NEEDS : SEXUAL EDUCATION	OBSTACLES	OPPORTUNITIES
	◦ Poor standard of condoms ◦ Gross ignorance about use of condoms ◦ Inefficient social marketing ◦ Perceived reduction of sexual pleasure ◦ Low acceptance of condom usage ◦ Quality control assurance of condom is low ◦ No faith in condom ◦ Condoms perceived as a method of family planning. ◦ Cost of condom – poor affordability ◦ Inaccessibility of condom in rural areas ◦ Lack of co-ordination and procurement of condoms ◦ Tariffs on condoms ◦ Inadequate information on condom utilization ◦ Absence of local production of condom.	

NEEDS : Psychosocial help and Counseling support	OBSTACLES	OPPORTUNITIES
Medical Field Social	MEDICAL • Ignorance (Health Care and clients) • Inadequate number of trained personnel • Poor health seeking behaviour • Inadequate and misdistribution of health facilities • Inadequate protective devices for health workers • Poor infection control • Lack of infection control policies in various institutions • Fear and stigma of healthcare workers • No continuum of care • Inadequate facilities for diagnosis of opportunistic infections • Inadequate drugs for treatment of opportunistic infections • Poor access to ARV drugs for opportunistic infections • High cost of drugs • No monitoring facilities for disease markers. PSYCHOSOCIAL HELP AND COUNSELLING SUPPORT • Inadequate number of trained counselors at all levels • Counselors not part of curriculum in training institution • No organized training institution for HIV/AIDS/STD counseling • Inadequate number of guidelines for counseling • No monitoring/evaluation of counseling that is going on. • No networking between trained personals • Inadequate psychosocial help • Lack of sustainability (Inadequate funding for psychosocial support) • Poor referral systems • Poor logistics for follow up • Stigmatization. Lack of confidentiality • Poor continuing education facilities	PSYCHOSOCIAL HELP AND COUNSELLING SUPPORT • Existing health facilities • Existing NGOs, CBOs, religious organizations involvement • Existing commitment • Existing guidelines • Existing association of PLWHAs MEDICAL • Existing medical facilities • Existing NGOs, CBOs etc • Existing health facilities • Existing NGOs, CBOs, religious organizations involvement • Existing commitment • Existing guidelines • Existing association of PLWHAs • Private medical practitioners • Pharmaceutical companies SOCIAL • Existing health facilities • Existing NGOs, CBOs, religious organizations involvement • Existing commitment • Existing guidelines • Existing association of PLWHAs

NEEDS : Psychosocial help and Counseling support	OBSTACLES	OPPORTUNITIES
	• Competition with spiritual healers • Competition with traditional healers • Negative medical effects. SOCIAL • Religious barriers • Cultural practices • Fear of the unknown • Ignorance • Poverty • Access to information, diagnostic and treatment facility • Gender inequality	• Poverty alleviation program

NEEDS : HUMAN RIGHTS AND ETHICS	OBSTACLES	OPPORTUNITIES
	• Legal department staff not sensitized enough on the importance of HIV/AIDS • Conservatism • Laws are not following all new issues related to the HIV/AIDS epidemic and the profound changes that may have an impact on society as a whole. • Non compliance with existing laws • Poor monitoring and implementation of existing laws • Gaps in existing laws on rights • Non enforcement of laws • Poor involvement of the legal profession on HIV/AIDS/STI issues • Poor circulation of documents • Populations are not sufficiently aware about existing laws on HIV/AIDS • Poor institutional backup at state and LGAs • Not enough political drive • Traditional/Religious laws do not address HIV/AIDS • Strong Traditional/Religious laws which may be contrary to HIV/AIDS • Stigmatization • Ignorance • Prisons not protected enough.	• Existing laws • Existing human rights organizations • NGOs,CBOs, PLWHAs, professional Associations • Existence of formal judicial systems • Existing international laws • Traditional Laws • Religious laws • Rights of the Child

