NATIONAL AGENCY FOR THE CONTROL OF AIDS (NACA)

NATIONAL AIDS PRIORITY PLAN (2008-2009)

February 2008

FOREWORD BY DG, NACA

ACKNOWLEDGEMENT BY MANAGER STRATEGIC PLANNING

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ACRONYMS

CDC	**-**	**Centre for Disease Control and Prevention (US)**
CSOs	**-**	**Civil Society Organizations**
CiSHAN	**-**	**Civil Society on HIV/AIDS in Nigeria**
DAC	**-**	**Development Assistance Committee**
DFID	**-**	**Department for International Development**
FLM	**-**	**Federal Line Ministries**
GTT	**-**	**Global Task Team on HIV/AIDS**
LEEDS	**-**	**Local Economic Empowerment and Development Strategy**
NACA	**-**	**National Agency for the Control of AIDS**
NAPP	**-**	**National AIDS Priority Plan**
NEEDS	**-**	**National Economic Empowerment and Development Strategies**
NEPWHAN	**-**	**Network of People Living with HIV/AIDS in Nigeria**
NSF	**-**	**HIV/AIDS National Strategic Framework**
OECD	**-**	**Organization for Economic Cooperation and Development**
SACA	**-**	**State Action Committee on AIDS/State AIDS Control Agency**
SEEDS	**-**	**State Economic Empowerment and Development Strategy**
UNAIDS	**-**	**Joint United Nations Program on HIV/AIDS**
UNDP	**-**	**United Nations Development Programme**
USG	**-**	**United States Government**
USAID	**-**	**United States Agency for International Development**

1.0 INTRODUCTION

1.1 Background

The HIV/AIDS Emergency Action Plan which guided the National Response from 2001-2003 was extended 2004 following the expiration in 2003. In the same year 2004, the National Agency for the Control of AIDS in conjunction with the other stakeholders such as the Non-Governmental Organizations, Faith-based Organizations, People Living With HIV/AIDS, Federal and State Line Ministries, State Action Committee on AIDS (SACA), LACAs, Private Sector Organizations, and development partners started the process of developing an HIV/AIDS National Strategic Framework for the country. The process was highly participatory and it involved all the stakeholders. The development of the National Strategic Framework was completed in June 2005 while the dissemination was held in October 2005.

1.2 The HIV/AIDS National Strategic Framework (2005-2009)

Below is the goal, objectives and strategies of the HIV/AIDS National Strategic Framework.

1.2.1 Goal of the NSF (2005-2009)

Reduce HIV/AIDS incidence and prevalence by at least 25%, and provide equitable prevention, care, treatment, and support while mitigating its impact amongst women, children and other vulnerable groups and the general population in Nigeria by 2009.

1.2.2 Objectives and Strategies of the NSF

Objective 1: To increase programme implementation rate by 50% from 2005 to 2009 through improved coordination mechanisms and effective mobilization and utilization of resources.

Strategies:

1.1. Strengthen coordination mechanism and build capacity at Federal, State and Local Government levels.
1.2. Promote, strengthen and coordinate partnerships by implementing the new Nigerian HIV/AIDS Partnership Forum.
1.3. Removal of information barrier on resource availability, utilization and accountability.
1.4. Promote effective resource mobilization and management at all levels.
1.5. Adopt innovative approaches to funding HIV and AIDS programmes.

Objective 2: To have 95% of the general population make the appropriate behavioral changes (safe sex, abstinence etc) through social mobilization and greater access to information by 2009.

Strategies:

2.1 Promote the implementation of the National HIV/AIDS BCC Strategy.
2.2 Promote BCC through community outreaches.
2.3 Promote BCC through special events and activities.
2.4 Expand BCC through Mass and News media.
2.5 Expand the innovative use of telecommunications and information technology for BCC.
2.6 Implement youth targeted communications programmes.

Objective 3: To increase access to comprehensive gender-sensitive prevention, care, treatment and support services for the general population, PLWAs and PABAs, including OVC by 50% in 2009, and mitigate HIV/AIDS impact on the health sector.

Strategies:

3.1 Promote development and delivery of sustainable, comprehensive quality approaches to prevention, treatment, care and support services in both public and private sector facilities, including CSOs.
3.2 Develop a condom policy and strategy to improve access and utilization of condoms.
3.3 Promote access to safe blood.
3.4 Promote the practice of universal precautions and infection control (including medical waste management).
3.5 Improve accessibility, affordability and quality of STIs/ reproductive health services.
3.6 Increase equitable access to ART and ensure uninterrupted supply of good quality ARV drugs.
3.7 Promote access to treatment of opportunistic infections, including TB management.
3.8 Expand access to gender-focused VCT services, including access to youth-friendly VCT.
3.9 Promote joint programming between HIV/AIDS /TB, RH, STIs as well as linkages between sectors and levels of health care delivery.
3.10 Reduction in mother-to-child transmission of HIV infection.
3.11 Define, promote and implement gender-sensitive community and home-based care services.
3.12 Strengthen socio-economic, nutritional and psychosocial support programme at all levels for vulnerable groups, including OVC, PABA and PLWAs.
3.13 Strengthen and build capacity for implementation of HIV/AIDS technical responses.
3.14 Strengthen capacity of health sector institutions, systems and personnel to plan and manage a well coordinated and adequately resourced health sector response to HIV and AIDS at all levels.

