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HIV MAINSTREAMING IN NIGERIA



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ACRONYMS

ARFH	Association for Reproductive and Family Health
ART	Antiretroviral Therapy
CBNRM	Community-Based Natural Resource Management
DRG	Debt Relief Gains
FMLP	Federal Ministry of Labor and Productivity
FME	Federal Ministry of Education
FMI	Federal Ministry of the Interior
FMIC	Federal Ministry of Information and Communication
FMOH	Federal Ministry of Health
FMOT	Federal Ministry of Transport
GHAIN	Global HIV/AIDS Initiative Nigeria
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments, and Agencies
MDGs	Millennium Development Goals
MFPED	Ministry of Finance, Planning and Economic Development
MOE	Ministry of Environment
NACA	National Agency for the Control of AIDS
NACSO	Namibian Association of CBNRM Support Organizations
NEEDS	National Economic Empowerment and Development Strategy
NGO	Nongovernmental Organizations
NMOD	Nigerian Ministry of Defense
NYSC	National Youth Service Corps
PEAP	Poverty Eradication Action Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
SFH	Society for Family Health
UAC	Uganda AIDS Commission
UNAIDS	Joint United Nations Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
USAID	United States Agency for International Development
USG	United States Government

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EXECUTIVE SUMMARY

With nearly 3 million people living with HIV (PLHIV) and an adult HIV prevalence of 4.1 percent, Nigeria continues to face serious challenges in addressing the HIV epidemic. One of these challenges is how best to mainstream HIV into ongoing activities of ministries, departments, and agencies (MDAs).

Mainstreaming HIV is an important aspect of HIV mitigation that allows non-health stakeholders to use sector-specific strategies to address the HIV epidemic. These stakeholders are often better placed to address the societal and environmental factors that increase vulnerability to HIV than health-specific actors. When mainstreaming HIV, an institution should seek to understand the following:

- How its sector contributes to the spread of HIV
- How the HIV epidemic is likely to affect its sector's goals, objectives, and programs
- Where its sector has a comparative advantage to mitigate the impact of HIV

The research team conducted in-depth interviews with the National Agency for the Control of AIDS (NACA) and 17 MDAs that are mainstreaming HIV, such as the Federal Ministries of Defense, Education, Labor, and Health. Sampling was done purposefully, to ensure that both MDAs that have worked on HIV mainstreaming efforts for the last 10 years and those that had only recently begun mainstreaming HIV would be interviewed. Document review was a key part of the data collection, as sector strategic plans, work plans, budgets, performance reports, and financial reports were reviewed from the various MDAs in order to analyze the impact of non-health ministries and agencies on HIV mitigation. These interviews were then analyzed using the six guiding principles of HIV mainstreaming.

Although HIV mainstreaming continues to face significant challenges, the study found impressive results in implementing a multisectoral response to HIV. All of the 17 MDAs interviewed had conducted HIV-prevention trainings with their staff, nine had developed workplace policies, and another six are currently developing workplace policies. In addition, 12 have implemented sector-specific activities, such as developing education modules on HIV or youth mentoring programs.

Activity implementation, however, has currently come to a halt in many MDAs. Until 2009, activities had been driven by NACA-distributed World Bank and debt relief funding, with only a few MDAs obtaining a line item from their own budgets or securing funding from an external source. Some MDAs that had provided a budget line for HIV ceased funding activities when NACA-distributed funding, primarily from the World Bank, arrived. Currently, many HIV activities lack funding from any source, including NACA, MDA budget lines, or implementing partners. Many interviewees noted that obtaining line item funding was difficult, because the HIV Program Units had to convince MDA senior managers that a line item was needed and the National Assembly believes that NACA should be funding all HIV-related activities. Continued denial of funding from senior managers and the National Assembly could cause MDA staff to stop requesting funding, since the requests have little chance of being filled.

This assessment found the financing situation of HIV activities implemented by MDAs to be a key challenge, and proposes the following key recommendations:

- Clarify the coordinating role of NACA with MDAs
- Advocate the need for a line item within MDA budgets specific to HIV activities to members of the National Assembly
- Use work planning sessions with MDAs to develop skills and knowledge, especially concerning advocacy

- Identify a champion at the senior management level to advocate for improved financing HIV activities to members of the National Assembly

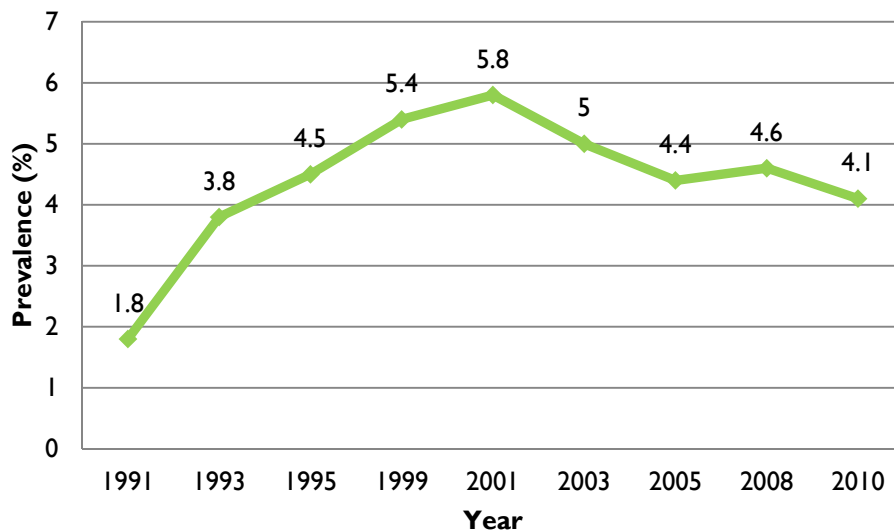
In addition, this assessment found that although many MDAs had identified clear entry points, many MDAs are focusing on HIV prevention workshops and workplace policies instead. In order to fully integrate HIV mainstreaming efforts, this assessment recommends that MDAs convene regular meetings, with senior management participation, to review mainstreaming efforts, think through new challenges, further refine the mainstreaming strategy of the MDAs, inform senior management of their progress, and educate senior managers about the importance of mainstreaming efforts.

I. BACKGROUND

I.1 OVERVIEW OF HIV IN NIGERIA

Nigeria has nearly 3 million people living with HIV (PLHIV) – the second largest number of PLHIV in any country, after South Africa (United Nations 2010). With a population of 155 million, however, Nigeria’s adult prevalence (4.1 percent) is roughly in line with other West African countries and is considerably less than countries in East and Southern Africa (CIA 2011, Federal Ministry of Health 2011). In addition, the country has made significant progress in the last 10 years, with HIV prevalence decreasing from a high of 5.8 percent in 2001 to 4.1 in 2010, as shown in Figure 1.

FIGURE 1: ADULT HIV PREVALENCE IN NIGERIA BY YEAR



(Source: Federal Ministry of Health, 2011)

As a result of the number of PLHIV, Nigeria has been the recipient of HIV funding from several international entities, such as the President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund, and the World Bank. These programs provide the vast majority of HIV funds in Nigeria. According to a sustainability analysis Abt Associates conducted in 2009, domestic revenues accounted for only 5 percent of the resources required to sustain the HIV/AIDS program at current levels (Resch et al. 2009). Therefore, one of the goals of the National Agency for the Control of AIDS (NACA) has been to assist ministries, departments, and agencies (MDAs) to develop sector-specific responses to the HIV epidemic and increase the level of funding dedicated to HIV mitigation efforts within their budgets.

I.2 WHAT IS MAINSTREAMING?

A joint report by the World Bank, Joint United Nations Program on HIV/AIDS (UNAIDS), and the United Nations Development Program (UNDP) defines mainstreaming as “a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace” (Annan and Kouass 2005). Mainstreaming can also be either internal or external to an institution. Internal mainstreaming addresses mitigating the impact of

HIV within an organization, such as through staff training or HIV workplace policies. This type of mainstreaming often has a strong human resources component, as it addresses such issues as nondiscrimination, accessibility of antiretrovirals to employees living with HIV, and workplace prevention programs. External mainstreaming is focused on what the organization can do to mitigate the impact of HIV on clients and the broader community. External mainstreaming includes providing community outreach programs or ensuring that HIV is considered when developing policies or regulations. Organizations seeking to successfully mainstream HIV into their work need to address both internal and external issues.

Mainstreaming HIV also allows non-health specific stakeholders to play a role in how the HIV epidemic is addressed within their sector. These stakeholders are often better placed to address the societal and environmental factors that increase vulnerability to HIV than health-specific stakeholders. According to a United Nations Educational, Scientific and Cultural Organization (UNESCO) report, mainstreaming HIV should not be an “add-on” activity with little relevance to the other activities of the institution, rather, an institution should seek to understand the following:

- How its sector contributes to the spread of HIV
- How the epidemic is likely to affect its sector’s goals, objectives, and programs
- Where an institution’s sector has a comparative advantage to mitigate the impact of HIV (UNESCO 2008)

Mainstreaming efforts are then designed to address sector-specific issues that arise as a result of the HIV epidemic. These efforts should build on existing strengths of the institutions conducting mainstreaming and reflect the comparative advantage that they have in addressing the HIV epidemic in the communities that they support.