NEEDS : Basic and Applied RESEARCH	OBSTACLES	OPPORTUNITIES
	Both Basic and Applied Research • Poor documentation of social – cultural research findings • Inadequate number of trained personnel • Poor research into pharmaco-kinetics of medicinal agents • Poor funding of research • Inadequate number of institutions for research • Hoarding of information • Inadequate networking • Inadequate sharing of information • No national ethics committee • Poor co-ordination and evaluation of findings • Poor dissemination of results/poor feedback • Poor access to current information (Internet, E-mail, library etc) • Poor mobilization of resources (Human and material) • Very high competition • Poor co-ordination of finding at local and national level. • Poor coordination with international research at regional level and international level • No feed back Basic Research • Lack of central research directive / priorities Applied Research • No continuity of research • No functioning regulatory body • Little exchange of information between private and public sector.	• Existing research institutions, universities and teaching hospital • Availability of some data • NGO, donor, professional association, pharmaceutical company • Conferences and meetings • Fellowship and scholarships • Existing department of planning, research and statistics.

CROSS CUTTING ISSUES

In addition to key areas some cross cutting issues have been analyzed, these are:

- Management
- IEC
- Data collection
- Education
- Monitoring and evaluation
- Partnership
- Funding
- Multisectoriality
- Community involvement

NEEDS Management	OBSTACLES	OPPORTUNITIES
	• Poor funding at all levels • Bureaucratic bottlenecks (Lack of Autonomy) • Weak coordination at all levels • Non implementation of multisectoral approach and qualities • Inadequate number and quality personnel • High turnover rate of personnel • No continuing education opportunities • Frequent change of leadership at both Program level and ministerial level • Very few officers at state/LGA levels dedicated to HIV/STD programs • Non functional state and LGA AIDS committees • Poor training of personnel in management issues • Poor coordination of NGOs • Inability of program to recruit relevant technical staff • Weakness of financial mechanisms to allow States and local government to manage their own budgets. • weakness of financial management /funds take time to reach the decentralized level. • Weakness in the procurement system: no standardization of prices for consultations, prices of drugs, reagents. • Weakness of management system at all levels • Weakness in human resources management • Organogram so far is within the health sector and does not respond to multisectoral approach. • Personnel is unevenly distributed, with high concentration of essential staff in large towns at state capitals. • NGO/CBO's lack management capacities/procedures	• Existing structure at all level • Evolving new structure • Political commitment • Improved funding • NGOs/CBO's • Management reforms at all levels

NEEDS IEC	OBSTACLES	OPPORTUNITIES
	▪ Conception ▪ Not enough planning ▪ Duplication of efforts ▪ Some areas are not sufficiently covered: youth, labour ▪ Not enough coordination among sectors (ministries – NGOs – international agencies. ▪ Not enough sharing of experiences ▪ Little networking ▪ Production ▪ IEC is too often centrally produced – not enough production at state level. ▪ Insufficient funding ▪ Funding tends to be uncoordinated and mainly coming from donors. ▪ Funding comes for a one project at a time, insufficient programming- ▪ Radio and TV programs are too often going on air without any guidance from the authorities in the field of STD/HIV/AIDS. ▪ Same thing for the print media ▪ Information is not controlled ▪ Insufficient IEC in local languages. ▪ Too much Media in the health fields, but not sufficiently in the other fields: education, youth, women, sports, culture, labor, defense, prisons, etc. about HIV/AIDS	▪ Excellent private sector involved in publicity ▪ Excellent media of good reputation ▪ Well trained national personnel in IEC ▪ Best practices available

NEEDS IEC	OBSTACLES	OPPORTUNITIES
	▪ Not enough involvement of the PLWAs ▪ IEC materials still respond to the needs of literate persons, but very little to illiterate populations. ▪ Communication is only one way with no feedback. Distribution ▪ Not enough funding for distribution ▪ Poor distribution mechanisms, the channels are always very limited. ▪ IEC materials usually go to Health infrastructures. ▪ There is no mechanism to ensure that it gets to the beneficiaries. ▪ Materials often stored away without distribution ▪ Many international agencies, and international NGOs distribute the materials which have been adapted to other countries, but not always adapted to Nigeria. Monitoring and evaluation ▪ There is hardly any system for monitoring and evaluating the IEC programs ; the only indicator is the number of materials published or programs done. ▪ Poor feed back mechanism ▪ Absence of measurement of the impact of IEC at field level no behavior changes ▪ Not enough KAP studies in the area of IEC.	

