FEDERAL REPUBLIC OF NIGERIA

PROGRESS TOWARDS UNIVERSAL ACCESS TO HIV PREVENTION,TREATMENT, CARE AND SUPPORT

JUNE 2008

INTRODUCTION

In compliance with the Declaration of Commitment and the Political Declaration on HIV/AIDS signed by UN member states in June 2001 and June 2006 respectively, Nigeria has submitted her UNGASS 2007 report to UNAIDS. The report, submitted every two years reflects the progress made by Nigeria in her response to the AIDS epidemic.

However beyond the UNGASS 2007 report there are expanded issues that have particularly contributed to the progress made so far in the national response. These issues are drawn from the political, policy, monitoring & evaluation and civil society environments and will be discussed at the 2008 High – Level Meeting.

Furthermore, this year's High-Level Meeting is taking place mid-point towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010 and the Millennium Development Goals (MDGs) by 2015.

This report intends to highlight progress made by Nigeria towards achievement of the universal targets particularly and the way forward.

COUNTRY PROFILE

Figure 1: Map of Nigeria

DEMOGRAPHY

Nigeria lies on Africa's west coast and occupies 923,768 square kilometres (356,669 sq miles) of land bordering Niger, Chad, Cameroon and Benin and is Africa's most populous country with a population of 140 million[1]. According to the breakdown of the 2006 census figures, the rural population is 64% compared to 36% of the urban population, about 70% of the population is under the age of 30 years while those under 15 years make up 44%. Interestingly the trend in this population has implications for HIV prevalence and interventions. Below are the sizes of some population groups according to the National Population Commission.

Table 1: Size of Population Groups (Nigeria)

Population Groups	Population Size	Source of Data	Year of Estimate
Total Country Population(all ages)	140,003,542	NPC	2006
Women > 25 years	27,562,035	NPC Population Projection	2008
Women 19-24 years	7,739,063	''	2008
Women 15-18 years	6,074,293	"	2008
Men > 25 years	26,720,053	"	2008
Men 19-24 years	7,748,622	"	2008
Men 15-18 years	6,266,798	"	2008
Girls 0-14 years	31,397,321	"	2008
Boys 0-14 years	32,614,223	"	2008

[1] NPC 2006

Nigeria has over 373 ethnic groups spread around the country. The major indigenous languages are Yoruba, Ibo and Hausa. However, English is the official language in the country. In addition to the human resource, Nigeria is endowed with a lot of other natural resources, the major ones being crude oil, bitumen and agricultural products. The main exports include petroleum, petroleum products and cocoa.

GOVERNANCE

The country is a Federation, operating a 3-tier governance system at the National, State and Local Government level. It has 36 states including the Federal Capital Territory and 774 local government areas; though Lagos is the largest city. For ease of administration and accelerated development, the states have been divided broadly into six geopolitical zones namely North East (NE), North Central (NC), North West (NW), South East (SE), South South (SS) and South West (SW). Interestingly, the HIV and AIDS coordination also takes along the governance structure.

The country is currently under a democratic government for a third consecutive term of 4 years each after about 30years of military rule. The emerging economic and political reforms arising from the democratic rule since 1999 have made significant impact in the health, financial, transport, environment and agricultural sectors etc.