In addition to defining mainstreaming, UNAIDS, the World Bank, and UNDP have outlined six guiding principles for mainstreaming HIV. While not designed to be exhaustive, these six principles provide direction for organizations that are considering mainstreaming HIV into existing programs and developing new programs. As such, they provide clear guidelines for how mainstreaming activities should be designed and implemented. These principles are as follows:

A clearly defined entry point. Effective HIV mainstreaming requires that institutions utilize their strengths and develop a unified theme to address HIV, ensuring they have the focus necessary for their efforts to significantly impact the sector.

Alignment with national HIV strategies. National governments often have defined frameworks, strategic plans, and agencies for addressing the HIV epidemic. Mainstreaming activities should be aligned with these structures through scope, project reporting, and monitoring and evaluation (M&E) systems to ensure that the activities support national goals.

Advocacy and capacity building. Advocacy and capacity building are required to foster local ownership and input into mainstreaming activities, especially within external activities. Advocacy can also be directed toward national decision makers, to ensure that HIV is a priority throughout government.

Internal vs. external mainstreaming. Mainstreaming can take place internally, within the workplace, and externally, with beneficiaries or other stakeholders who work with the MDA. Internal mainstreaming focuses on developing HIV workplace policies, training staff, and addressing the risks that HIV poses for MDA staff members. External mainstreaming focuses on supporting local and national efforts to mitigate and prevent HIV, based on the MDA’s mandate and abilities. External mainstreaming often requires collaboration with other MDAs, civil society, and unions.

Strategic partnerships. Partnerships with other government agencies, universities, or civil society organizations knowledgeable in HIV activities provide an opportunity to improve cost-effectiveness and obtain needed expertise.

Exceptional action. Exceptional action does not indicate that mainstreaming needs to take place outside the context of ongoing activities; rather, it means that action needs to take place in addition to what the institution is doing by integrating HIV mitigation approaches into existing programs and activities.

This report will use these six guiding principles as a framework to analyze the efforts of Nigerian actors, such as NACA and various MDAs, to mainstream HIV. In addition, examples of how other countries have used the concepts in the six guiding principles to mainstreaming HIV will be highlighted. Best practices from inside Nigeria, especially from MDAs that have been working on HIV issues for a substantial period of time, will also play an important role in providing context for the six principles. Finally, recommendations, based on how to strengthen the six principles within Nigeria, will be presented to provide ideas for ongoing support and coordination provided by NACA.

2. METHODOLOGY

This study was conducted using in-depth interviews with NACA and MDAs that perform HIV mainstreaming activities, such as the Federal Ministries of Defense, Education, Labor, and Health. The 17 MDAs, chosen from among 30 possibilities, were interviewed to understand their various HIV mainstreaming activities. Sampling was done purposefully, to ensure that MDAs that have worked on HIV mainstreaming efforts for the last 10 years as well as MDAs that had only recently begun mainstreaming HIV would be interviewed. A full list of interviewees can be found as an annex in this report. In addition, document review was a key part of the data collection, as sector strategic plans, work plans, budgets, performance reports, and financial reports were reviewed from the various MDAs in order to analyze the impact of non-health ministries and agencies on HIV mitigation.

The in-depth interviews included questions on HIV workplace policy development, the level of senior management support, HIV work planning, funding sources, partnerships, challenges and opportunities, and the structure of the Critical Mass Committees and HIV Program Units. In order to analyze the data from these interviews and documents, the six principles of HIV mainstreaming, as outlined in Section 1.2, provided a benchmark for understanding best practices on mainstreaming HIV into institutions and organizations.

3. HIV MAINSTREAMING EFFORTS

3.1 HISTORY

In 1999, the Federal Ministry of Labor and Productivity (FMLP) and the Federal Ministry of Health (FMOH) began addressing HIV within their ongoing programs. The FMLP began addressing HIV issues through externally and internally focused activities, including rallies and HIV prevention workshops for private sector workers, HIV counseling and testing (HCT) services and antiretroviral therapy (ART) provision for FMLP employees. At the time, the national HIV prevalence was 5.4 percent, and these activities were developed to address both the threat of HIV to workplaces throughout the country and the issues that the FMLP was facing in terms of employee retention. In designing the programs, the FMLP believed it could reach people inside the workplace who might otherwise be missed due to their work schedule. The funding for these programs came directly from World Bank credits, as NACA did not yet exist. The FMOH became involved in HIV issues around the same time as the FMLP, with a heavy focus on HIV prevention messages in health centers. Treatment and testing were not yet an option, due to the expense of the drugs and test kits.

NACA was created in February 2000 to spearhead a coordinated multisectoral response. The need for NACA was first identified in the HIV/AIDS Emergency Action Plan, which was a national strategic work plan, jointly funded by the government of Nigeria and external donors. Coordinated mainstreaming efforts under the direction of NACA began in 2002, with four line ministries, including the FMLP, the Federal Ministry of Education (FME), the Federal Ministry of Women's Affairs and Social Development, and the Federal Ministry of Information and Communication (FMIC). This effort saw the beginning of what NACA called the "Critical Mass Committee," which was an attempt to develop a critical mass of knowledgeable people who were responsible for HIV efforts within each MDA and for setting the broad direction of HIV mainstreaming efforts within the MDA.

In addition to the Critical Mass Committees, NACA helped the MDAs develop HIV Program Units that would implement the work plans developed by the Critical Mass Committees. NACA received funding from the World Bank through the Multi-Country AIDS Program to implement these plans. Further funding was provided in 2007 from the direct Debt Relief Gains (DRGs), which had been set aside to involve other MDAs in achieving the Millennium Development Goals (MDGs). As with the World Bank funding, this funding flowed through NACA to the MDAs.

In 2007 and 2008, additional World Bank funding to develop HIV workplace policies was used to complement ongoing mainstreaming activities and improve the internal mainstreaming efforts of MDAs. In 2009, however, World Bank funding ceased to exist, and MDAs were asked to include HIV efforts within their own budgetary line items. Occasionally, funding for sector-specific activities has been provided by the USAID-funded Global HIV/AIDS Initiative Nigeria (GHAIN) project, UNICEF, and USAID.

Currently, 30 MDAs have played some role in the national response to HIV. The activities have varied by MDA and include items as diverse as distributing condoms, setting up support groups for PLHIV, providing ART, and developing a variety of communication materials. These programs are vital to the HIV response in Nigeria, as they provide sector-specific responses to the HIV epidemic (NACA 2011).

3.2 STRUCTURE

Nigeria has made huge strides in designing a structure for implementing a multisectoral response since the formation of NACA in 2000. Since that time, NACA has assisted MDAs in implementing HIV prevention and mitigation activities that have included both internally and externally focused components. NACA has provided support that encompasses a range of different strategies, including helping MDAs organize a structure for planning and conducting HIV programs, providing funding for HIV work plans, offering technical assistance on HIV prevention messages, and supporting the development of HIV workplace policies.

In order to provide this type of assistance, NACA developed a standardized structure for MDAs. These structures have two main features: the Critical Mass Committee and the HIV Program Unit. In its original conception, the Critical Mass Committee was to provide oversight and strategic direction to the HIV Program Unit. The Critical Mass Committee would be made up of directors from different departments and be chaired by the Permanent Secretary of the relevant MDA. These committees would represent the broader interests of the MDA regarding HIV. These Critical Mass Committees were not designed to be staffed by HIV technical specialists, rather, members are chosen based on their level of authority and interest in responding to the HIV epidemic. Efforts were also made to get broad representation from within ministries.

The HIV Program Unit was designed to be more specialized than the Critical Mass Committees. These units consist of five staff members: a program manager, a program accountant, a procurement officer, a monitoring and evaluation officer, and a program auditor. The HIV Program Unit would implement the work plans developed by the Critical Mass Committees. The members of the HIV Program Unit are not specifically assigned to HIV work; they have other responsibilities and only work on HIV activities as time and funding permit. Table 1 shows their HIV-related responsibilities.

TABLE 1: ROLES OF THE HIV PROGRAM UNIT MEMBERS

Unit Member	Role
Program Manager	Oversees HIV activities and directs how they are carried out
Program Accountant	Manages the finances of HIV activities
Procurement Officer	Procures material, such as condoms and printing materials
Monitoring and Evaluation Officer	Tracks program implementation against the work plan
Program Auditor	Audits financial transaction to ensure that they are in line with guidelines

The relationship between the Critical Mass Committees and the HIV Program Unit is somewhat analogous to a board of directors and the staff of an organization: the Critical Mass Committee makes strategic decisions regarding HIV activities for the MDA, while the HIV Program Unit carries out the work plan developed by the Critical Mass Committee (see Table 2).