3.15 Enhance efficient and sustainable logistics system for improved access to health commodities for HIV and AIDS-related services.

Objective 4: To increase gender-sensitive non-health sectoral responses for the mitigation of the impact of HIV/AIDS by 50%.

Strategies:

4.1. Build capacity and establish linkages among key social and economic development institutions for HIV/AIDS impact mitigation among the affected and afflicted.
4.2. Provide economic empowerment targeting vulnerable groups.
4.3. Develop and scale up implementation of workplace policies in all sectors.
4.4. Expand and scale up education sector response.
4.5. Expand agricultural and rural sector response.
4.6. Strengthen FBOs and the organized private sector response.
4.7. Mainstream HIV/AIDS into all national economic development planning process and fiscal policy.
4.8. Manpower planning in all sectors to mainstream HIV/AIDS.
4.9. Mainstream HIV/AIDS into regional cooperation programmes.

Objective 5: To have 95% of groups with special needs make the appropriate behavioral changes (safe sex, abstinence etc) through social mobilization by 2009.

Strategies:

5.1. Scale up HIV/AIDS response targeted at groups with special needs, such as:

- Uniformed persons
- Prison inmates
- PESSP
- Sex workers
- IDUs
- IDPs
- Transport and migrant workers
- Trafficked persons
- Physically & Mentally challenged persons
- Substance abusers
- Communities at junction towns.

Objective 6: To strengthen national capacity for monitoring and evaluation of the HIV/AIDS response such that the national monitoring and evaluation plan is 100% implemented by 2009.

Strategies:

6.1 Strengthen mechanisms for monitoring and evaluation.
6.2 Strengthen capacity for monitoring and evaluation
6.3 Regular update of national strategic HIV/AIDS information.

6.4 Monitor and evaluate the implementation and impact of the NSF.

Objective 7: To build national capacity for research, knowledge sharing, and the acquisition and utilization of new HIV/AIDS technologies.

Strategies:

7.1 Strengthen HIV/AIDS-related researches.
7.2 Conduct gender disaggregated research of the impact of HIV/AIDS on key sectors.
7.3 Promote operational research.
7.4 Promote the development, acquisition and utilization of new HIV/AIDS technologies.
7.5 Improve HIV and AIDS Learning, Knowledge-Sharing and Information Management.
7.6 Promote ethical issues in research and ensure community participation.

Objective 8: To improve the policy environment (policies, guidelines, legislations) that supports safer sex practice, reduces stigma, promotes positive living and rights of women and the general population, particularly PLWAs.

Strategies:

8.1. Create an enabling policy environment for an effective and gender-sensitive national HIV and AIDS response.
8.2. Remove impediments to the attainment of enabling legal environment.
8.3. Enact new laws to take care of the legal needs of those infected and affected by HIV/AIDS.
8.4. Create gender-sensitive and human rights-friendly environment for effective management of HIV/AIDS responses.
8.5. Advocacy targeting policy makers and opinion leaders.

1.3 Joint Mid-Term Review of the HIV/AIDS National Strategic Framework (2005-2007)

1.3.1 Goal and Objectives of the JMTR

When the NSF was developed, it was planned that there would be an exercise to assess the level of implementation half-way into Strategic plan period. The Joint Mid-Term Review of the NSF (JMTR) was thus carried out between November and December, 2007.

The goal of the **JMTR of the NSF** is to undertake a forward looking mid term review of the HIV/AIDS National Response implementation of the National Strategic Framework for Action (2005-2009) in Nigeria. The specific objectives are as follows:

- To review progress towards attaining and delivering on the goal and objectives of the engendered NSF 2005-2009.

- To undertake an assessment of achievements, constraints, opportunities, threats and challenges in implementing HIV prevention, Treatment, Care and Support and Impact mitigation interventions, and related policies under the NSF.
- To review the management, coordination and institutional arrangements at all levels (national, state and local government levels) related to the implementation of the NSF.
- To assess and document best practices in the national response and make recommendations to address identified gaps and challenges.
- Identify and set direction to the remaining period of the NSF and future priorities as well as planning.
- To provide detailed documentation/base lines/ analysis of the national response comprehensively.
- To supplement the evidence necessary for the development of evidence based National Annual Priority Plan for 2008-9.

