NATIONAL HIV/AIDS STRATEGIC PLAN 2010-2015

JAN. 2010

FOREWORD

Significant progress has been made in the fight against HIV and AIDS since the "United Nations declaration of Universal Access" in 2005. The population of PLWHIV has leveled off at 33 million people with about 4 million receiving ART globally. Nigeria remains one of the most burdened nations with about 3 million people living with the disease. Despite mounting a vigorous and sustained response, the HIV/AIDS epidemic has remained a major challenge and obstacle to the attainment of national development goals including the MDGs and the vision 20/20/20. These realities compel the need for the regular review of the national response and the strategies in order to achieve a more effective control of the HIV epidemic in the country. The National Policy on HIV/AIDS remains the corner stone and the main thrust for the renewed vision and efforts to combat the HIV/AIDS challenge. The strategies as enunciated in the National HIV/AIDS Strategic Framework and Plan are derived and designed to achieve the goals set forth by the National Policy on HIV/AIDS.

The first National HIV/AIDS Strategic Plan (HEAP- HIV/AIDS Emergency Action Plan 2001-3) was developed in 2000/2001 and mainly addressed the issues of creating public awareness, at a time when the epidemic was beginning to spread in the country and when awareness, knowledge and behavior change were critical to nip the epidemic in the bud. The HEAP was reviewed in 2004/2005 at its expiration and a new National Strategic Framework for action tagged NSF 2005-9 developed, with the expectation that all stakeholders within the response will draw and derive their implementation plans from it. In December 2007, the implementation of the NSF 2005-9 was reviewed through a joint mid-term review process in collaboration with partners and stakeholders in the response with the outcome influencing the implementation in the remaining period of its life span.

The expiration of the NSF 2005-9 has provided yet another opportunity to review the National response with a view to deploy new strategies to ensure the attainment of national development goals and objectives such as the vision 20/20/20, MDGs, 7 point agenda, etc.

The overall goal of the current review is to provide a framework and plan for advancing the multi-sectoral response to the epidemic in Nigeria so as to achieve effective control of the disease by reducing the number of new infections, providing equitable care and support, and mitigating the impact of the infection. Consequently the thrust of the National HIV/AIDS Strategic Plan 2010-15 include Behavior Change and prevention of new infections while sustaining the momentum in HIV/AIDS treatment, care and support for adults and children infected and affected by the epidemic. In addition the plan aims to address gender inequality, knowledge management and research in a bid to ensure that interventions are evidence driven.

I, therefore, hope that this National HIV/AIDS Plan 2010-15 will bring not only an added impetus to our fight to halt and reverse the spread of HIV by 2015, in line with the nation's development goals and MDGs but also an inspiration to redirect our energies and investments to ensure we remain on course to achieve our goal of eliminating HIV from our communities.

Prof. Emeritus Umaru Shehu CFR. FAS. DFMC
Chairperson
NACA Governing Board
January 2010

PREFACE

The last five years has seen significant progress in the national response to HIV. The level of awareness has greatly increased, behaviour change is slowly improving and many more people are accessing antiretroviral therapy. In spite of the progress made, Nigeria still remains one of the most burdened countries globally with 3 million people living with HIV, gaps in treatment and an imbalance between prevention and treatment. The dynamics of the epidemic show significant variations within the country possibly a reflection of the social and cultural diversity.

Our common goal is to halt and reverse the spread of HIV by 2015 and in so doing contribute to the MDGs and the national developmental goals including the President's seven point agenda and the vision 20/20/20. To achieve this, we need to provide Universal access to comprehensive HIV prevention, treatment, care and support. Greater effort and focus is being placed on HIV prevention as it represents our best hope while effective strategies will be built on a detailed knowledge of the current epidemic including the factors that drive the epidemic and future progression. In addition, greater efforts will also have to be made in order to sustain the momentum in AIDS treatment and supporting the needs of all adults and children living with and affected by HIV.