TABLE 2: ROLES OF THE CRITICAL MASS COMMITTEES AND THE HIV PROGRAM UNITS, AS DESIGNED

Critical Mass Committees	HIV Program Units
Oversight	Implementation
Planning	Monitoring
Advocacy	Accounting

3.3 PLANNING AND COORDINATION

Most MDAs plan HIV activities in a centralized workshop hosted by NACA, typically held at the beginning of the year. At these workshops, NACA provides a structured place for Critical Mass Committees to develop work plans for the coming year, provides technical assistance on those work plans, and aligns the work plans with the national policy on HIV/AIDS. The result is MDAs have a fully aligned work plan that describes the work they would like to perform. In order to achieve this, NACA provides each Critical Mass Committee with a template that outlines activity categories and the recommended funding amount within four main categories: coordination; behavior change communication; access to prevention, care, treatment, and support services; and M&E. These areas align directly to four of the six strategies in the national policy on HIV/AIDS.

This workshop allows time for the Critical Mass Committees to get together and plan their activities for the upcoming year, giving MDAs a concrete idea about the activities that they would like to do. Many MDA staff interviewed expressed their support for the annual workshop; however, the workshop has some drawbacks in that it standardizes the types of activities that each MDA performs, placing them within predefined categories. As a result, MDAs may not have the opportunity to brainstorm about how they could better mainstream HIV into their MDA. This system appears to have prioritized alignment over creativity.

Despite significantly scaling back funding for mainstreaming activities, NACA continues to organize these planning workshops annually. The workshops, however, are no longer an opportunity to advocate for funding from NACA; rather, the work plans that are developed as a result of the workshops are advocacy tools for senior management and must be integrated into MDA funding requests to the National Assembly in order for them to be funded and executed. Without line item funding, the work plans have little to no chance of being implemented.

3.4 IMPLEMENTING

Although mainstreaming continues to face significant challenges, impressive results have been achieved in implementing a multisectoral response to HIV using the structure described in Section 3.2. According to NACA, 30 MDAs have conducted HIV activities. All 17 MDAs interviewed for this study had conducted HIV prevention trainings with their staff, nine had developed workplace policies, and another six are currently writing workplace policies. In addition, 12 have implemented sector-specific activities, such as creating education modules on HIV or youth mentoring programs (see Table 3).

TABLE 3: TYPES OF HIV ACTIVITIES DONE BY MDAS

Type of Activity	Number
Staff HIV prevention trainings	17
Workplace policy completed	9
Workplace policy started	7
Sector-specific activities	12

Activity implementation, however, has currently come to a halt in many MDAs. Until 2009, activities had been driven by NACA-distributed World Bank and debt relief funding, with only a few MDAs obtaining a line item from their own budgets or securing funding from an external source. In fact, some MDAs that had provided a budget line for HIV ceased funding activities when NACA-distributed funding, primarily from the World Bank, arrived. Currently, many HIV activities lack funding from any source, including NACA, MDA budget lines, or implementing partners. As a result, the 13 MDAs interviewed that did not have access to external financing were forced to cut back on their activities. These MDAs are seeking funding from the national budget, waiting for NACA to continue funding HIV activities, or searching for external donor funding. For example, the Federal Ministry of Transport (FMOT) operated

15 HIV counseling centers near transportation centers in six states; these were supported by both debt relief and World Bank funding. These centers employed HIV counselors, supplied condoms, and offered transportation workers the opportunity to get tested for HIV. When funding ended, the FMOT asked local nongovernmental organizations (NGOs) to take over the operation of the centers. While it is unknown exactly how many counseling centers were still operating, anecdotal evidence showed that some were still open and functional under the management of local NGOs. At least one, however, had been appropriated by a transport union for use as an administrative office.

In order to get line item funding, five MDAs submitted work plans and budgets to the National Assembly for fiscal year 2011; however, most interviewees claimed that obtaining line item funding was futile, because members of the National Assembly believe that NACA should be funding all HIV-related activities. The situation was similar in fiscal year 2010, which was the first year NACA-distributed funds were eliminated: six MDA had line item funding removed from their budget submissions by the National Assembly in FY 2010. Financing issues will be discussed in more detail in Section 3.5.

Discussions with MDA staff also uncovered vast differences between how Critical Mass Committees and HIV Program Units were originally developed and how they actually function. For example, eight of the Critical Mass Committees were providing oversight, as designed by NACA. In contrast, nine Critical Mass Committees had varying degrees of responsibility for activity implementation. Some overlap existed, however, with three Critical Mass Committees conducting both oversight and implementation of activities. Three other Critical Mass Committees were deemed “not functional” by the interviewees, as they no longer had the staff necessary to oversee HIV programs due to attrition.

The changes in the mandate of the Critical Mass Committees by the various MDAs were often brought about to better match the structure of the MDA itself or to streamline the decision-making functions of the committee. For example, MDAs that had a significant number of staff at zonal or state offices often included representatives from these offices into their Critical Mass Committees to develop a broader consensus on strategies. These committees often included 40 or more participants.

Another variation in the Critical Mass Committees was to merge them with the HIV Program Units to reduce the total number of people involved in MDA HIV activities and make it easier for MDAs to get a quorum at committee meetings. In effect, the five members of the HIV Program Units took over the role of the Critical Mass Committees to minimize the number of staff needed to make a decision. This combination streamlined the decision-making process and led to a stronger “core” group of staff who were more engaged in HIV-related issues.

A third variation used the Critical Mass Committees as peer educators for the activities that the HIV Program Units were conducting. In this role, the committees were trained by either consultants or the HIV Program Unit on HIV prevention. The Critical Mass Committee members were expected to return to their departments and promote HIV prevention and stigma reduction through peer education, mentoring, and behavior modeling.

In contrast to the variety of ways that the Critical Mass Committees operate, HIV Program Units tended to be more uniform. Almost universally, the five HIV Program Unit staff members mentioned under Section 3.2 come from various departments and work on HIV activities as time and funding allow. MDAs interviewed reported few variations on the structure of the program units; in general, variations existed only because one of the five slots was vacant.

One major challenge faced by HIV Program Units is the constant turnover of staff due to transfers of civil servants between different ministries and posts. On average, civil servants spend about 2-3 years in each post, and with 5 members of the HIV Program Unit, the composition of that unit changes constantly. Additionally, NACA must continually train new staff for these program units. When turnover within the Program Units is high, it reduces the effectiveness of the units, as continuity is lost and new staff are often not provided with the necessary orientation to their responsibilities on the HIV

Program Unit. This problem is especially acute when the Program Manager leaves, as they often have the most knowledge of the activities of the HIV Program Unit.

3.5 FINANCING

As noted in Section 3.1, a variety of organizations have funded HIV mainstreaming activities. Over the last 10 years USAID and its implementing partners, the World Bank, the MDG Office, UNICEF, the Global Fund, and the U.S. Department of Defense have supported mainstreaming efforts. In addition to external sources of funding, a total of 10 MDAs have had a dedicated budget line for HIV mainstreaming at one time or another. As funding became coordinated by NACA, many MDAs scaled back the funding allocated from their own budgets.

In order to combat the decreasing line item funding for HIV priorities within MDAs, NACA advocated for and won a policy decision that all MDAs should devote one percent of their total budget to HIV priorities. This policy, however, does not have the force of law, rather it is a decision made by the Federal Executive Council (FEC), Nigeria's cabinet. The National Assembly (NASS), which has budgetary authority, and MDAs, which submit their budgets to the NASS, are free to follow, or not follow, the directives of the FEC.

Following NACA advocacy to the FEC, they turned their focus to the Federal Ministry of Finance (FMOF), asking them to followup with the Permanent Secretaries of each MDA to ensure that the one percent is included in their budget submissions. Convincing Permanent Secretaries, however, has been the easy part, with 10 of 17 MDAs interviewed submitting budget requests that include HIV priorities.

Once MDAs get a budget line for HIV activities into their proposed budgets, they face the challenge of getting their funding requests for HIV activities approved by the NASS, who removed the funding for six of the 10 MDAs who requested funding. NACA interviewees noted that MDAs are submitting budgets with HIV as a separate line item, rather than integrated into other subheadings; which promotes the idea of HIV as a standalone activity. Many members of the National Assembly feel that these activities should be the responsibility of NACA and remove the separate line item from MDA budgets. NACA staff also noted that members of the NASS change frequently and NACA must convince each new member of the need for MDAs to have funding set aside for HIV priorities within their budgets. Many MDAs have requested funding in their budgets for 2011, but at the time of this assessment, most of the budgets had not yet come back from the National Assembly.

Interviewees expressed frustration that HIV activities do not have a dedicated source of funding, with some stating that NACA should be providing funding and others claiming that financing HIV activities is the responsibility of their MDA. The lack of clarity around which organization should be providing money

The Ministry of Defense: Strong Programs, Ongoing Challenges

The Ministry of Defense (NMOD) has had ongoing HIV activities since 2002, starting with a small activity providing HIV prevention information to civilian staff. Currently, the NMOD has three programs that focus on different challenges: infrastructure improvement, comprehensive testing and treatment, and a large-scale HIV prevention program. Taken together, these programs provide a strong response to HIV, covering a wide range of issues with both civilian staff and soldiers, including care, support, treatment, and prevention.

