inadequate domestic funding; Budget inefficiencies; Policies developed without	Increase domestic resource mobilization; Address disbursement delays; Improve policy consultation
Pediatric HIV/PMTCT	Low pediatric ART coverage (<50% vs 90% adult); Poor linkage from EID to ART	Children missed in family testing; Parents' refusal due to stigma	Strengthen community-facility linkages; Integrate services; Address stigma through IEC
Systems Integration	Limited integration into social protection; Inadequate humanitarian HIV delivery	No HIV-sensitive social protection policy; Weak inter-agency collaboration	Develop HIV-sensitive policies; Strengthen collaboration frameworks
Partnerships/Coordination	Weak collaboration among stakeholders; Overlapping parallel reporting systems	No counterpart funding; Unsynchronized reporting systems	Enhance collaboration; Harmonize reporting systems; Improve data use
Data, Research, Innovation	Gaps in behavioral surveillance; Parallel donor reporting systems	High survey costs; Limited state-level capacity	Implement state-level surveillance; Mandate government frameworks
Sustainability	82.8% donor dependence; HIV Trust Fund underperformance; Service disruptions from	Limited domestic resource mobilization; Weak state capacity; Political commitment variations	Operationalize Trust Fund; Develop state sustainability plans; Graduated co-financing models

Annex F: NSP Strategic Priorities and Indicator Mapping

Strategic Priority 1: Equitable and Equal Access to HIV Services for All

Linked Workshop Group Recommendations:

- **Group 1 (Prevention):** Result area 4.1.1, 7.2.2, 8.2
- **Group 2 (Testing/Treatment):** NSP 3.1 (Pg 13), NSP 4.1.2.4 (Pg 17), NSP 4.1.2.8 (Pg 17)
- **Group 4 (AYP):** Strategic Priority 2, Result Area 2
- **Group 5 (KPs):** Strategic Priority 2, Result Area 3

Key Performance Indicators:

- Percentage of PLHIV achieving 95-95-95 cascade targets
- PMTCT coverage among HIV-positive pregnant women
- Key population service coverage and viral suppression rates
- Comprehensive HIV knowledge among youth (15-24 years)

Strategic Priority 2: Break Down Barriers to Achieving HIV Outcomes

Linked Workshop Group Recommendations:

- **Group 3 (Human Rights):** Strategic Priority 2, Result Areas 2 and 3
- **Group 4 (AYP):** Strategic Priority 2, Result Area 2
- **Group 5 (KPs):** Focus on structural and legal barrier removal

Key Performance Indicators:

- Percentage of states with domesticated HIV anti-stigma legislation
- Number of functional Gender and Human Rights State Response Teams
- Reduction in reported stigma and discrimination incidents
- Legal protection framework implementation rates

Strategic Priority 3: Fully Resource and Sustain Efficient HIV Responses

Linked Workshop Group Recommendations:

- **Group 6 (Leadership/Financing)**: Strategic Priority 2, Result Area 3
- **Group 8 (Systems Integration):** Focus on sustainability and domestic ownership
- **Group 9 (Partnerships):** Coordination and harmonization for efficiency

Key Performance Indicators:

- Percentage of HIV funding from domestic sources (target: 50% by 2027)
- Number of states with costed sustainability plans
- HIV Trust Fund disbursement rates and impact
- Integration of HIV services into health and social protection systems

NSP Implementation Monitoring Framework

Cross-Cutting Indicators:

- Annual budget allocation and spending for HIV services
- Number of coordination meetings across sectors and levels
- Data quality and system integration progress
- Community-led organization capacity and sustainability

Evidence base: This mapping synthesizes NSP target linkages identified by each workshop group in their analytical frameworks, combined with strategic priority frameworks from the desk review and implementation indicators from stakeholder interviews.

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