NEEDS Monitoring and evaluation	OBSTACLES	OPPORTUNITIES
1. Monitoring	▪ Monitoring is not yet regarded as a major needed activity often put on paper but not regarded as an exercise of its own ▪ Weaknesses in programming monitoring ▪ Weaknesses in monitoring activities ▪ Weaknesses in monitoring staff ▪ Insufficient training of staff in monitoring activities ▪ Weaknesses in monitoring time frames ▪ Inadequate funding for monitoring activities ▪ Inadequate sharing of monitoring mechanisms ▪ Inadequate sharing of monitoring results ▪ Inadequate planning of monitoring indicators ▪ Monitoring is too centralized ▪ Monitoring is not enough done by parties at States and Local government levels. ▪ Communities and beneficiaries are not involved enough in monitoring	The culture of building systematic monitoring and evaluation components in planning and programming are starting to appear. Ministry of Planning Ministry of Finance Department of human resources Donors requests
2. Evaluation	▪ Evaluation is not sufficiently programmed ▪ Not enough work done on indicators of output and outcomes. ▪ Often done by same teams who are in charge of implementation, hence lack of objectivity ▪ Inadequate funding for evaluation ▪ Evaluations seem solely to be an exercise done by donors, but not enough yet understood as an exercise to be systematically led by government and national stakeholders: Ministries, NGOS, CBOs, ▪ Evaluation in STD/HIV/AIDS activities often requires getting to know impact on social behavior – little is known of where we are	

NEEDS Monitoring and evaluation	OBSTACLES	OPPORTUNITIES
	starting from and little is known about where what we really want to go. ▪ Evaluations are often too simplistic. ▪ Not enough financial evaluation built in programs and projects. ▪ Results of evaluations are not systematically shared. Hence difficult to build in best practices.	

NEEDS DATA Collection	OBSTACLES	OPPORTUNITIES
	▪ Data mostly come from sentinel sero surveys for pregnant women ▪ Insufficient data for the other groups at risk: STD patients, Tuberculosis patients, prisons, pediatric patients, sex workers, transporters, etc. ▪ Poor health seeking behavior in general leading populations not to voluntarily be tested ▪ Paucity of data from other sectors except health ▪ Paucity of social behavioral surveys, population based surveys, ▪ Paucity of data on STDs ▪ Inadequate information sharing of results between sectors and intra sectors. ▪ Poor management information systems, ▪ Paucity of personnel with skills to manage data ▪ Paucity of equipment for data management ▪ Poor utilization of data once collected ▪ Inefficient communication system ▪ Poor logistics for data collection.	▪ A management information system recently in place at federal Ministry of Health ▪ On going behavioral sentinel survey ▪ Ongoing capacity building done mostly by NGOs ▪ Recent renewed interest in the social fields around STD/HIV/AIDS ▪ Collection of bibliography recently done by Nigerian Institute of Medical Research ▪ Collection of best practices

NEEDS PARTNERSHIP	OBSTACLES	OPPORTUNITIES
	▪ Absence of a Strategic Plan to guide partnership: the country's new response to the epidemic has not been spelled out ▪ Hence partnership has not been able to ▪ STD/HIV/AIDS has interested a limited amount of partners ▪ Lack of political engagement until recently, leading to lack of advocacy and lobbying to encourage partnership ▪ Assistance from major donors was frozen during the large part of the period studied ▪ UN agencies have large amounts of priorities and HIV/AIDS is only one of them – still difficulties to give a coordinated response ▪ The past political situation in Nigeria forced donors to find ways to go on with their assistance notably by directly giving support to NGOs, without coordination. ▪ NGOs are numerous, but they are not organized in networks, apex does not exist, a large proportion of them are working in the Lagos State, while efforts have been made to identify them, not much has been done to evaluate their comparative advantages and the quality of their work. ▪ Few associations of PLWAs exist, PLWAs are still not yet seen as full fledged partners. ▪ CBOs and congressional organizations exist and in most cases do very good work, but their roles as official partners is not sufficiently considered. ▪ Mechanisms to finance CBOs and congressional organizations have not yet been established. NGOS are more likely to receive small grants than CBOs and congressional organizations.	▪ Creation of UN AIDS theme group trying to find a common response amongst co sponsoring agencies ▪ Retum of donors assistance to Nigeria (end of frozen assistance period). ▪ PLWAS beginning to organize themselves. ▪ Major donors are resuming their assistance to Nigeria ▪ NGOs and CBOs are starting to be given more importance and mechanisms to involve them more as partners are underway.