These programs, however, are mostly funded by the U.S. Department of Defense; no NMOD financial support has been provided in the last four years. Although the current Permanent Secretary is supportive of HIV activities, National Assembly members removed HIV funding from the 2010 budget, starving non-U.S. Government activities, such as the prevention program. Without the resources to continue providing key wrap-around services, NMOD risks continued reliance on donor funding to provide the military and civilian support staff with the resources they need to provide HIV care, support, and treatment.

for HIV activities has led to confusion, as many MDA senior staff and the National Assembly believe that HIV activities should be funded by NACA as the HIV coordinating entity.

In fact, the introduction of HIV funding by the World Bank, which was distributed through NACA, had the effect of crowding out nascent efforts by MDAs to fund their own, more organic, mainstreaming activities. As a result, funding for HIV activities has become more donor-dependent and less likely to be funded through MDA line items in the future. On the other hand, the World Bank funding allowed NACA to direct decisions about what HIV activities the MDAs would perform, notably asking MDAs to develop HIV workplace policies. Currently, 16 of the 17 MDAs interviewed have either developed, or are in the process of developing, an HIV workplace policy specific to their institution.

In general, MDA staff thought that line items for HIV priorities were important to ensuring the sustainability of their activities, as it allowed the MDA to have control over what activities would be conducted. One HIV program manager who disagreed with this point of view said that she trusted NACA to ensure that the money is used for HIV activities, but that she could not trust her MDA to do this same. She noted that her MDA could not reallocate funding to other priorities if the funding came from NACA, but could do so if the funding came from the MDA budget. She also noted that having a separate account for the money prevented attempts to reprogram the money for non-HIV priorities.

Once MDAs get a budget line for HIV activities into their proposed budgets, they face the challenge of getting their funding requests for HIV activities approved by the National Assembly. In fact, the Critical Mass Committee at the Federal Ministry of Works became so discouraged by the removal of their funding requests in 2009 and 2010 that they did not include HIV activities in their 2011 funding request. In the future, continued denial of funding from the National Assembly could cause more MDAs to not add HIV activities into their funding requests. The work planning process would become moot at this point, since the work plans would have very little chance of becoming realized.

In addition to NACA and line item funding, many MDAs receive funding from other donors or other government initiatives, including the MDG office, UNICEF, GHAIN, Society for Family Health (SFH), and the Association for Reproductive and Family Health (ARFH), as shown in Table 4. The activities supported by these organizations tend to be specific to each MDA.

TABLE 4: FUNDING SOURCES FOR MDA HIV ACTIVITIES

Funding Source	From 2000 to 2009	2010
World Bank	16	2
MDA line item	10	2
MDG funds	6	0
ARFH	2	2
SFH	2	0
USG-direct	1	1
UNICEF	1	0
GHAIN	1	0

For example, the National Youth Service Corps (NYSC) receives support for a variety of activities, each of which comprises a small piece of NYSC's overall mainstreaming strategy. A full profile of NYSC's mainstreaming efforts is provided in Section 4.1. The pattern is similar for other MDAs with direct donor funding; these MDAs receive external funding for a wide variety of HIV activities, including HCT, youth camps, and peer education efforts.

4. SUCCESS STORIES

In order to highlight examples of strong mainstreaming efforts and best practices, seven mainstreaming efforts are profiled in this section: four from Nigeria and three from other countries. These examples show how mainstreaming can go well and how it can be derailed. Each example emphasizes specific aspects of strong mainstreaming efforts, such as developing partnerships, identifying an entry point, or diversifying funding sources.

4.1 NIGERIA

The Federal Ministry of Labor and Productivity: At the Forefront of the Response

As noted in Section 3.1, the FMLP was the first ministry, outside of health, to develop a program to address the HIV epidemic. These early activities focused on providing care and support for PLHIV, including palliative care, and HCT services to FMLP employees. In addition, the FMLP hosted rallies and HIV prevention workshops for private sector workers, developed model workplace policies, and provided ART to its employees.

These accomplishments are generally the result of strong leadership that recognized the importance of addressing HIV issues within the workplace and allocated FMLP funding to addressing HIV issues, even before NACA existed. In order to scale up these activities, the FMLP took a proactive approach, reaching out to the World Bank for funding. Once NACA was developed in 2002, other ministries became involved in HIV issues, and World Bank funding began to be channeled through NACA.

By 2008, the FMLP was receiving funding for its activities from the World Bank, the FMLP budget, and the Global Fund, and each of these funding sources was developed through ongoing relationship building and advocacy, mostly through one-on-one meetings. Shocks to the national budget in subsequent years, however, severely reduced what the FMLP could do. First, World Bank funding ended in 2009. Then, the FMLP budget was reduced in the middle of 2010, which zeroed out the line item for HIV. The variety of funding sources, however, allowed the FMLP to continue its work, and the Global Fund grant permitted the FMLP to organize trainings for 201 small and medium enterprises on how to address HIV within their workplaces.

Even in light of the end of World Bank funding and the HIV budget line item, mainstreaming activities continue to be an important part of the FMLP's work. FMLP staff noted in their interviews that they have some advantages when it comes to mainstreaming. First, they have a constitutional mandate to regulate workplaces. Therefore, the ministry has the authority to go into workplaces and enforce workforce legislation and directives, including those related to HIV. This mandate allowed them to identify a clear entry point for their HIV mainstreaming work. Second, mainstreaming at the FMLP has the support of a director, rather than a project manager. The higher level of support allows greater access to decision makers within the ministry, something that many HIV program managers do not have. Third, the people within the FMLP working on HIV have been in place for many years, and as such have vast experience and passion for dealing with HIV issues. The interviewees believed that many HIV-related activities within other MDAs are driven solely by the availability of money and not by passion. These factors allow the FMLP to maintain a focus on addressing HIV issues in the workplace, regardless of shifting donor and funding priorities.

The Federal Ministry of Transport: Focusing on Strengths

Since 2005, the FMOT has led a robust response to the HIV epidemic that has focused on its strengths in reaching out to transport unions and workers, as well as the FMOT's role in regulating trucking centers, ports, and railways hubs. To address external factors that contribute to HIV in the transport sector, the FMOT organized counseling centers in junction towns, where truck drivers would often spend the night. These centers provided HCT services and prevention methods, such as condoms, in six states. One key to the success of these centers was enlisting the involvement of local NGOs, who provided local knowledge, management, and staffing support. The FMOT also partnered with the Nigerian Union of Road Transport Workers to develop a peer education activity within the motor parks and to understand the union's viewpoint on how HIV affects land transport issues. These partnerships allowed the FMOT to better understand the local context for its activities. In addition, the FMOT developed an advertising campaign, putting up billboards along major roads and branding items with HIV prevention messages.

To address HIV issues internal to the FMOT, the ministry called on NACA to conduct HIV workshops for its staff members. In addition, some parastatals underneath the FMOT, such as the Nigerian Ports Authority and the Nigerian Maritime Administration and Safety Agency, organized HCT centers within their offices to address the needs of their staff.

These activities clearly highlight a number of points from the six guiding principles. First, the FMOT clearly defined an entry point: HIV awareness among truck drivers in junction towns. In working through this entry point, the FMOT worked with stakeholders and issues with which the FMOT were already familiar. Second, the FMOT focused on identifying how to address HIV, both internally and externally, using a wide range of approaches. Third, the ministry identified a wide range of strategic partnerships, with local NGOs and unions, that strengthened the counseling centers and outreach strategies. That the FMOT has worked within the framework of the six guiding principles has led to some level of sustainability, even without continued funding, as local NGOs and unions have continued to operate at least some of the counseling centers since the original NACA funding ended.

The National Youth Service Corps: Sustainability through Variety

The NYSC has many natural advantages in addressing the HIV epidemic, including the availability of an inexpensive, well-educated pool of young people, local level relationships, and a structured training program for standardizing HIV messages. However, funding is required if the NYSC is to take advantage of these strengths. In 2002, NYSC developed the "National RH, HIV & AIDS Prevention, Care and Support Project," which focused on peer education to improve HIV knowledge among youth, including the importance of getting tested and taking preventative measures.

Rather than rely on one donor to organize the needed input for this project, NYSC developed Memorandums of Understanding, which provided a framework for monetary and nonmonetary support from a wide variety of sectors, including the following:

- **Government:** FMOH, NACA, FME, Federal Ministry of Youth Development
- **Private Sector:** MTN (Mobile Telephone Network) Foundation, Coca Cola
- **Civil Society Organizations:** SFH, Action Aid, Hope Worldwide, ARFH, GHAIN, Planned Parenthood Foundation of Nigeria, One Worlds, Christian Health Association of Nigeria, Civil Society HIV/AIDS Network, Network of People Living with HIV/AIDS in Nigeria, Nigeria Youth Network on HIV/AIDS, Nigerian Business Coalition Against AIDS
- **Development Partners:** United Nations International Children's Fund, Academy for International Development

Although many of these partnerships are small or nonmonetary (e.g., technical assistance), they show the breadth of the relationships that NYSC has cultivated to mainstream HIV activities into its ongoing work. In addition to these partnerships, NYSC is a subrecipient through the Global Fund. Finally, although the NYSC budget no longer includes a dedicated line item for HIV activities, NYSC leadership provides funds for HIV activities out of other line items. In 2010, the National Assembly removed this line item from NYSC's proposed budget.