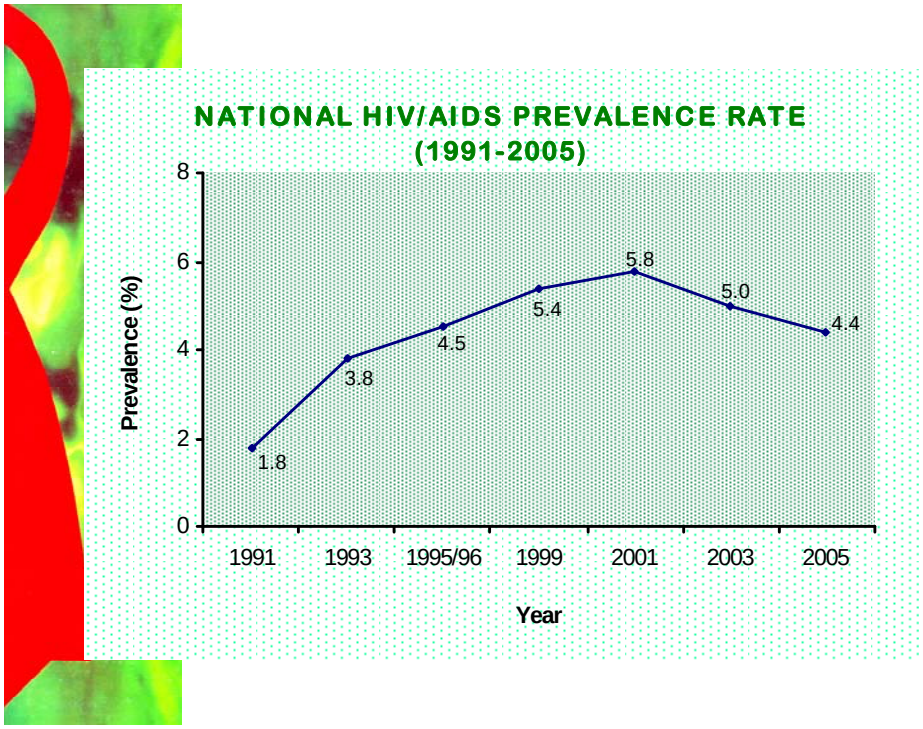
DEVELOPMENT INDICATORS

There are more than 100 national and local newspapers and publications, some of them state owned. Radio is the key source of information for many Nigerians. The GNI per capita is US $560 (World Bank, 2006). Life expectancy for men is 46 years and for women 47 years (UN, 2006).According to the 2007/2008, Human Development Index Report, the country's Human Development Index Value (2005) is 0.470.

HIV/AIDS EPIDEMIOLOGY

Since recording her first case of AIDS in 1986 Nigeria's HIV prevalence rate increased steadily from 1.8% (1991) to 5.8% (2001) but with a gradual decline to 5.0% (2003) and 4.4% (2005). See Figure 2. Although the prevalence rate appears low, Nigeria ranks third in terms of the actual number of people infected with HIV after India and South Africa.

Figure 2: National HIV Prevalence Trend (1991-2005)



In 2005, the overall HIV prevalence among young women aged 15-24 years was 4.3%, while the highest prevalence of 4.9% was recorded among the 20-29 age groups. See Table 2 for HIV epidemiology of some other selected population groups.

The drivers of the epidemic have been evidently linked to poverty, negative peer influence, poor access to health services and poor health seeking behavior of most Nigerians. The existence of some religious and socio-cultural practices has also contributed significantly to this rise and particularly those that reduce the status of women in the society.

Table 2: HIV Epidemiology of Selected Target Population groups

Population Groups	Estimated Number	Source of Data	Year of Estimate
Number of people living with HIV *(all ages)*	3,191,200	Spectrum Analysis	2005
Women living with HIV > 25 years(25 – 80+)	1,205,461	Spectrum Analysis	2005
Women living with HIV 19 – 24 years (20 – 24)	294,997	Spectrum Analysis	2005
Women living with HIV 15 – 18 years (15 – 19)	119,114	‘’	2005
Pregnant women living with HIV (15 – 49)	24,695	FMoH (HIV/AIDS Division)	2008
Men living with HIV > 25 years(25-80+)	1,123,676	Spectrum Analysis	2005