NEEDS PARTNERSHIP	OBSTACLES	OPPORTUNITIES
	▪ Congressional organizations tend to rely on donations which are not sufficient, not constant, and which are not always easy to obtain. ▪ Nigeria has not sufficiently benefited throughout the period of assistance of regional partnership. ▪ Nigeria is not sufficiently working in networking fashion with the neighbouring countries, the regional bodies, and the international community. Research is the only exception to this. ▪ Donors are willing to support organized NGOs, but not necessarily community associations who lack status and accepted procedures. ▪ Communities organized or not organized have little power to get themselves known to the Government officials at whatever level, unless they reach the status of NGOs, and even then it is not always automatic. ▪ Communities have not sufficiently been considered as partners – while a list of NGOs involved in the field of STD/HIV/AIDS exists, no list concerning CBOs exist.	

NEEDS: FUNDING	OBSTACLES	OPPORTUNITIES
	▪ Funding is directly aimed at the Ministry of health. ▪ Other sectors do not make provisions for funding in the field of AIDS, some present their requests to the Ministry of Health. ▪ NGOs receive funding directly from donors, without prior knowledge and consultation from MOH: ▪ States and Local governments are supposed to make their own budgetary provisions from their own fund raising mechanisms and they receive some funds from the Federal Government only to cover the World AIDS Campaign. ▪ Funding mechanisms are following the general laid down financial regulations observed by the Government. ▪ Local governments and communities have been insufficiently involved in raising funds at their level to take part in activities at field level. ▪ Ministries other than health have to request their budget ▪ No funding is planed for maintenance and there is no depreciation policy over the materials and equipment that are necessary in the frame of STD/HIV/AIDS policies. (research, laboratory, logistics, computers and other materials for epidemiology) ▪ Delays in the release of funds from approved and voted budgets. ▪ Only a % of the budgets are really made available, while the planing, programming, approval and vote of budgets were favorable to the entire budgets to be released. ▪ From 1993 till 1998, 605.355 US$ was allocated to AIDS through MOH. Hence 101 000 US$ on average per year for a population of approximately 110 millions inhabitants. ▪ Out of this allocation only 428,113 US$ were spent (total real expenditure) hence 30 % of this allocated funds were unutilized during the same period. ▪ These funds only cover the national level requirements (IEC, Program monitoring, training, surveillance, ETC,	▪ PCA and NACA have the mandate for resource mobilization for the entire AIDS program that will be specified by the Strategic Plan ▪ NACA is reviewing the Organogram at national , State and Local Government levels and also the financial mechanisms that will become necessary to have a multisectorial STD/HIV/AIDS program in place. This will no doubt require some reforms on financial mechanisms to allow more flexibility , rapidity and field level management. ▪ Cost recovery is introduced and is promising ▪ Once a year audits are conducted by the Ministry of Finance, Office of Auditor General of the Federation. ▪ Political Commitment ▪ Renewed interest of donors ▪ Organized private sector and multinational organizations.

NEEDS: FUNDING	OBSTACLES	OPPORTUNITIES
	etc.) ▪ Running costs (without salaries) ▪ Some years, for ex: 1994 and 1996, the funding was grossly insufficient less than 10 000 dollars. ▪ From 1993 onwards, the other sectors than health were supposed to provide a total of 736 000 US$ (Information, Education , Defense, Justice, Labor, Internal Affairs , Foreign affairs, Social Affairs, etc. But these funds never materialized even though the sectors were involved in MTP. ▪ Donors froze their assistance during the major part of the period. However, the overall STD/HIV/AIDS program, has been financed in larger proportion by donors than by Government. - ▪ The situation analysis has been unable to provide information concerning the budget of the private sector in the field of STD/HIVAIDS alleviation (even though we know that it is inadequate) and equally there is no information about the donations to NGOs and CBOs.	