1.3.2 The Key Achievements and Challenges in the implementation of the NSF (2005-2007)

Based on the findings of the JMTR of NSF along the now adopted six thematic areas are as contained below:

(a) Institutional/Governance arrangements, coordination, resource mobilization and utilization

Achievements

- Strong coordination at federal level.
- Good capacity at Federal level
- Reasonably good coordination at state level though varied.
- Weak capacity at LGA level
- Functional relationships and partnerships mostly at the Federal and to some extent in the State.
- National Strategic Framework (NSF) costed
- Information provided on available and utilized resources from 2005 at Federal level
- Grant procedures published
- Some trainings conducted on resource mobilization and management.
- SACA attended meetings of SPC/SMFEP with donors in few states
- Tripartite meetings between National Planning Commission (NPC)/Ministry of Finance (MOF), donors and NACA held.
- Country Coordination Mechanism (CCM) expanded
- HIV and AIDS budget lines inflow tracking mechanisms
- Shell, MTN and Coca Cola Foundations represents main new source of funds from the private sector.
- Only about a ninth of states have successfully explored new funding sources (private sector, FBOs, communities)
- Slow progress on state level CCMs

- HIV and AIDS mainstreamed into some poverty reduction programmes (e.g. debt relief funds) at Federal level.
- HAF extended, aligned
- The National Economic Council (comprising of all the governors and the economic team) have agreed to commit 1% of their annual budget to HIV/AIDS.

Challenges

- ❑ Coordination challenge at Federal level, given that only some 25% of Federal level resources pass through NSF
  - However, largest spenders have complied with NSF
  - Proposal for NACA to warehouse MDA resources will need laws
  - Joint Funding Agreement being explored by some donors
- ❑ Poor funding at sub-national levels, in particular by states and LGAs
  - National Economic Council (NEC) intervention needed to ensure increased state government funding.
  - Will need this to motivate further private sector funding
- ❑ Weak capacity at state level and among some CCEs, especially in terms of staffing levels
- ❑ NACA-NASCP relations have improved but still sub-optimal, same with SACA-SMOH relationships in most states.
  - Agency status should help further clarification of roles
- ❑ Too few SACAs as agencies, which limits both role and funding availability.
- ❑ Weak coordination at LGA levels.
- ❑ LGAs yet to take responsibility for own roles, and LACAs yet to show up, thereby limiting response at grassroots level.
  - Nationwide problem, so could be amenable to centrally-initiated responses

Recommendations

- ✓ Encourage better coordination and harmonization between partners and sectors, but especially between NACA/SACAs and FMOH/SMOHs.
- ✓ More investments and greater capacity in NACA and SACAs to improve targeting, especially as it relates to gender, poverty and OVCs
- ✓ NACA should intensify its resource mobilization advocacy support to states.
- ✓ Adopt/adapt national policies and guidelines on coordination at all levels
- ✓ Complete State Strategic Plans and gender action plans.
- ✓ Expand and deepen partnership with the private sector.

(b) Prevention and Behavioural Change Communication

Major Achievements

- Significant level of awareness and knowledge attained in most parts of the country.
- National BCC Strategy, 2004—2008 is being implemented & 15 states developed respective engendered BCC/SBC Plans.

- Enormous amount of IEC materials developed, produced and disseminated.
- Enormous investments have been made in promoting and strengthening BCC through community outreaches.
- Tremendous capacity building on advocacy, message development and dissemination and channel selection
- Positive outcomes of advocacy activities at the federal, state, and local levels.
- Thousands of people trained as peer educators.
- Over 640 HCT user friendly and gender sensitive centres have been established at different levels.
- There are 253 active PMTCT sites.
- Scale up in the quantity of condoms distributed in the country, particularly female condoms
- Increase in private sector interventions

Constraints

- ❑ Present advocacy activities have not yielded the total effects desired.
- ❑ Quality of some of the interventions is low.
- ❑ Inadequate attention to integration of STIs management.
- ❑ Inadequate capacity for CSOs to provide HBC and palliative care services at the community and household levels.
- ❑ The continuous resistance to condom use by some FBOs, governments and few stakeholders.
- ❑ Low scale PMTCT and HCT services in all the states and LGAs.
- ❑ Insufficient attention to gender dimension in the prevention process

Recommendations

- ✓ Intensify behavior change communication using various channels and approaches.
- ✓ Undertake situational analysis at different levels in the country to establish baseline data on the specific communication gaps, needs and circumstances of each component of the society.
- ✓ States and implementing partners that have not developed their BCC Strategic Plans should do so.
- ✓ Consolidate on efforts made so far in strengthening the skills and capacity of media people, film makers, dramatists, entertainers, etc.
- ✓ There should be increased focus on perspectives like creation of enabling environment (policy, governance and resource mobilization), effective mainstreaming of gender dimension and reduction of stigma and discrimination in the content of BCC messages
- ✓ Strengthen the communication units in NACA and SACAs
- ✓ Strengthen capacities of Implementing Agencies (IAs) to offer prevention services
- ✓ Foster partnerships
- ✓ Integrate prevention to treatment and care issues
- ✓ Increase the capacity of use and availability of female and male condoms
- ✓ Link blood safety to other prevention programmes
- ✓ Increase access to PEP
- ✓ Increased partnership with the private sector.