The wide variety of funding sources and partnerships that NYSC has cultivated ensures the sustainability of its programs into the future, while enabling NYSC to adhere to the guiding principles of mainstreaming such as identifying an entry point, aligning with the National HIV/AIDS Strategic Plan through the NACA work planning process, and fostering partnerships. This strategy has yielded strong results for NYSC. As NYSC stated in the *ARH/HIV/AIDS Project Response Review* (NYSC forthcoming 2011), "Over-reliance on a single or a few donors or source of funds is a risk for the continuity of programs and the sustainability of organizations. Diversification of resources provides a foundation for an organization to achieve a greater impact."

The Federal Ministry of Information and Communications: Engaging State-Level Staff Members

The FMIC's Critical Mass Committee is made up of the directors of all 37 federal information centers to ensure that staff members outside the main office in Abuja are engaged in HIV issues. These directors play various roles, including the following:

- Championing HIV mainstreaming efforts
- Disseminating HIV prevention information
- Executing HIV prevention workshops
- Providing input to the committee on the needs of ministry staff outside Abuja

Interviewees noted that there are challenges to including this many stakeholders in the process, such as transport costs for meetings and ensuring that directors have the necessary knowledge and interest to play a meaningful role on the Critical Mass Committee.

They also noted that the advantages to this approach outweighed the drawbacks. By identifying a specific position that was responsible for working on the Critical Mass Committee and including that responsibility in the job description, the FMIC was able to replenish the committee's ranks without having to purposefully replace every committee member who left the ministry. In addition, this approach significantly increased middle-management leadership and representation on HIV-related issues and allowed field offices to provide input on these issues. While this approach may not be appropriate for all MDAs, the FMIC's state-level structure provided a good opportunity to change the structure of the Critical Mass Committee to better suit the ministry's needs.

Federal Ministry of Education: Integrating HIV Prevention into Schools

The FME has the mandate to "provide policy direction, build capacity, partnerships, mobilize resources, and perform oversight" of the response to HIV within the education sector. (Federal Ministry of Education 2006) In order to accomplish these goals, the FME has developed a strategic plan that outlines their approach. This plan identified a two pronged approach to address HIV prevention in school settings. First, HIV curriculum development and integration into ongoing educational efforts is a key priority, including building a Family Life and HIV/AIDS Education (FLHE) curriculum into primary and secondary schools. The FME's strategy of integrating FLHE into schools has been a resounding success, as many states have picked up the curriculum, conducted teacher training, and began using it in their schools. Schools represent an opportunity to educate people before they are at risk of HIV, and teach

them strategies for prevent HIV transmission. Currently, FLHE is supposed to be in every primary and secondary school in the country, but the actual implementation of the curriculum varies by state.

The second prong is to develop co-curricular activities such as clubs and peer education forums to spread HIV prevention messages in school. The activities under this strategy have not had quite the level of uptake at the state level as the integration of the FLHE curriculum. Currently, the FME is attempting to develop a support group for teachers in Benue State, which has one of the highest HIV prevalence rate in the federation. Additionally, this strategy has focused on the development of Youth Friendly Centers at universities and colleges in Nigeria. These centers provide students with the opportunity to discuss HIV and sexual health in a safe space. Finally, partnerships with civil society organizations have led to the development of peer education groups, but these partnerships have been ad-hoc and uncoordinated.

The success that the FME has had in scaling up HIV prevention efforts in school settings is due mainly to the depth of their program beyond the FME. The member of the critical mass committee at the FME come from the different parastatals, departments, and agencies within the ministry. These people are responsible for implementation within their own institution; as such they have responsibilities beyond providing strategic advice. Each state ministry of education has an HIV/AIDS desk and a critical mass committee to support its work. Each LGA is also working toward having HIV focal points and critical mass committees for education, further expanding the depth of the response to HIV within the education sector. This depth has allowed the FME to train teachers and integrate curriculum throughout all level of the educational system. Finally, the FME has benefited greatly from having staff members who have received health training and understand HIV specific issues.

4.2 INTERNATIONAL EXAMPLES

Uganda: A Coordinated Multisectoral Response

For the last 20 years, Uganda has been a leader in developing and implementing responses to the HIV epidemic. From 1992 to 2001, HIV prevalence fell from 20 percent to 6.1 percent, mostly as a result of strong HIV prevention measures, which led to significant changes in sexual behavior (Butcher 2003). Uganda is also the first country to adopt a multisectoral approach to HIV, creating the Ugandan AIDS Commission (UAC) in 1991, which was tasked with coordinating the response among the various government agencies. The national AIDS commissions that now exist in many countries were modeled on this commission from Uganda. One primary step Uganda took to improve the national response was to integrate HIV concerns into the 1997 – 2001 Poverty Eradication Action Plan (PEAP), which framed HIV as a threat to the entire country and laid out targets related to eradicating HIV. The national strategic framework built on the PEAP by outlining how HIV issues would be addressed through partnerships with line ministries, civil society, donors, and other stakeholders. For line ministries, programs were to be established that focus on issues within their respective mandates. In addition, each ministry appointed a focal point officer for HIV/AIDS.

As a result of this early coordinated effort, the UAC, as a part of its AIDS Control Project, was able to help each of Uganda's 17 ministries develop AIDS control programs within their ongoing work (Elsy and Kutengul 2003). Supported by the World Bank, the project responded to the HIV epidemic by focusing on HIV sensitization and condom distribution. Sector HIV/AIDS committees were also established by World Bank funding at most line ministries to oversee and implement sector-specific activities (MFPED 2007).

Mainstreaming efforts in Uganda have faced some difficult challenges. Most notably, sector HIV/AIDS committees are often present in name only; they only become active when project money, typically from the World Bank, arrives (MFPED 2007). This method of functioning inhibits true mainstreaming, because the ministry does not have a truly integrated approach to mitigating the impact of HIV into its daily

work. When the World Bank first began funding mainstreaming activities, there was some debate about the appropriateness of funneling the money through the AIDS Control Project, rather than within the ministry budgets. The decision to have UAC distribute the funding was justified by the desire to have an immediate impact, because of the emergency situation, rather than wait for the longer term improvements available through sector-wide approaches to the HIV epidemic (Elsy and Kutengul 2003). When World Bank funding for HIV activities stopped, ministries were expected to integrate HIV activities into their ongoing work by dedicating a line item to these activities. As of 2007, only two non-health ministries, Finance and Energy, had dedicated line items for HIV (MFPED 2007).

Other challenges included the project-specific nature of the funding, which promoted verticalized HIV activities rather than true integration. As a result, many mainstreaming activities in Uganda consisted of one-time HIV sensitizations and workshops, rather than a reappraisal of how HIV affected the core business of each ministry that led to sector-specific approaches (Elsy and Kutengul 2003). In addition, strong, high-level support has not translated into sustained action within the ministries, partially due to fragmented and uncoordinated efforts among key actors, including the UAC, the Ministry of Finance, Planning and Economic Development (MFPED), line ministries, and development partners (MFPED 2007).

Despite these challenges, the roots of the response to HIV in Uganda remain strong. Government policy remains supportive of HIV mainstreaming, especially for the budgeting and planning processes. For example, guidelines have been proposed to better implement mainstreaming. These guidelines would make it easier for ministry staff to understand the importance of mainstreaming and give practical advice on adopting the process. Finally, ministries are making a renewed push to include HIV-specific line items in each ministry's budget, to ensure that the resources available to address future HIV needs are under the control of each ministry. The net effect of these changes is to make HIV mainstreaming a Uganda-driven process, rather than one brought on by external funding.

Botswana: A Ministry with Several Mandates

Mainstreaming HIV into ministries that have several different mandates requires having each department within the ministry assess its own unique position vis-à-vis the HIV epidemic and the core business into which HIV must be integrated. In Botswana, the Ministry of Labor and Home Affairs oversees 13 departments, including immigration, libraries, prisons, youth and culture, civil registry, and the industrial court. Each of these departments has its own distinct sets of circumstances and issues relating to HIV.