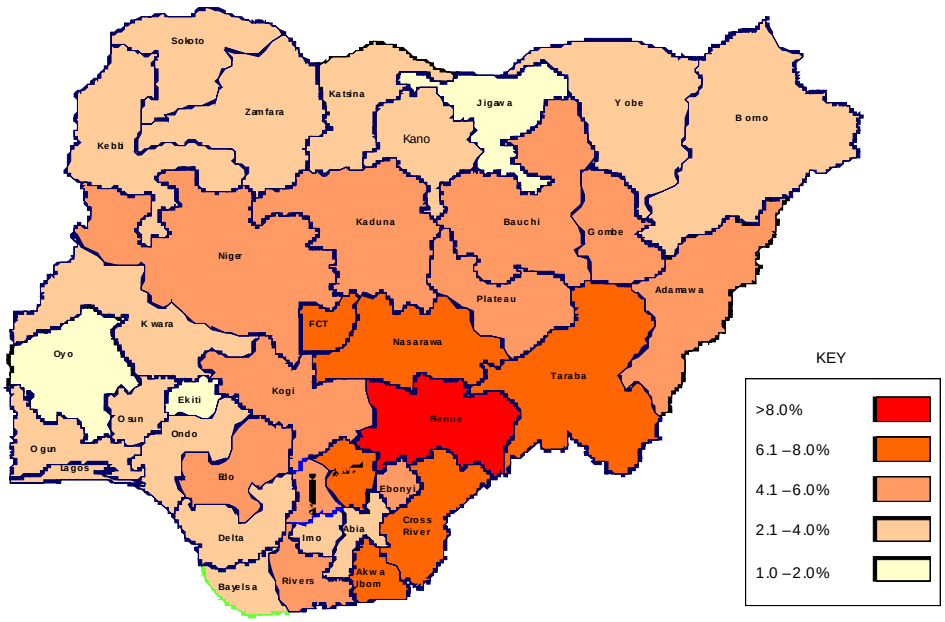
Population Groups	Estimated Number	Source of Data	Year of Estimate
Men living with HIV 19 – 24 years (20 – 24)	111,446	ANC Sentinel Survey	2005
Men living with HIV 15 – 18 years (15 – 19)	57,207	Spectrum Analysis	2005
Girls (0 – 14 years) living with HIV	136,284	Spectrum Analysis	2005
Boys (0 – 14 years) living with HIV	142,639	Spectrum Analysis	2005
Average number of new cases of HIV reported annually	369,870 (adults and children)	ANC Sentinel survey	2005
Number of people in need of ARVs	507,440 (adults and children)	ANC Sentinel survey	2005
Estimated annual number of women (15 – 49) with unmet need for contraception	17%	NDHS	2003
Estimated number of people with TB/HIV co-infection	51,163	WHO Country TB Estimates	March, 2007

Population Groups	Estimated Number	Source of Data	Year of Estimate
Number of women and men separately >14years in need of ARVs	Men – 125,753 Women – 158,925	Spectrum Analysis	2005
Number of women and men separately >14years receiving ARVs	Total – 236, 000	FMOH Programme report	2008

HIV PREVALENCE IN NIGERIA

The HIV prevalence rates across the various states differ (See Figure 3) and these have been attributed to the socio-cultural, socio-economic, sexual behavioural differences of the specific sub-populations across the nation.

Figure 3: HIV Prevalence by States (2005)