(c) Treatment, Care and Support

Achievements

- 14 Policy documents /technical Guidelines and 3 technical reports developed and disseminated
- ART sites increased from 25 in 2005 to 215 in 2007
- PMTCT sites increased to 253 in 2007.
- HCT sites from 153 in 2005 to 640 in 2007.
- TB-DOTS and HIV management integrated at sites by 2007.
- Pediatric ART initiated for 5,279 by 2007.
- Improvement in the capacity and quality of Home Based Care services in the country.
- Expansion in the enrollment of persons into the ARV programme.

Challenges

- ❑ Most treatment sites are found at Tertiary Health facilities which are largely located in the urban areas.
- ❑ Disease burden compared with achievements appear very low -e.g. projected one million PLWHAs out of 3.083 million PLWHA are expected to be on ART by 2009 (NASCP) while only 166,734 persons are on ART as at 2007.
- ❑ State/LGAs hands off in treatment.
- ❑ Increasing demand due to success of awareness creation and PLWHA doing well on treatment
- ❑ Weak coordination at state/LGAs levels
- ❑ Donor dependence
- ❑ Non involvement of support groups and PLWHA in treatment and care in many of the health care settings.
- ❑ Inadequate provider capacity-availability, numbers, distribution, training
- ❑ Availability of ARV and OI drugs
- ❑ Sites not enough for increasing demand
- ❑ Poor infrastructure – water, electricity, space
- ❑ Non-use of technical guidelines
- ❑ Weak non-PMTCT PEP implementation at facilities
- ❑ Inadequate HIV/RH-Family Planning integration
- ❑ Inadequate blood safety measures
- ❑ Poor universal safety precautions and waste management
- ❑ Lack of services for youths/youth friendly sites
- ❑ Weak OVC and HBC linkage to treatment sites
- ❑ Sustainability

Recommendations

- ✓ Increase sites for all services
- ✓ Develop quality assurance principles
- ✓ Support ARV procurement and manufacturing
- ✓ Universal safety precautions & PEP
- ✓ Decentralize treatment, Care, Support to PHC level
- ✓ Work with local NGOs/CBOs
- ✓ Need for emphasis on adherence

- ✓ Increase drive for safe blood and regulation of access/use
- ✓ Integrate HIV/Reproductive Health-Family Planning
- ✓ Facilitate procurement of HIV related equipment
- ✓ Involve for- profit medical SDPs in treatment, care and support
- ✓ Support the training of adequate manpower and ensure equitable distribution
- ✓ Step-down Technical Working Group
- ✓ Promote active collaboration between LACA/SACA and Treatment, Care and support network active collaboration

(d)Non-health Sectoral Responses

Achievements

- Conducted capacity building on HIV/AIDS mainstreaming in key sectors.
- Advocacy conducted by NACA, SACA and line ministries at federal and state levels.
- Trained HIV/AIDS desk officers & focal persons in line ministries at federal and state level.
- Workplace policies developed, disseminated and being implemented (line ministries, OPS etc).
- FLHE curriculum developed and integrated into the teaching of ten subjects and being implemented in 26 states.
- Several teachers, guidance counselors and peer educators are trained all over the country.
- HIV/AIDS BCC had been integrated into NYSC programme.
- Increase in the knowledge of HIV/AIDS change the perception and attitude of religious leaders towards PLWAS and PABA.
- FBOs Strengthened by HAF fund
- Over 10,000 OVC are currently on scholarships.
- Several PLWAS are receiving gender sensitive micro credit and skill acquisition
- Increased organized private sector (OPS) response.
- Mainstreamed HIV/AIDS into mid-term economic frame work (NEEDS/SEEDS)
- Mainstreamed HIV/AIDS programming into annual budget preparation.

Challenges

- ❑ Rural and urban dichotomy.
- ❑ National OVC situation analysis yet to be conducted.
- ❑ Dis-aggregation survey on the impact on food production, food security and gender not yet done.
- ❑ Budget line allocation not sufficient for HIV/AIDS intervention activities.
- ❑ Inadequate understanding of need for HIV/AIDS programs by political office holders especially national and state assembly members.
- ❑ Inability of some NGOs, INGOs to share information with NACA/SACA.
- ❑ Many private sector organizations especially the banking sector are yet to respond adequately to the call on fight against HIV/AIDS.

Recommendations

- ✓ National OVC situation analysis should be conducted as soon as possible.

- ✓ Dis-aggregation survey on the impact of HIV/AIDS on food production, food security and gender should be conducted as soon as possible.
- ✓ Integrated rural development policy pursued vigorously.
- ✓ Advocacy to political office holders, National and State assembly members to mainstream HIV/AIDS.
- ✓ Improve budgetary allocation to HIV/AIDS intervention activities.
- ✓ There should be increased commitment from the organized private sector.