In order to address specific needs, each department developed its own mainstreaming plan. These plans were required to align with the six principles of mainstreaming, and specifically address:

- National priorities outlined in the National Strategic Framework on HIV/AIDS. (Principle 2)
- Both external and internal needs. Internal human resources issues were addressed through simple and routine activities, such as condom distribution or information sessions, while external activities at the district level involved engagement with community-level actors. (Principle 4)
- Partnership with other departments within the ministry, as well as external agencies. (Principle 5)

In order to facilitate timely distribution of funding, the initial tranche of funding flowed through the AIDS/STD (Sexually Transmitted Disease) Unit, which was the primary channel for donor funding at the time. Over time, the Ministry of Labor and Home Affairs replaced this funding with line item support to become more sustainable. If the process for obtaining funding through the ministry budget line delayed project implementation, the ministry allowed each department to finance HIV activities from existing training budget lines. In addition, external funding through Gesellschaft für Technische Zusammenarbeit (GTZ) or UNDP flowed directly to the departments. This process allowed the departments to have flexibility in determining how to address HIV within their own circumstances and gave them multiple sources of financing to reduce gaps and address a wide range of HIV-related issues (UNAIDS 2002).

Some successes from the ministry's efforts have included using environmental impact assessments to review the impact of infrastructure projects, such as dams and roads, on the spread of HIV and supporting the integration of HIV-related training modules into the curriculum of vocational training centers¹ (Tschoetschel and Erber 2011). As a result of the ministry's efforts, HIV assistance that flows to the parastatals is better coordinated, and the parastatals have a cabinet-level advocate for continued funding of their HIV mainstreaming efforts.

Namibia: Building Local-Level Engagement

Namibians live in a fragile environment that requires active management to survive. A solution to this concern is Community-Based National Resource Management (CBNRM). CBNRM allows communities to manage their land in a conservancy, which promotes group decision making and takes into account local and national needs. At the national level, CBNRMs are supported by the Namibian Association of CBNRM Support Organizations (NACSO), which builds the capacity of CBNRMs by training peer educators and developing guidelines and policies.

Mainstreaming HIV into NACSO's ongoing activities was a key strategy for the organization, as HIV directly challenges a community's ability to take care of its natural resources. For NACSO, mainstreaming meant a review of its core business to understand the threats posed by the disease. During the review, NACSO decided that the focus of its HIV activities should be in preventing and mitigating the effects of the disease on CBNRM members to ensure the continued vitality of the organizations' resource management goals.

Considering the rural nature of many CBNRMs, NACSO noted that access to prevention and treatment services was a significant problem for its membership. As CBNRMs are community-based organizations, NACSO was ideally placed to help develop community-specific responses to HIV to increase access to these services. At the base of the program was a community-led peer education program that integrated HIV messages into the ongoing work of the peer educators. Ongoing studies, however, found that HIV prevalence was not decreasing; access to HIV information, through the peer educators, had not changed high-risk behaviors, and a new strategy was needed. As a result, NACSO decided to develop a pilot program that focused on key populations instead of the entire community, and recruited individuals from these key populations to participate in ongoing discussion groups.

In addition, NACSO's coordinating role ideally placed the association to develop policy guidelines that could serve as a model for the CBNRMs and others working at the community level. These guidelines addressed the following areas:

- Workplace policies
- Nondiscrimination clauses
- Working conditions
- Information access
- Affordable access to treatment
- Rights and responsibilities of all parties

The flexible, community-led activities promoted by NACSO's mainstreaming process now provides an opportunity for HIV services to reach remote parts of Namibia that are not covered by government health services. NACSO's review of the organization's core business, followed by identification of where NACSO could leverage its strengths, such as in working with community networks, led to sustainable

¹ <http://168.167.134.24/en/Ministries--Authorities/Ministries/State-President/National-AIDS-Coordinating-Agency-NACAI/News-from-NACA/Efforts-to-mainstream-HIV-and-AIDS-into-large-scale-development-projects-on-going/>

programming that addresses core HIV-related needs of the 250,000 members of CBNRMs in Namibia (Berger 2009).

5. THE SIX PRINCIPLES

This section reviews HIV mainstreaming within the MDAs according to the six guiding principles. Breaking down the analysis by each of the six principles makes it possible to understand the common successes and challenges across all of the MDAs interviewed and allows an integrated approach to providing recommendations on how to improve mainstreaming efforts.

5.1 ENTRY POINTS

As explained in Section 1.2, the first guiding principle is to have a clearly defined entry point, which is key to successful mainstreaming efforts. Therefore, a clear concept of exactly what constitutes an entry point is necessary. Too often, entry points are confused with beneficiary groups (i.e., the people that the activity seeks to target). The beneficiary group, however, is only one piece of identifying an entry point. An institution seeking to mainstream HIV also needs a thematic focus that is complementary to its core business. This thematic focus must address the impact of HIV on its core business and fill an HIV-related need for the beneficiary group. In order to clearly identify how an MDA will address the HIV epidemic, it is necessary for MDA staff to reflect upon what HIV means to their core business.

In interviews with MDA staff, it became clear that only some MDAs have completed a thorough review of how HIV affects their core business. Unsurprisingly, MDAs with longer standing programs and more experience on sector-specific HIV issues have better developed thinking and, consequently, more integrated HIV programming. Table 5 shows entry points developed by MDAs in the course of their work.

TABLE 5: ENTRY POINTS IDENTIFIED BY MDAS

Ministry, Department, or Agency	Entry Point
National Youth Service Corps	Youth education through peer educators
Federal Ministry of Interior	Staff education and HIV prevention
Federal Ministry of Education	Classroom module development on HIV prevention
Federal Ministry of Women's Affairs and Social Development	Integration of HIV services for orphans and vulnerable children
Federal Ministry of Information and Communication	Promotional material development for mass media outlets
Federal Ministry of Transport	Access to transportation hubs, networks, and unions
Federal Ministry of Defense	Military hospital HIV service strengthening/Civilian staff and soldier peer educators and support groups
Nigerian Police	Police officer engagement with communities
Nigeria Prisons Service	Prevention among prisoners
Federal Ministry of Labor	Workforce policy development, education, and enforcement /Access to private workplaces
Federal Ministry of Youth	Education through youth development centers
Nigerian Customs Service	Workforce issues with customs officers
Federal Ministry of Science and Technology	HIV-related research coordination
Federal Ministry of Works	Access to construction contractors who hire a largely mobile, male workforce
Federal Ministry of the Environment	Rural communities through forestry program / medical waste management
Federal Ministry of Agriculture	Subsistence farmers through rural development program

As Table 5 shows, many MDAs have clearly identified entry points, while other MDAs have not gotten much beyond one-time information sessions on HIV. The NYSC, for example, has identified clear entry points through its community engagement and work with youth educators, and has developed focused and sustained activities that have been ongoing for nearly 10 years. See Section 4.1 for a more detailed discussion of NYSC efforts. The Ministry of the Interior, on the other hand, oversees the activities of other parastatals, such as Customs, Police, and Prisons. Each of these parastatals has separate issues and concerns regarding HIV, including separate workplace policies. As a result, the Ministry of the Interior focuses on employee workshops and on implementing its own specific HIV workplace policy. The ministry has not yet been able to develop a clear concept of how HIV affects its core business in the way that NYSC has. In the case of the Ministry of the Interior, this challenge is understandable, as its coordination role does not lend itself to specific HIV activities and the ministry is often not involved in the mainstreaming efforts of the parastatals.

Most MDAs, however, fall somewhere in between. They have identified specific entry points, beneficiary populations, and skills that are relevant to HIV work, but have not yet determined the best ways to use their skills to engage those entry points effectively, or do not have the resources to do so.

Because the external engagement piece is unclear, many ministries find it easier to focus on internal mainstreaming instead; workshops on HIV prevention and workplace policy development are common activities. In fact, all 17 MDAs interviewed had conducted prevention workshops with their staff, and 16 had started development of an internal HIV workplace policy. While internal mainstreaming is important, HIV mainstreaming requires more than developing a policy and conducting workshops. Sector-specific approaches, such as the ones identified in Table 5, are required.

5.2 ALIGNMENT WITH NATIONAL STRATEGIES

The second guiding principle is that mainstreaming activities should be aligned with national development strategies and priorities. In this context, alignment connotes the following:

- HIV mitigation and prevention strategies are included in national development policies
- Activities to support those HIV mitigation and prevention strategies are developed and executed
- M&E of these activities is integrated with the national M&E system
- Financing is supported at the national level

Efforts in Nigeria to align HIV mainstreaming efforts have been far reaching and coordinated. The National Economic Empowerment and Development Strategy (NEEDS), which is Nigeria's most recent Poverty Reduction Strategy Paper, mentions HIV in many contexts, including youth development, health services, multisectorality, and as a contributor to poverty (Nigerian National Planning Commission 2004). In addition, the National HIV/AIDS Strategic Plan 2010–2015 empowers NACA to “advocate for mainstreaming HIV/AIDS in all sectors of society” (NACA 2010). In order to accomplish this goal, NACA leads a day-long work planning exercise that brings MDAs together to develop their work plans for the coming fiscal year. One aspect of this exercise is the development of a work plan from a predetermined template. This template is standardized according to NACA's M&E framework, ensuring that any activities that the MDAs carry out are aligned with the framework.

This approach has both benefits and drawbacks. As noted, any activity that an MDA wants to carry out must fit within the work plan template, resulting in activities that are aligned to national priorities. The drawback, however, is that the work plan is a very prescriptive approach and does not allow for creative programming or for reflection on how HIV can be best addressed using current or possible future resources. The work plan template makes it simple for MDAs to place some educational workshops on the work plan and avoid developing comprehensive activities that may better address previously identified entry points.