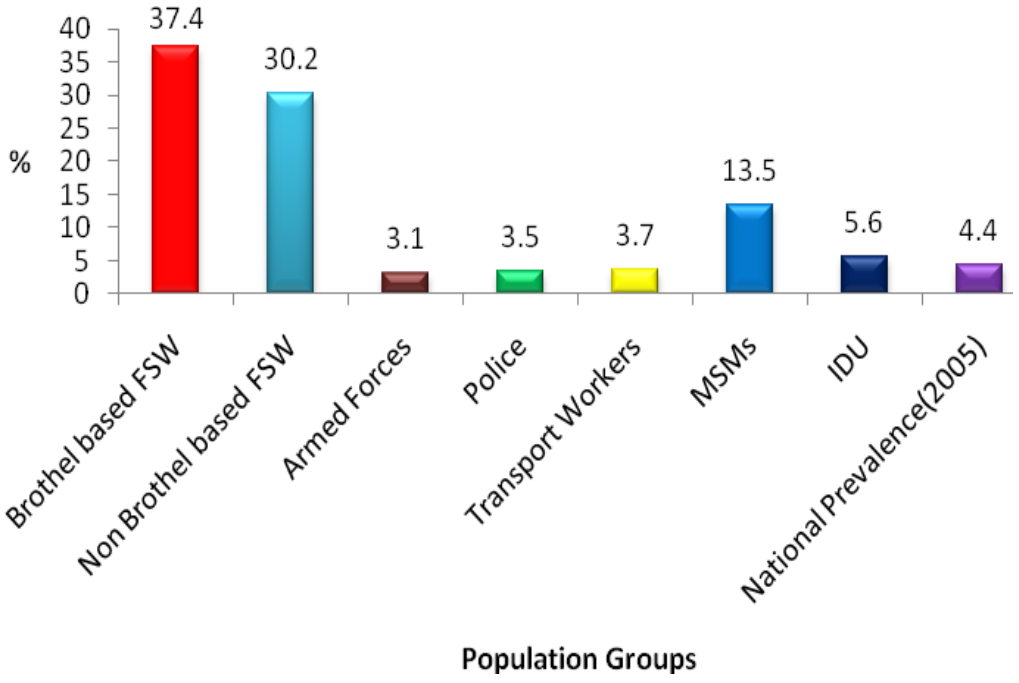


HIV PREVALENCE AMONG SELECTED POPULATION SUB-GROUPS

The results of the HIV/STI Integrated Biological and Behavioural Surveillance Survey (IBBSS) 2007 conducted in Nigeria among high-risk groups in Anambra, Cross-River, Edo, FCT, Kano and Lagos States showed an average prevalence of 37.4% and 30.2 % among brothel based Female Sex Workers (FSW) and non - brothel based Female Sex Workers (FSW). The prevalence among the Armed Forces, Police and Transport Workers are 3.1%, 3.5% and 3.7% respectively while among the MSM, IDUs the prevalence rates are 13.5% and 5.6% respectively.

These figures seem to support the proposition that Nigeria may be witnessing cases of sub-epidemics in a generalized epidemic if the prevalence among the general population is compared to that among specific high –risk populations. (See Figure 4).

Figure 4: HIV Prevalence among selected Population Sub-Groups



Source: IBBSS 2007

Furthermore, the prevalence rates of bordering countries are also of interest due to the cross-border activities that may increase incidence of HIV infection. For example Cross-River and Benue which are border states with Cameroon, a country with an HIV prevalence of 11% in 2005(UNAIDS) are two of the states with the highest prevalence rates in Nigeria (6.1% and 10.0% in 2005 respectively). (FMOH, ANC 2005).See Figures 1 and 3.

RESPONSE COORDINATION

The National Action Committee on AIDS was established in 2001 to coordinate the multisectoral response to mitigate the spread and impact of HIV/AIDS in Nigeria. The committee was transformed into an agency by an act of parliament in August 2007. There are also State and Local Government Committees on HIVAIDS with eight state committees already transformed into agencies between 2003 and 2007 by acts of parliament.

The first National AIDS council meeting was held in November 2007 with a view to convene a national forum to discuss issues on all the national plans and strategies towards the response. The membership of National Council consists of representatives from NACA, States, Line Ministries. Civil Society Platforms and Development Partners.

KEY ACHIEVEMENTS

POLITICAL ENVIRONMENT

The political environment in Nigeria has progressively been favorable towards the AIDS response. The emergence of democratic rule in 1999 brought increased political commitment at national and sub-national levels. There has also been significant increase in government budgeting and disbursements to AIDS expenditures at the national level and in line with this, the National Economic Council in March 2007 directed all states to ensure that a minimum of 1% of their annual budgetary provision to the Ministry of Health, Agriculture, Education, Youth and Women Affairs is dedicated to HIV and AIDS programming in their respective states by June 2008.

Due to the religious and socio-cultural peculiarities of the drivers of HIV infection in the country, the strategy of advocacy has been utilized to increase the commitment of political and religious leaders towards the enforcement of establishment of SACAs and LACAs. The effort which has been applauded and being led by NACA has the sustainable structure to be relied upon at each state and local government of the federation.

Nigeria has also followed suit in the formation of the Global Coalition of Women and AIDS by establishing and inaugurating NAWOCA under the auspices of the First Lady Hajia Turai Yar'Adua. The wives of Governors of eight other states of the federation have also inaugurated the state chapters of NAWOCA. Furthermore, a five-year strategic plan will soon be put in place to guide the activities of NAWOCA .

FUNDING FOR THE NATIONAL RESPONSE

The national response is funded through multiple sources that include Governments, Bilateral donors, Multilaterals, Foundations and International non governmental donors. Many of these organizations administered the funds directly to implement HIV/AIDS programmes within the context of the NSF.

It has been challenging obtaining information on expenditure on HIV/AIDS from donors in Nigeria but it is hoped that the current efforts between NACA and the National Planning Commission will address this perennial challenge.