(e) Monitoring and Evaluation

Achievements

Significant effort was devoted to strengthening M&E systems

- National M&E system as part of implementing "Three ones"
- Mechanism for M&E coordination
- NNRIMS implementation is limited to few states with database (12 states) – Human resources, Infrastructure, Forms, trained implementers
  - Over 2,780 persons (66% Males and 33% Females) trained at national, state and LGA levels including 40 trainers
- Production of National Operational Plan and 6 state M&E plans

Concerted effort was reported in advancing researches and new technologies on HIV

- National Ethics and Operational guidelines for Research on Human Subjects developed in 2005
- 1st National Ethical Policy Review Board and another NEB named NHREC at FMOH
- Nigeria HIV Vaccine & Microbicides Advocacy (NHVMAG)
  - Standard of Care document for trial participants to protect the rights of the subjects
- Increased HIV operational researches at state & project levels.
- National surveys are ongoing.
  - Planned Socio economic studies in 2008.

- Dissemination and utilization of information reported from researches and new technologies
  - National conferences held-HIV summit 2005 & 2007, ICASA 2006, AVAG, International conferences, 1st AIDS Council Meeting, ETG,
  - Publication of NNRIMS bulletins at NACA and 13 SACAs
  - NACA and some state websites created
  - NACA M&E web blog
  - Media network active in information dissemination-publications, discussions and web presence

Challenges

- ❑ National M&E and Program M&E system
  - Uncoordinated or poor documentation of National M&E system and program implementation at all levels.

- Poor reporting by stakeholders into National M&E system.
- Inadequate and lack of funds for M&E implementation.
- Limited manpower and complementary M&E skills at all levels compounded by staff attrition and transfers.
- Limited involvement of private sector in National M&E system. E.g NNRIMS implementation.

- ❑ Lack of ownership has resulted in ineffective utilisation of data for planning and decision making.
- ❑ Limited focus on baseline researches and new technologies.
- ❑ Limited coverage of researches.
- ❑ M&E presents an incomplete information base on all the activities of the response.

Recommendations

- ✓ Budgetary allocation for M&E: Joint pool of funds.
  - Partners assigned to state should manage /pool resources for M&E management
- ✓ Coordination: NACA coordinates, program/sectors take responsibility to implement M&E according to National Operational Plan
- ✓ National M&E system is more than routine facility based data collection and extends to supportive supervision & on the job training.
- ✓ Provide technical support to achieve this.
- ✓ Enhanced performance of M&E TWG at all levels including the sub committees and National Vaccine Working Group
- ✓ "If you will not use it, then don't collect it"!

(f) Enabling Environment

Achievements

- Good progress - NSF informed development of 23 HIV and AIDS related policies.
- These policies and pre-existing ones focus on:
  - Sexual and Reproductive Health / Workplace / Gender and HIV and AIDS/ OVC / Elimination of Female Genital Mutilation / Human Rights Issues / etc.
- 28 states have developed/ratified new policies towards local solutions to HIV and AIDS policies.
- 11 states have reviewed provisions of laws which are gender discriminatory.
- 21 states have advocated for the enforcement of laws to reduce stigma.
- All states have domesticated HIV/AIDS related instruments for supporting combinations of:
  - safer sex practice, reduction in gender disparities and promotion of rights of women, reduction in stigma and promotion of rights of PLWAs
- All states are undertaking effective advocacy targeting policy makers and opinion leaders

Challenges

- ❑ in governments, religion and belief systems, and even in funding as they relate to HIV and AIDS exists
- ❑ Successful implementation, coordination, harmonization and enforcement of the HIV and AIDS policies
- ❑ Non-adoption and/or popularization of policies of the National policies in some states
- ❑ States are at different levels of political commitments;
- ❑ To adopt, domesticate, implement and enforce the HIV/AIDS policies

Recommendations

- ✓ Transform SACA into agencies to achieve statutory mandates.
- ✓ Support SACA to establish and manage partner coordination and harmonization in their states.
- ✓ Facilitate utilisation of HIV/AIDS policy & enforce supportive laws.
- ✓ Advocacy on specific HIV and AIDS policy issues.
- ✓ Facilitate policy coordination & harmonization.
- ✓ Facilitate enforcement of laws that protect the rights and privileges of PLWAs
- ✓ Strengthen the National Assembly Response HIV/AIDS
- ✓ Provide culturally appropriate gender sensitive bills in indigenous languages.

(g) Gender Mainstreaming

Achievements

- Strong visibility of Gender Technical Working Group.
- Efforts on-going to ensure data dis-aggregation by sex
- Gender technical expert recruited-resume in Jan.2008.
- Gender mainstreaming efforts are evident in sectoral responses.
- Consciousness of gender mainstreaming in the NSF review process.
- Establishment of National women's coalition on HIV/AIDS.
- Several CSOs including women's groups have been supported to implement HIV/AIDS programmes.