In addition, the implementation of those work plans is a major challenge for MDAs. Many MDAs interviewed noted that the work plan is an ideal, or at best an advocacy tool. The end of the World Bank credits has given MDAs little hope of getting the activities in the work plan funded, and without funding, the MDAs do not know how to implement these activities. As noted in Section 3.5., centralized funding appears to have crowded out nascent efforts by ministries to get budget line items for their HIV activities. The centralized funding that existed until 2009 convinced many Permanent Secretaries and members of the National Assembly that funding for HIV activities should come from external sources and be provided through NACA. One interviewee summed up the situation well: “If neither NACA nor my ministry is going to provide resources, where is the funding going to come from?”

5.3 ADVOCACY AND CAPACITY BUILDING

Advocacy and capacity building for HIV mainstreaming in Nigeria has met with successes and challenges. In terms of external advocacy to foster local ownership and stakeholder input, some MDAs, such as the FMOT, do a strong job of reaching out to NGOs to advocate for input into mainstreaming activities. Others, such as NYSC, are able to do community-level advocacy through their network of peer educators. By the same token, the HIV workshops that many MDAs conduct shows a strong commitment to building the capacity of staff members on HIV issues.

Advocacy directed at educating decision makers about the need for MDAs to take over mainstreaming, however, has had mixed success. Most interviewees noted that support from the relevant Permanent Secretary is the most important factor in getting a ministry line item, even when the National Assembly had denied funding requests. In MDAs without a Permanent Secretary, structures vary, though most interviewees noted that they advocated to someone at a senior leadership level, especially those in charge of budgeting, within their institution.

As a result, most advocacy conducted by the HIV Program Unit consisted of one-on-one meetings with the Permanent Secretary and the development of documents to showcase the accomplishments of ongoing activities. This type of advocacy, however, was clearly not sufficient for the needs of the MDAs interviewed. In many cases, interviewees clearly did not know the best ways or methods of approaching the senior leadership at their MDA. In some cases, the necessary advocacy target was the National Assembly, as six MDAs noted that their senior management included a budget line item for HIV activities in the ministry budget, but the National Assembly had removed the line item. Interviewees reported that National Assembly members still believe that NACA should be funding HIV activities and that NACA needed to educate National Assembly members about the need for line items specific to HIV activities.

5.4 INTERNAL VS EXTERNAL MAINSTREAMING

In general, MDAs have activities that reflect both the internal and external effects of HIV on their work. In reviewing MDA work plans and interviewing staff in HIV program units, the research team discovered that 13 of the 17 MDAs interviewed had previously carried out external mainstreaming activities. All of the MDAs had some focus on internal mainstreaming, as shown by several HIV prevention workshops and workplace policies (see Table 2). Most MDAs understood the difference between internal and external mainstreaming and the need to address both internal and external issues in order to fully tackle HIV issues within their sector. The difference between internal and external mainstreaming is reflected in past activities and outlined in work plans for 2011, which detail trainings and workshops for MDA staff and many sector-specific activities that address the core HIV challenges of each sector.

Although the overall analysis of how MDAs are addressing both internal and external mainstreaming is quite good, four MDAs had not yet addressed the external mainstreaming needs of their sector. These four MDAs – the Federal Ministry of the Interior (FMI), the Federal Ministry of the Environment (MOE), the Nigerian Police, and the Nigerian Customs Service – all have different challenges with regards to

external mainstreaming. The MOE, for example, has identified possible external mainstreaming entry points, including medical waste management issues and work to prevent deforestation in rural communities. The ministry has not, however, been able to put significant effort into developing these possible entry points into fully fledged programs due to confusion over where HIV mainstreaming efforts should exist within the ministry, high turnover, and weak financial support. Instead, it has focused mostly on internal trainings and workshops that seek to improve HIV knowledge among staff or on holding one-off clinic days for HCT.

The FMI has a different set of challenges, as it oversees a number of parastatals. The FMI's external mainstreaming needs are unclear, because its overall role consists of coordinating the different parastatal agencies and it does not have a specific service delivery role to play. In addition, each parastatal agency has separate HIV activities that address the specific needs of its sector. In effect, the FMI operates in a similar environment as the Botswana Ministry of Labor and Home Affairs (see Section 4.2.) or the FMOT, which also play coordinating roles. Moving forward, the FMI could draw on the experience of other coordinating ministries to gain a better understanding of how HIV can be mainstreamed into its efforts.

For Customs and Police, the greatest challenge to external mainstreaming is the senior management viewpoint that addressing HIV is not a core function of their business. Neither parastatal has ever allocated money from their respective budgets to HIV activities; in addition, interviewees noted resistance at the senior management level as a challenge to mainstreaming HIV. Noting that these challenges exist, however, is not to say that these parastatals have not worked on HIV activities. Both Customs and Police have developed workplace policies and conducted some HIV workshops. These parastatals, however, have relied on these activities as a stand-in for true mainstreaming for three reasons: (1) these activities are suggested in the work plan NACA provides, (2) such activities are easy to carry out, and (3) external funding is available. These activities, however, are not rooted in a complete review of the impact of HIV on the work of these parastatals, and, therefore contribute poorly to the overall goal of mainstreaming HIV.

5.5 STRATEGIC PARTNERSHIPS

No organization can address the challenges posed by HIV alone. As a result, many MDAs have reached out to external partners, such as other MDAs, NACA, international partners, Nigerian NGOs, and United Nations agencies, to obtain needed expertise. Strategic partnerships are often formed to fill a variety of gaps in knowledge and capacity, such as an MDA's need for additional resources, technical expertise, and community outreach.

Aside from NACA and line item funding, a number of MDAs receive funding from external partners, such as United Nations agencies and international partners. These relationships often focus on a need identified by the donor, the MDA, or both. In the case of the NYSC and FMLP activities profiled in Section 4.1, the MDA identified the need and communicated that need to a partner looking to support similar activities. In the case of the Nigerian Police, however, SFH identified the Nigerian Police as a potentially important stakeholder, especially in terms of reaching police officers with HIV prevention messages. At the outset, SFH organized HIV prevention trainings with the police, and later supported a broader strategic planning process that would give the Nigerian Police a framework in which to plan and develop activities and advocate for resources. These types of partnerships risk imposing external agendas onto an MDA and moving the MDA in a direction that is not driven by its needs or owned by the MDA. On the other hand, external assistance of this type can help an MDA identify a need it had not previously determined was important by bringing a fresh perspective into the planning process.

Technical assistance provision is another common type of partnership. MDAs that conduct HIV prevention workshops call on NACA, SFH, or other partners with HIV expertise to assist with training by providing facilitators and/or developing modules for the workshop. The Federal Ministry of Works

and the FMI, for example, did precisely this when conducting HIV prevention workshops. Another type of technical assistance is in the form of counselors coming into MDAs during HCT sessions. Many MDAs, for obvious reasons, do not have trained HIV counselors on staff, therefore, when HCT sessions come up, they need the expertise of outside partners. GHAIN was specifically mentioned as a partner that performed this role for the Nigerian Customs Service and the MOE. In some cases, technical assistance came from other MDAs. The FMLP has been instrumental in helping other MDAs develop HIV workplace policies. Many MDAs also mentioned that they called on the FMOH to provide assistance on specific activities as well. Table 6 provides examples of such assistance.

TABLE 6: FEDERAL MINISTRY OF HEALTH SUPPORT TO OTHER MDAS

MDA	Federal Ministry of Health Support
Federal Ministry of Labor and Productivity	Stigma reduction training
Federal Ministry of Education	HIV awareness module development; HCT
Federal Ministry of Women’s Affairs	Gender issues and pediatric care
Federal Ministry of Science and Technology	Technical assistance on HIV prevention workshops
Federal Ministry of Youth	Discrimination and safety in sports; general awareness

Finally, a less common, but still important, role for partners was organizing community-level support and outreach. As noted, the FMOT partnered with local NGOs in order to staff and manage its counseling centers. MDAs forged these partnerships with local NGOs for a number of reasons. First, local NGOs can provide on-the-ground knowledge of local communities that MDAs do not have. Second, many have volunteer networks that can provide community mobilization or peer education. Third, they can provide staffing for events and activities that are within the scope of their mission. Finally, many NGOs have technical knowledge and experience, especially in HIV, that the MDA itself may not have.

5.6 EXCEPTIONAL ACTION

One of the goals of mainstreaming, whether the issue is HIV, gender, or climate change, is to ensure integration into daily work. In support of this goal, the final guiding principle, “Exceptional Action” promotes the concept of integrating HIV mitigation and prevention strategies into existing programs, activities, and structures. Examples from Uganda and Botswana (as described in Section 4.2) have clearly shown the benefits of taking this approach, as Uganda was able to decrease its HIV prevalence significantly over the last 20 years due to the country’s cross-cutting approaches, while Botswana’s Ministry of Labor and Home Affairs had the more narrow success of carving out a niche for its HIV mainstreaming efforts in coordinating and advocating for the different HIV activities of the parastatals that report to the ministry.