However Government appropriation to NACA has increased considerably from ₦573, 080, 456 in 2005 to ₦1, 435,000,000 in 2007 and expenditure by state governments on AIDS for 2006 was ₦4, 861, 734,421. More than 90% of these funds were from the IDA credit. Nigeria has evolved an overseas development assistance policy which ultimately seeks to make domestic resources the core support for all our programmes, thus ensuring sustainability over time.

Key funding partners in Nigeria include PEPFAR, World Bank, Global Fund, DFID, GON, DRG, CIDA, and the UN system. NACA has decided to sign a Joint Financing Agreement with its partners in the last quarter of 2008 as a means of bringing all development partners under a common national response programming umbrella

STRATEGIC PLANNING AND POLICY FORMULATION

In 2005 Nigeria developed a new strategic framework, which was put in place as her first multisectoral strategic plan expired in 2004. Given the federal nature of Nigeria, the federating states have also developed states' strategic plans, which derive from the principles of the National strategy. The different sectors including the health sector, education, youth, and women affairs have also established strategic plans which are providing templates for implementing their various responses.

The life span of the strategic framework is 5years and, at its midterm in 2007 it was reviewed. The outcome of the review has provided information for a two-year evidence-based National Priority Plan, which is currently being costed for implementation. Three outstanding features of note in the priority plan are the need to deepen interventions in the prevention arena, re-strategize behaviour change communication systems and provide greater care for orphans and vulnerable children. Thus in the last year NACA has evolved a national prevention plan and is currently reviewing the BCC strategy in order to address the unique features of the national epidemic. The OVC strategy and plans are also being strengthened.

In addition to these policy initiatives and given the dynamics of the global response to HIV, the HIV Counselling and Testing, Prevention of Mother to Child Transmission and treatment guidelines have been reviewed. This has all been achieved through a deliberate inclusion and active participation of all stakeholder groups at national level and in all 36 states and 774 Local Government Areas.

MONITORING & EVALUATION

Since the adoption of the "three ones" and the intensive efforts to improve the M & E system in Nigeria, quite a number of programmes in the areas of capacity building, development of plans and guidelines have taken place.

NACA with the support of partners embarked on a wide scale capacity building of M & E officers at the national and state levels through training on various aspects of M & E particularly on the NNRIMS which is the fulcrum of M & E activities in Nigeria. In 2007,846 state-level M & E officers and those from LGA and NGOS/CBOS were trained. There are efforts in place designed for the employment and re- training of more M & E officers at the state and local government level so as to increase capacity for an efficient M & E system in country.

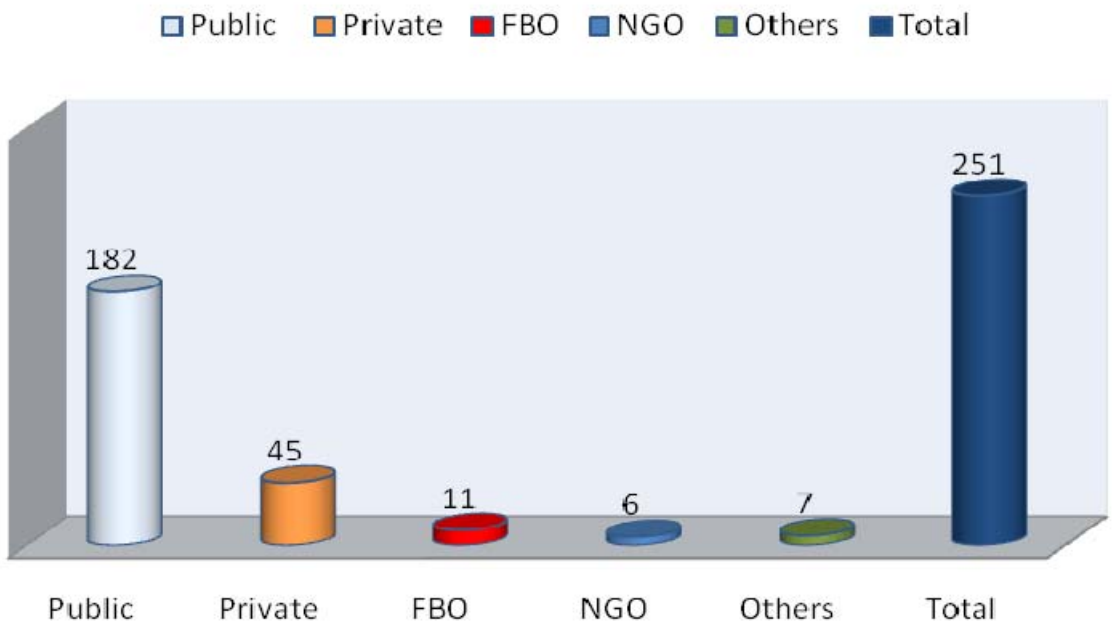
The National Agency for the Control of AIDS in 2007 initiated the formation of National M & E Technical Working Group to backstop the gap in technical capacities in monitoring & evaluation (MIS, Prevention, Treatment, Care & Support, Evaluation, Research & Surveillance and Capacity Building).