Challenges

- ❑ Obvious recognition of gender mainstreaming in HIV/AIDS at the national level. However, technical expertise for operationalization remains a challenge at all levels
- ❑ The NSF itself is not widely disseminated among stakeholders at all levels.
- ❑ There are weak technical capacities in programme areas in the states.
- ❑ There is limited understanding of gender as a concept at all levels.
- ❑ Paucity of disaggregated data at the SDPs.
- ❑ Cultural and traditional norms.
- ❑ Some states are yet to begin implementation of NNRIMS.

Recommendations

- ✓ Development of gender policy for HIV/AIDS programming.
- ✓ Capacity Building on implementation of Gender mainstreaming at all levels.

- ✓ Development and use of an operational capacity building plan.
- ✓ Development of tool kit for gender mainstreaming in HIV/AIDS.
- ✓ The NSF should be shared more widely among stakeholders with emphasis on gender targets & indicators.
- ✓ Enhance capacity of SDPs to institutionalise collation & reporting of gender disaggregated data.
- ✓ SACAs should be strengthened by recruiting technical persons on gender.

2.0 The Process of Developing the National AIDS Priority Plan (NAPP)

2.1 Background Information

The June 2005 report of the Global Task Team (GTT) on HIV/AIDS contained major recommendations on what the World must do more to effectively tackle AIDS in the years ahead. The recommendations of that report include: the need to situate and strengthen the various activities related to coordination, alignment and harmonization of HIV/AIDS plans and interventions within the context of the "Three Ones" principles, the UN reform, the Millennium Development Goals, and the Organization for Economic Cooperation and Development (OECD)/Development Assistance Committee (DAC), Paris Declaration on Aid effectiveness. This report further identified what is essential for a rapid scale-up of the AIDS response as well as assuring that "National ownership of plans and priorities" is the overarching rubric in which efforts to harmonize, align and coordinate HIV/AIDS activities should occur.

Pursuant to the above, the National Agency for the Control of AIDS (NACA) adopted and domesticated those recommendations and was perhaps one of the first few National AIDS coordinating authorities to do so. Prior to the domestication of the GTT recommendations, the HIV/AIDS National Strategic Framework (NSF) for Action (2005 – 2009) had already been developed and was being implemented by stakeholders. This document examined the issues of HIV/AIDS in Nigeria holistically from eight broad thematic areas and also made appropriate recommendations for action. It further articulated a logical framework of action for the next five years. The NSF document was developed with the active involvement and participation of all stakeholders.

With the formal adoption of the GTT recommendations and the NSF in place it was decided that there should be annual priority plans which would indicate the annual

priorities of the country, with NACA and other tiers of government leading the process at the various levels and being in line with the recommendations of the GTT, thus ensuring national ownership. It was also agreed that the NSF already developed, being very comprehensive in nature, should guide the implementation of the national response to the epidemic. And **all** stakeholders, including bilateral and multilateral partners, are meant, in the spirit of the "Three Ones" principle, to buy into, adopt and adapt aspects of its provisions to meet their respective needs within the national framework.

Thus 2005 actually marked the beginning of the development of the annual priority plans and the annual work-plan template which had been earlier adopted by the majority of States Action Committee on AIDS (SACA), Federal and State Line Ministries, Civil Society Organizations, private sector organizations and the development partners within the country. While the annual work-plan template represented the first major attempt at using a single template by all the major stakeholders in HIV/AIDS in Nigeria, there were some observations by a range of stakeholders that have resulted in the template being reviewed and modified.

It is expected that this new plan will continue to drive implementation, improve oversight, emphasize results and provide a basis for the alignment of multilateral institutions and international partners' support within related efforts to progressively strengthen the national response. Furthermore, it is also expected that the National AIDS Priority Plan (NAPP) will be mainstreamed into the new National Economic Empowerment and Development Strategy (NEEDS), State Economic Empowerment and Development Strategy (SEEDS) and the Local Government Economic Empowerment and Development Strategy (LEEDS) implementation plans.

Despite the fact that NACA has substantially complied with the provisions of the GTT recommendations and developed a national five-year HIV/AIDS strategic plan, it was discovered that there was no universal acceptance and compliance with the leadership role it was playing in the national response to this epidemic in Nigeria. This had been a very disquieting situation for the organization. Accordingly, NACA, with support from some its partners, appointed Consultants to examine and review the situation and make recommendations on the way forward especially with regard to the buy-in processes for determining the national priority interventions for HIV/AIDS, its annual AIDS plans and

the planning procedures. The Consultants also assisted the organization in developing a two-year National AIDS Priority Plan (2008-2009).