NEEDS MULTISECTORIALITY	OBSTACLES	OPPORTUNITIES
	▪ NASCAP has tried to develop a multisectorial approach in the last part of its leadership. ▪ However this has not really been translated to multisectorial actions. As of today the actions led at MOH remain more important than those done with other sectors. ▪ One important reason attached to this is that the STD/HIV/AIDS funding remains earmarked to MOH, and other sectors have been awaiting that MOH shares its budget or its personnel to plan and undertake actions. ▪ Several important sectors have not been sufficiently involved: education, women and youth, sport, prisons, private sector, finance, while others are not involved at all: agriculture, environment, Labor and production , Power and Steel. ▪ Other sectors have only mostly been considered through NGO work e.g. transport. ▪ Even in non health sectors some trials have been done with success, not always taking into account the whole problem. For example: the defense ministry has developed a program for the men and women in uniform, but the police, the custom, and the prison wardens have not yet been included in schemes. ▪ Difficulties to coordinate multisectoriality at central level, and more especially at State and Local Government level ▪ In the mind of many actors, STD/HIV/AIDS is still a health problem ▪ In the mind of beneficiaries, STD/HIV/AIDS is still a health problem ▪ Media has covered more of the Health aspect of the situation than the multisectorial approach ▪ Not enough publicity has been undertaken to explain that AIDS is not only a health problem, but it is also a societal problem that can have very hard social rooting, and social political and economic causes and consequences which can only be solved through a multisectorial approach. ▪ Actors at central, state and local governments are not sufficiently informed about the multisectorial approach. ▪ Funding mainly goes to the MOH.	▪ Recent creation of NACA, which is a truly multisectorial body, although not all sectors are yet represented: ex: agriculture and rural development. NACA has the intention of bring all partners on board. ▪ Political engagement to bring a real multisectorial response throughout the strategic Plan ▪ Good understanding of Ministry of Health to let other sectors come on board.

NEEDS COMMUNITY INVOLVEMENT	OBSTACLES	OPPORTUNITIES
	▪ Communities have not received sufficient support to organize themselves and play specific roles: in education, advocacy for prevention, care and support ▪ Communities which are well organized for other matters have not received enough information on what kind of roles they could play at their own community level. They lack information on STD/HIV/AIDS. ▪ Data and epidemiological data is seldom shared with communities, hence they have no idea about the prevalence and incidence rates in their communities – hence communities are little concerned about the danger and do not organize themselves, except when they are led by NGOs. ▪ Donors are willing to support organized NGOs, but not necessarily community associations who lack status and accepted procedures. ▪ Communities organized or not organized have little power to get themselves known to the Government officials at whatever level, unless they reach the status of NGOs, and even then it is not always automatic. ▪ Communities have not sufficiently been considered as partners – while a list of NGOs involved in the field of STD/HIV/AIDS exists, no list concerning CBOs exist.	▪ NGOs and CBOs ▪ Congressional organizations of all faiths ▪ Local governments ▪ Successful trials made to involve communities in the care and support of PLWAS ▪

Bibliography of major sources

- A-Syndrome Based STD Surveillance System for Nigeria, Weir, M.J Ogundiran, A. Department of Genito-Urinary Medicine, Glasgow Royal infirmary, UK. STD Control Program, Oyo State Ministry of Health, Ibadan. Nigeria.

- Acceptance of People living with AIDS (PLWAs) at Work place Pat No Monye G. Iroka J.A Adegbite S. Agbogun C.E Adigwe P.K Omole. Life Continuity Foundation 31 Church Street Mushin Lagos Nigeria.