An HIV/AIDS NNRIMS Operational plan (NOP) was developed in 2007 as a guide to data collection/analysis, decision making and programme planning and implementation. The presence of the NOP has also led to harmonization of M & E tools by all partners.

SCALE UP OF TREATMENT PROGRAMMES

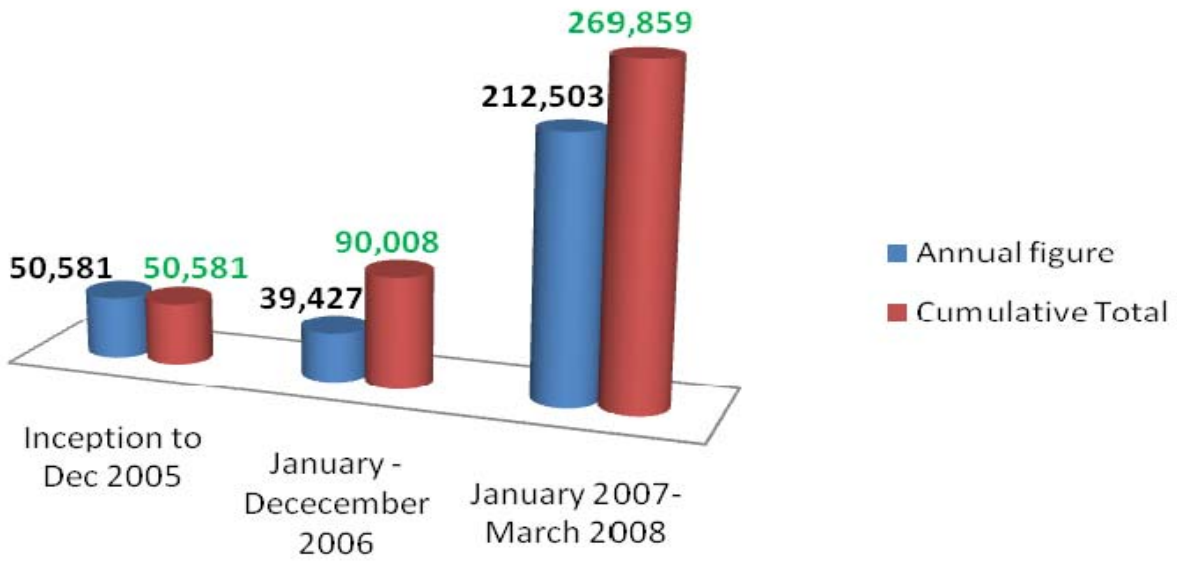
There is an ongoing scale up of ART, PMTCT and HCT services across public, private and faith-based institutions across the country. As at March 2008, there were 251 ART sites across the country from an initial 20 sites in 2002.

Figure 5: Number of ART Sites in Nigeria as at March 2008



Source: FMOH (HIV/AIDS Division)

Figure 6: Annual Cumulative/Number of Clients on ART as at March 2008



Source: FMOH (HIV/AIDS Division)