The National AIDS Priority Plan (NAPP) is meant to refocus the vision of and provide support to all the key sectors of the national socio-economic terrain such as Federal line Ministries, SACAs, LACAs, the Civil Society groups, the private sector of the economy and other willing organizations in the development of their annual HIV/AIDS plans. The expectation, by so doing, is that all efforts at implementing the national response will be accelerated, strengthened and enhanced. Consequently, NACA with the support of the development partners engaged consultants to develop the Annual AIDS Priority Plan.

2.2 The Process

(a) Desk Review of Relevant Documents

At the start of the process, consultants reviewed documents that were considered very relevant to the assignment. These include:

- National HIV/AIDS Prevention Plan Draft 2007 – 2009
- National HIV/Syphilis Sero – Prevalence. 2005
- NNRIMS Operational Plan 2007 – 2010
- National Situation Analysis of the Health Sector 2005
- HIV/AIDS National Strategic Framework for Action 2005 - 2009
- Design of a Framework for a Joint financing agreement for the Nigeria (JFA) Part 1& 2
- Work plan/ activity and implementation 2007 (3 copies)
- National Policy on HIV/AIDS 2003
- Private Sector Response and Public – Private partnership on HIVAIDS in Nigeria 2005
- Paris Declaration on AID effectiveness (Handout)
- Institutional Reviews – Progress and Key Next Steps
- Nigeria National Response Information management system of HIV/AIDS
- National HIV/AIDS Behavioural Change Communication Strategy (2004-2008)
- Joint Mid-term Review of the HIV/AIDS National Strategic Framework

The rationale behind the review of these documents is to have a comprehensive and deeper understanding of the diverse and varied issues involved in the development of the plan as well as what the principles should be.

Based on this we agreed that the following principle will guide the process:

- Participation, involvement and ownership
- Bottom –up approach.
- Documentation should be evidence-based.
- Effective communication including constant feedback.
- Mutual cooperation and collaboration.
- Rapid process that does not impede ongoing activities

(b) Stakeholders' Mapping and Meetings

In conjunction with some of the NACA management staff, the consultants identified the major stakeholders that would be consulted in the course of developing the plan. This was in a bid to ensure ownership, inclusiveness and eventual buy-in. These are: Federal Line Ministries, SACAs, State Line Ministries, Civil Society Organizations, Private sector, NACA as well as the Development Partners amongst others. Consequent upon this, various meetings and workshops were held with them. In addition to these meetings, survey questionnaires were also used in eliciting information from some of the stakeholders particularly in terms of what the priority intervention areas and activities should be for the next two years. The reports of the various meetings and workshops with different stakeholders were then analysed and compiled to come up with the priority intervention areas and activities.

(c) Identification of Priority intervention Areas and Activities

The priority intervention area identified by the range of stakeholders after collation is as follows:

1 Behavioural Change Communication and Education

2 Coordination structure and systems strengthening at all levels
3 Monitoring and Evaluation system strengthening
4 VCT
5 Universal access to ART
6 Social support, economic empowerment and impact mitigation
7 PMTCT
8 Condom social marketing
9 Blood transfusion and medical waste management
10 Enabling Legislations
11 Universal Precautions
12 Syndromic management of STIs
13 Hospital care and Community Home based Care
14 Surveillance
15 Operations/New technologies Research
16 Local Manufacturing

Stakeholders also identified the priority intervention activities which formed the bedrock of the activities contained in NAPP.

(d) Joint Mid-term Review (JMTR) of the National Strategic Framework

Though the development of the National AIDS Priority Plan commenced before the JMTR, there were indeed meeting points between the JMTR and the NAPP. Equally, since the process followed in the development of NAPP was very inclusive and participatory, there were little or no fears that outcomes of the JMTR would be significantly different from what was obtained through the NAPP process. It was agreed though that since the JMTR would cover all the States of the Federation, more detailed information on the assessment of the status of current implementation of the HIV/AIDS response throughout the country would be obtained while recommendations also made will be used to validate NAPP findings in terms of what the future priorities should be.

Based on the foregoing, the NAPP team was actively involved in the JMTR process and particularly in the consultants' orientation, development of questionnaires, field visits and

report-writing. In fact members of the NAPP team served as Team leaders/members to the State visited.

(e) Development of the Draft National AIDS Priority Plan, Annual Priority Plan Template and Guidelines for Completing the Annual Priority Plan Template

Following the series of consultations and meetings as well as the findings of the JMTR, the consultants developed the NAPP, Annual Priority Plan Template as well as the guidelines for completing the annual priority plan template. They were passed to the management of NACA for further action.

(f) Feedback.

Efforts at combating HIV/AIDS effectively and efficiently throughout the world demand appropriate collaboration and cooperation of all stakeholders in their respective national response. As indicated earlier, meetings were held with representatives of various development partners and donors as part of the process of developing the two-year National AIDS Priority Plan. This was to ensure ownership of the output and the processes.