- Clinical Pattern of Human Immunodeficiency Virus infection (HIV) in pulmonary tuberculosis patients in Jos, Nigeria. Anteyi EA; Idoko JA; Ukoli CO; Bello CS. African Journal of Medical Sciences 1996 Dec. 25(4): 317-21 – 1996

- Evaluation of Training on Syndromic management of STDs in Nigeria. Derex-Briggs, Ofosu-Barko K, Organization: National AIDS/STDs Control Program (NASCP), Federal Ministry of Health, Nigeria; UNAIDS, Nigeria. Email: izeduwa@excite.com

- HIV Associated Disorders in Unsuspected Patients at a Nigerian University Teaching Hospital. Harry, D.N Bukbuk and A.E Moses, University of Maiduguri Teaching Hospital, Maiduguri, Nigeria

- Increasing Risk of Transfusion – asscciated AIDS as the pandemic spread experience in Maiduguri, Nigeria Harry, T.O; Moses A.E; Ola T.O; Obi S.O and Bajani M.D. Journal of Tropical Medicine and Hygiene. 1993; 96(2): 131-3

- New AIDS policy in Nigeria raises the stakes – but optimism remains scarce Falobi O AIDS Analysis Africa. 1999 Feb-Mar, 9(5) 10-1. 1999

- Problems of Communicating HIV/AIDS Prevention and control in Nigeria: How has the Media coped? Omololu Falobi. Punch Newspapers, 1. Kuyeti street Onipetest Ikeja, Lagos, Nigeria.

- Sexually Transmitted Disease (STD):- Six years experience in Jos University Teaching Hospital Bello CSS, Egah DZ, Okwori EE, Nwokedi EE, Katung PY, Zoakah AI, Opajobi SO, Ayeni JA, Barau C, Mafuyai S.

- Sickle Cell Anaemia and the Risk of HIV Infection in Lagos, Nigeria Ibironke Akinsete, Alani S. Akanmu, R. O. Olatunji, O.S Njoku, Dept. of Haemotology and Bld Trans. LUTH PMB 12003, Lagos; Dept of Haemotology, Luth, Lagos; Dept of Haemotology, GH, Lagos; Army Base Hospital, Yaba Lagos, Nigeria.

- Sickle Cell Anaemia and the risk of Transfusion Transmitted Human Immunodeficiency and Hepatitis B Viral Infections in Lagos, Nigeria Olatunji R.O Ajanmu A.S. Akinsete I, Njoku O.S 1998

- STD Treatment and Prevention among Nigerian Adolescents. Friday E. Okonofua, P.M Coplan, Mtemin, Women's Health and Action Research Center 4 alofeje Street Benin City, Edo state, Nigeria; Merch and CO INC. West point, USA WHO Geneva, Switzerland.

- STDs and AIDS: a vicious circle of risks. AIDS watch. (1989), (7):2-4 Ogunseitan O; Mariasy J, - (Research/conferences)

- STD Aids Prevention Strategy; appeal to conscience and evangelization

Annex

Team Members

Members of Evaluation Teams	States Visited
North East:	
Dr. A. Ogundiran (Team Leader)	
Dr. H.S.Labo	Bauchi
Dr. A. A. Kalejaiye	Taraba
Major Abigail Omolola	Adamawa
Mal Mohammed Sani Umar	Borno
Dr. M. F. Gboun	
Mal. Mohammed Gajo	
Mr. Cletus Wui	
South-South	
Dr Tekena O. Harry (Team Leader)	Edo
Abdul-Azeez Kolo	Delta
Suleiman Abullahi	Rivers
Ms. Maureen Onyia	Cross River
Festus Oyaide	
Gabriel Ikwulono	
North-Central	
Mrs. Omolara Euler-Ajayi (Team Leader)	Niger
Dr. J. Nwabufo Ijezie (Secretary)	Kwara
Mrs. Charity Ibeawuchi (DFID)	Kogi
Mr. A. D. Abalaka	Nassarwa
Dr. O. A. Sotimehin	Benue
Mrs. Shukuriya Salim Ali	Plateau
Mr. O.F Awopeju	FCT
North-West	
Dr. I. Dutse (Team Leader)	Sokoto
Dr. I. J. Daudu	Zamfara
Mr. A. Adepoju	Kano
Mr. J. Olakanmi	Kaduna
Mr. S. O. Agboola	
Mrs. A. Akinola (Secretary)	
South-West	
Col. (Dr.) O. S. Njoku (Team Leader)	Lagos
Dr. Ibrahim A. Umar (Secretary)	Ogun
Dr. Ibrahim Lawal	Osun
Dr. Ola Kunle Odumosu	
Dr. Joseph Nnorom (USAID)	
Mr. O. G. Akilapa	
Mr. Nathan Nzekwue	