As noted in Section 5.2., HIV is identified as an important cross-cutting issue in NEEDS, and mainstreaming HIV into other sectors is a goal of the HIV/AIDS Strategic Plan. Direction from these documents is an important starting point for HIV mainstreaming efforts. Strategies, however, are only the first piece of the puzzle. The next piece is to put those strategies into action.

Some MDAs have managed to maintain their focus on HIV activities despite the disappearance of external funding. The mainstreaming efforts of NYSC and FMLP are strong precisely because they are an important part of the work that each MDA conducts. In addition, their activities are not viewed as externally driven, even if many of them are externally financed. This ownership has to do with the development of the overall strategies employed by these MDAs; they identified HIV as a threat to their MDA problem before having HIV mainstreaming mandated from NACA.

Assisting other MDAs to have greater ownership of their HIV activities could pose a challenge, even if the MDA leadership identified HIV issues as crucial to their institution. The work planning sessions for MDAs are a step in the right direction toward strengthening the planning capacity of MDAs when it

comes to HIV, but these sessions do not go into the specific strategies that MDAs could take in addressing and funding their HIV activities.

5.7 ROLE OF NACA IN STRENGTHENING HIV MAINSTREAMING ACTIVITIES

NACA leadership has been commendable in putting HIV mitigation and prevention activities on the agenda of MDAs. Much has been accomplished in terms of establishing MDA work plans that are clearly aligned to the national strategy, ensuring that activities have defined entry points, and increasing the awareness that advocacy is required to make HIV mainstreaming a reality. For many MDAs, especially those with strong ongoing programs, NACA coordination has led to work plans that are explicitly linked to national strategies, while funding funneled through NACA has led to internal mainstreaming activities, such as workplace policy development, that would not have been completed otherwise. By these metrics, NACA efforts to better coordinate the MDA response to the HIV epidemic have been largely successful.

Future challenges exist, however, as NACA clarifies the coordinating and facilitating role that it plays in the multisectoral response to the HIV epidemic. This facilitating role will require guiding activities, strengthening national-level advocacy, and providing technical assistance to HIV Program Units that are trying to secure line item funding. This clarification will also require NACA to strengthen its own institutional understanding of mainstreaming and the types of technical assistance that MDAs require.

Coordinated structures for NACA to help MDAs develop HIV activities have been a reality since NACA was first formed. Work planning meetings, Critical Mass Committee structures, and HIV Program Unit staffing requirements are all example of these types of assistance. In many cases, MDAs have modified these structures to better suit their needs by expanding membership in the Critical Mass Committees for greater stakeholder involvement or combining the Critical Mass Committees with their Program Units in order to streamline decision making. Neither solution is necessarily right or wrong; rather, each MDA has adjusted the structure provided to better fit its needs. As NACA's future role will involve more collaboration, coordination, and technical assistance, rather than directing MDAs on which activities to conduct, these varied structures could provide a model for other MDAs to modify their mainstreaming structures, as needed.

6. RECOMMENDATIONS

As previously noted, NACA leadership on HIV mainstreaming in Nigeria has been strong, and many MDAs have worked hard to strengthen the structures provided and implement the activities developed in collaboration with NACA. The reduction of funding support through NACA, however, has led HIV mainstreaming efforts in Nigeria into a new phase that will involve less direct support. This section will address what NACA and MDAs can do to improve mainstreaming in light of the need to better coordinate HIV activities. While the recommendations for NACA are relatively straightforward, the 17 MDAs interviewed for this assessment have a wide range of abilities and challenges in mainstreaming HIV into their ongoing activities. As a result, recommendations will focus on common challenges. From these recommendations, MDAs should choose what best applies to their situation.

6.1 RECOMMENDATIONS FOR NACA

Clarify NACA's role with MDAs. While NACA has occasionally coordinated disbursements for funding entities, such as the MDG office and the World Bank, clarifying their role as a coordinator of HIV activities with MDAs should be one of NACA's main priorities, as many MDAs continue to believe that NACA is and should be providing funding for HIV activities. Since requesting line item funding for HIV activities must start with the HIV Program Unit, the first priority should be to educate the HIV Program Unit and senior managers about the implication of this role, especially the necessity of obtaining and maintaining a budget line for HIV within MDA budgets to ensure operational sustainability.

Advocate to members of the National Assembly. NACA, as an independent agency, has the ability to educate members of the National Assembly on the need for line items specific to HIV to be included in MDA budgets. Developing a NACA-specific advocacy strategy to educate members about the need for a stronger multisectoral response would assist MDAs in their efforts to obtain line item funding. With both NACA and MDAs providing the same messages about this need, the National Assembly will receive multiple viewpoints explaining the importance of HIV mainstreaming and the need to provide the necessary financing.

Use work planning sessions with MDAs to develop skills and knowledge. The annual work planning sessions are currently an opportunity to develop MDA activities and align them to national strategies. These sessions are a good start in addressing the six guiding principles. The scope of these sessions, however, could be expanded to help MDAs learn from each other and from NACA. MDAs with strong programs could share their successes and challenges with their colleagues at other MDAs. NACA could use these sessions to help MDAs develop advocacy strategies as part of their work plan. Expanding the scope of these sessions would also help NACA learn what specific challenges the MDAs face and what ongoing coordination support they need from NACA.

Take steps to reduce turnover of key HIV Program Unit staff. This assessment found that the MDAs with the best functioning HIV mainstreaming efforts were also the MDAs with the longest serving incumbents on their HIV Program Units. In the Nigerian civil service, employees often move posts every 2-3 years. The civil service-wide policy of rotating civil servants throughout different ministries and job posts has a significant effect on the capabilities of the HIV Program Units, as NACA is constantly retraining new staff on HIV program responsibilities. Identifying leaders of HIV Program Units that are not subject to transfers, and are able to build and maintain a vested interest in HIV programming would strengthen the capabilities of these units.

6.2 RECOMMENDATIONS FOR MDAS

Identify a champion at the senior management level. The first major challenge identified by MDAs is the difficulty they face in obtaining line item funding through their budgets. MDA senior management is receptive to proposing line item funding for HIV activities; however, these line items are often removed by the National Assembly. In order to improve the chances of getting the HIV line item through the National Assembly, each MDA should identify a champion at the senior management level who can explain the importance of the line item to the National Assembly. Some MDAs have managed to do this, and other MDAs could learn from their experience of successfully defending their line item funding.

Convene regular meetings, with senior management participation, to review mainstreaming efforts. Some MDAs have fully integrated HIV into their ongoing activities. Others continue to conduct standalone HIV prevention workshops or one-off testing days. Still others have developed strong ideas about where they would like to go with their mainstreaming efforts, but have been unable to achieve those goals. MDAs should conduct regular reviews, with senior management participation, on the challenges and successes that the MDAs' mainstreaming efforts have faced since the last meeting. These meetings would be an opportunity to think through new challenges, further refine the mainstreaming strategy of the MDA, inform senior management about progress, and educate senior managers about the importance of mainstreaming efforts. Regular written reports to senior management could also be incorporated into this process.

Focus on external mainstreaming efforts. Internal mainstreaming, through trainings and workplace policy development, has been strong within MDAs. In addition, most MDAs have a strong sense of where they would like to go with their external efforts. The problem has been moving from planning to action, often due to the removal of the line item for a specific activity by the National Assembly. MDAs should consider creative partnerships with other organizations, even if they are non-monetary. Learning from the experience of the NYSC would help to implement work plans and leverage the expertise of other organizations. Clear results from external activities that tell a story about how the MDA has strengthened HIV mitigation and prevention efforts can only improve the case for funding from the National Assembly in the future.

ANNEX A: LIST OF INTERVIEWEES

Name	Organization
Uchenna Onyebuchi	National AIDS Control Agency
Lawrence Anaweokhai	National Youth Service Corps
Dr. Magbadelo	Federal Ministry of Interior
Julius Ameh	Federal Ministry of Education
Ony Okwuonu, Titus Odo	Federal Ministry of Women's Affairs and Social Development
Victoria A. Agba Attah	Federal Ministry of Information and Communication
Dr. Okoronko Phillips	Federal Ministry of Transport
Dr. Philip Lenka	Federal Ministry of Defense
Emeke Okeke	Nigeria Police
Mrs. A.N. Nwosu, Dr. Labo	Nigeria Prisons Service
Paul Okwulehie	Federal Ministry of Labor
Janet Garba, Mary Anguel	Federal Ministry of Youth
Mohammad Abdul-Karid, Nnaji Ethelbert	Nigerian Customs Service
Dr. Manasseh Gwaza	Federal Ministry of Science and Technology
Emmanuel Arigu	Federal Ministry of Works
Dr. Nnenna Azikwe	Federal Ministry of the Environment
Dr. Segilola Araoye	Federal Ministry of Health
Daniel M. Dauda	Federal Ministry of Agriculture

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