Furthermore, when the consultants developed the final draft of the two-year plan, they forwarded it to NACA who in turn circulated it to her partners and stakeholders for review and comments. The feed-back obtained was quite positive but with the suggestion that the structuring of the plan should be done differently to ensure that the all the things contained in the plan can fit into A4 sized paper.

3.0 The National AIDS Priority Plan Matrix

3.1 Guide to the rows and columns in the National AIDS Priority Plan (2008-2009)

1. **Objectives** and **Strategies:** These are written in rows and they are somehow fixed and are as contained in the plan. Objectives are the improvement we want to see at the end of the plan period. Strategies are the methods for achieving the objectives.

In the same vein, it should be noted that at the end of **all** the Objectives and Strategies there is another row for the Operational/Administrative Costs. This may not necessarily have objectives and strategies but would surely have activities and all those activities and sub-activities to be implemented should be stated while all the other respective columns such as who's responsible, level of implementation etc should also be completed.

2. Activities: These are action steps to be taken during the planning period. For the avoidance of doubt, it is suggested herein that stakeholders articulate only the activities that are considered most essential to undertake within the year being planned for and which would have a quicker effect and a greater impact in the medium to long term in addressing and redressing the effect of HIV/AIDS on the target beneficiary and other members of the general population. It should also be noted that the priority activities are to a very large extent the ones already contained in the National AIDS Priority Plan. However, States/Ministries/Departments/Agencies should feel free to add activities and sub-activities as may be required.

3. **Sub-activities.** The sub-activities are the various action steps you have to take for the main activities to be performed. For instance, if an activity says "implement the capacity building plan", we know that this presupposes that you already have a capacity-building plan. But if you don't have, the first sub-activity may be to develop a capacity-building plan or even review your capacity-building plan where you already have one to make it current. It should also be noted that not all sub-activities may have costs.

4. **Target or Beneficiary** are the recipients of a particular service or product. It is relevant to observe that activities are meant to address particular situation(s) that affect either the entire population or a segment of it. For instance the beneficiary of ARV drugs will be the PLWA and rightly so because they However, if you carry out an advocacy activity with policy-makers they are only the target of that activity but not getting any direct benefit from the activity. For that reason, it is mandatory not only to articulate what needs to be done but also who is the target or beneficiary of that activity so that in the final analysis we can all improve the HIV/AIDS situation.

5. **Output:** is the product or service you want to deliver or delivered as a consequence of carrying out a particular activity. It is the yardstick for measuring the success of completed activities. It is the column where verifiable indicators or expected output for all activities would be inserted. This column provides the measure only for the immediate, verifiable and tangible results of each activity. For example, where training is expected to have been conducted, having the training delivered is a major output while the report of the training activity is also another output. The report should describe such details as where and when the activity took place, participation in and facilitation of the activity and costs incurred in conducting the activity.

6. Who is Responsible: is the individual/officer/official or agency that should be held accountable for the performance of that activity. In some cases, more than one person/official is responsible for carrying out a particular activity but where this occurs it is the name/designation of the official/officer and organization/agency that is primarily responsible that should be indicated.

7. Level of Implementation: refers to the level in which a particular activity is to be undertaken within the existing three-tier operational structure of Nigeria, i. e. at the Federal, State or Local Government level,

8. **Activity Implementation Period:** This merely indicates the expected time for commencing and completing activities and it is stated in quarters. Where activities would take more than one quarter to complete, the respective quarters should be indicated by marking the respective columns capital 'X'.

9. Funding. This column is further sub-divided into four: **Pooled, Earmarked, Direct and Total. Pooled funding** refers to funds put in a pool (by partners and government) and can be used to fund a range of activities as identified by NACA or SACA based on their plans. **Earmarked funds** are funds that are specifically provided by donors/partners and Governments to support certain activities while **the direct funds** are funds provided by partners for carrying out some activities which do not pass through NACA or SACA but are directly implemented by such partners. While it may be easier to get information on pooled and earmarked funds, getting information on direct

funding may pose some challenges. The challenges may be partially overcome by ensuring that stakeholders are involved in the development of the annual plans. Moreover, NACA in collaboration with some other bodies will ensure that such information is available. **Total funding** refers to the total amount of funds available for sub-activities/activity from all sources.

10. The final column seeks to highlight the **Funding Sources** for each articulated activity. Such sources are expected to be simply listed in that column. For the avoidance of doubt, where one activity is attracting more than one source of funding, all those contributing financially or materially to the implementation of that activity should be listed in this column.

11. At the end of each objective there is a row that states **'Objective X as a percentage of total cost'.** This is automatically calculated as you put in the figures. The objective of this row is to enable the capture the contributions of each objective to the total cost of the plan.

12. Others.

At the end of all the activities envisaged, you can still capture all the activities not captured above by expanding the rows but you are not in a position to expand the columns.

3.2 The NAPP Matrix