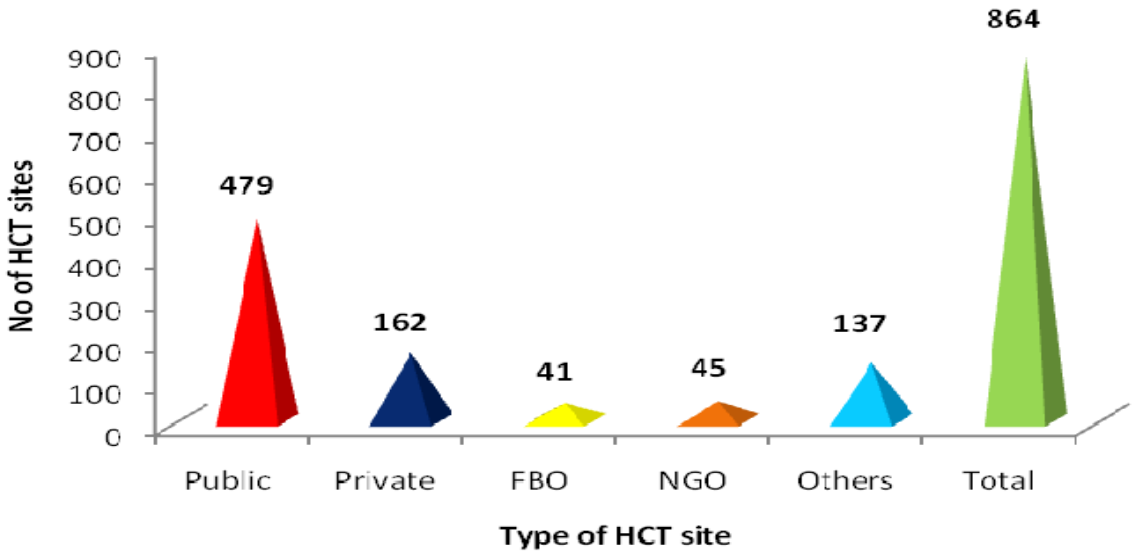
Free ARV provision policy in 2006 has led to increased access and uptake. Annual Cumulative number of clients on ART has increased from 50,581 at inception of ARV provision in Nigeria in 2005 to 269,859 as at March 2008. The contributions of the PEPFAR program within the country and the Global Fund Round 5 support have also played a significant role in the scale up of ART services in Nigeria.

Increased uptake of ARV drug in Nigeria is also prolonging and improving the quality of life of HIV/AIDS patients in the country. For instance the survival data collected in 2007 showed that about 95% of adults and children that are on treatment are still alive and healthy after 12months.

PREVENTION

The National HIV/AIDS Prevention Plan (2007-2009) has been developed to ensure the scale up of implementation of prevention activities at all levels in the country in the wake of new infections across the nation.

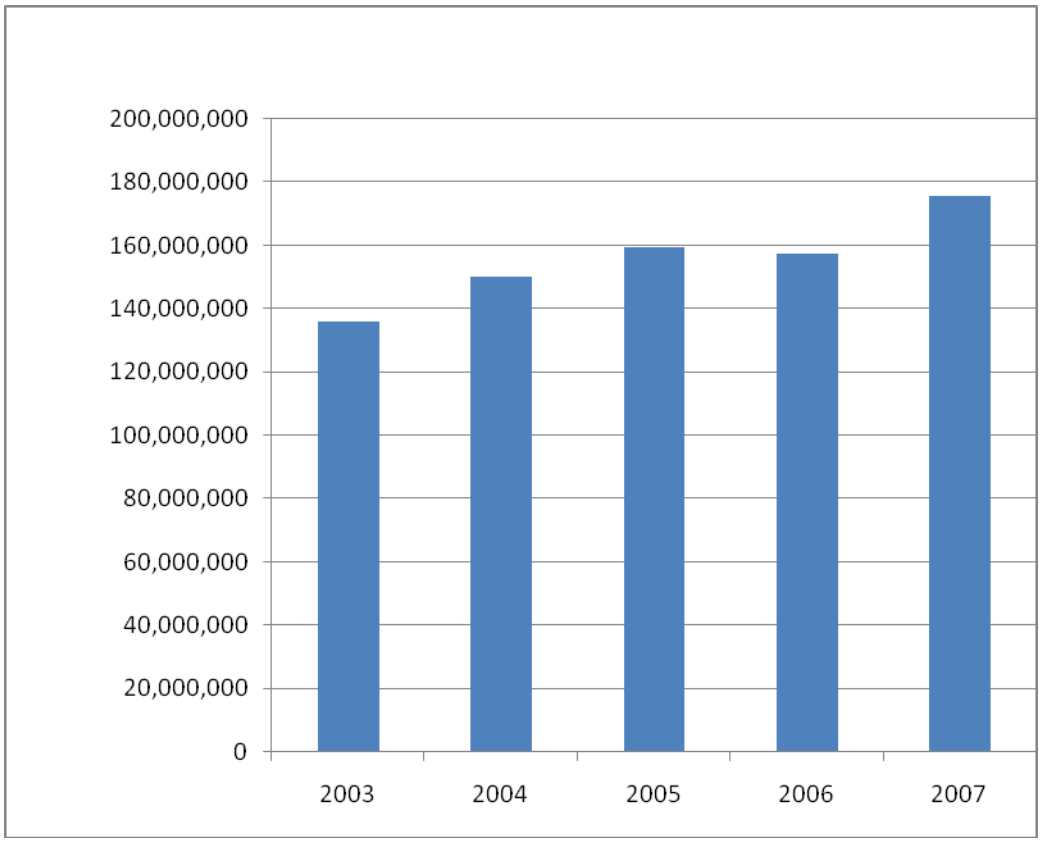
FIGURE 7: Number of HCT sites in the Country as at December 2007



Source: FMOH (HIV/AIDS Division)

As at December 2007, there are 864 functional HCT sites (See Figure 7) including (mobile sites) while 2,350,000 persons have been counseled, tested and received their results.

FIGURE 8: Annual Condom Distribution in the Country from Years 2003 to 2007



Source: Society for Family Health (SFH)

Condom distribution in Nigeria through the social marketing strategy and through the Federal Ministry of Health to State Ministries of Health/LGAs has increased significantly between years 2003 with a total of above 700,000,000 pieces of condoms distributed between years 2003 and 2005 respectively.

In order to reduce the spread of new infection especially among the youths in school, NACA in collaboration with FMOH facilitated the development and implementation of Family life HIV/AIDS education in the country. Reports collected from schools in Nigeria in 2007 showed that 34 % of all public secondary schools are teaching family life HIV/AIDS curriculum in Nigeria.

Most at risk population such as commercial sex workers and their clients, men having sex with men, uniformed men and migrant workers such as long distance drivers have continued to receive increased attention from the national response in a bid to reduce the spread of HIV/AIDS among these groups and between the groups and the general population.

In 2007, 30% of these Most at risk groups took the HIV test and received their test result, which is higher than general population of about 10%. Also 50% of these groups were provided with a minimum package of prevention programme while 92% of sex workers reported using condom with their clients.

Intensified behavior change activities, community mobilization and advocacy at all levels have continued to produce significant impact on the epidemics as exemplified by the following results:

- ✓ Age at which young people have first sexual intercourse has increased from 18.3yrs in 2003 to 18.5 years in 2005. Percentage of young men and women aged 15-24 who have had sexual intercourse before the age 15 was 9.8% in 2005.

- ✓ People having sexual intercourse with multiple non-spousal partners have reduced from 8.9% in 2003 to 7.3% in 2005 (NARHS 2005).

- ✓ Condom use trend in sexual intercourse with non-spousal partners has increased from 43% in 2003 to 55% in 2005(NARHS 2005).

CIVIL SOCIETY

PRIVATE PARTNERSHIP

Through the Nigerian Business Coalition against AIDS (NIBUCAA), the private sector – driven activities towards the mitigation of the impact of HIV/AIDS in workplaces in Nigeria has begun. Since establishment, NIBUCAA has strived to ensure that multi-national companies in Nigeria have initiated workplace programs for their employees. To date, NIBUCAA has a membership of 40 companies. The coalition is also partnering with other business organizations in Nigeria such as the Textile Union, Nigerian Labour Congress, Chambers of Commerce, Industry and Agriculture NECA, NANNM, TUC, SMEDAN and PIA.

In February 2008, NIBUCCAA in partnership with GTZ signed a memorandum of understanding with the Private Investors for Africa for the takeoff of a 2yr pilot project titled "Private Investors for Africa HIV/AIDS Workplace Programme in Supply Chain Companies in Nigeria" which has the overall objective of providing comprehensive AIDS treatment programme to over 4000 employees and their dependants.

The future objectives of NIBUCAA include strengthened public/private partnership for HIV & AIDS workplace programs and engaged, trained and supported SMEs on HIV &

AIDS workplace programs. These Small- Medium Sized Enterprises (SMEs) across the nation has a large number of workforces particularly those ages 15-45 years.