The period spanning the last national strategic HIV framework, witnessed renewed global and national interest and commitment to redouble efforts at mobilizing resources for HIV prevention, treatment, care and support. We observed the impact of the Universal Access globally and commitment from the public, private sector, civil society and development partners in Nigeria. The transformation of the National Action Committee for the Control of AIDS to the National Agency for the Control of AIDS (NACA) at the centre and such transformation in several states has helped to foster the “the three Ones” in the HIV response in the country. This will ensure better plan development, more efficient coordination and more effective monitoring and evaluation of programs. In this context, it will also provide for more optimal use of available resources by making the monies work for less HIV and AIDS.

The HIV situation in the country and even in specific populations within the country and its multifaceted determinants are constantly changing and in some cases rapidly and dramatically. Planning for effective and relevant responses must take cognizance of this. In addition, in order to achieve universal access by scaling out the national response, it is important that the “lessons learnt” from our last plan period be integrated with our current response to achieve the desired impact. In so doing, we can strengthen “what works” and discard “what does not work”.

Like previous plans, the development of this plan has been anchored on national leadership and ownership and it is hoped that implementation will follow those lines to ensure an effective and sustainable national response. In addition, there has been genuine and strong participation of all key stakeholders throughout the planning process including a broad range of national actors including the public and private sectors, Civil Society Organizations (CSOs), People Living with HIV and AIDS (PLWHIV) and Development Partners.

It is my fervent hope that by pinpointing interventions that are effective, adopting and adapting “best practices” or lessons learnt, setting priorities and allocating resources accordingly, the implementation of this plan will maximize the use of available resources thereby leading to a sustainable progress in the national HIV response.

Professor John Idoko,
Director General,
National Agency for Control of AIDS (NACA)
December, 2009

ACKNOWLEDGMENT

The development of the National Strategic Framework/Plans 2010-15 went through thorough evidence driven, participatory and consultative process that engaged the inputs and technical expertise of several stakeholders. The combined effort of all National response Stakeholders in the country to collaboratively produce a well structured six year (2010-15) National HIV/AIDS Strategic framework, and costed plans (1 National HIV/AIDS Plan, 34 State HIV/AIDS Strategic Plans, 5 Network Plans and 19 Ministries, Departments and Agencies' Plan) through an intensive, demanding but evidence driven process in a period of four months (SeptemberDecember 2009), deserves nothing but praise.

May I therefore express sincere gratitude to everyone that contributed to this significant achievement; Process Governing Teams Chaired by the Director General of NACA Prof. John Idoko, The Partners (National and International), States, MDAs, Team of National Consultants under the leadership of Dr. Pat Youri, Dr. Adesegun Fatusi (Co-lead), Dr. Comfort Agada-Kibogo, Dr. Enyantu Ifenne, Mrs. Nkechi Nwankwo, Dr (Mrs.) Ejiro Otive-Igbuzor, Dr. Iheadi Afonne Onwukwe, Dr. Khamofu Hadiza, Dr. Bunmi Asa, Prof. Femi Ajibola, Mrs. Jadesola Bello and Dr. Garba Magashi; the States, Networks and MDA consultants and my dynamic and tireless young men and women (15 in total) that manned the secretariat led by Mrs. Esther Ikomi with the support of Dr. Sam Abiem and Ms. Ifeoma Ofili.

The role played by all Project Managers/ Chief Executive Officers / Executive Secretaries/ Chairpersons of SACAs/MDAs/Networks must be acknowledged as there can be no National Response without the State, Sectoral and MDA responses. Your hard work, faith and enthusiastic support made this happen.

Furthermore, specific mention must be made of the Development Partners' support and contributions (technical, human and financial) to the process. These include members of the Development Partners' Group (DPG), USG, DFID, ENR, SFH, MSH, the United Nations System in Nigeria, UNAIDS, UNFPA, UNDP, UNICEF, World Bank, CIDA, GHAIN/FHI

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May I thank all my colleagues particularly the Directors at NACA for the team work Dr Kayode Ogungbemi, Dr Akudo Ikpeazu, Mrs Maimuna Yakubu Mohammed, Barrister Patrick Abbah and Mr. Edward Okpaire.
Finally but most importantly, gratitude must be expressed to God Almighty for providence and for allowing our intentions and proposals to become reality.

It is only the implementation of these plans that can justify the efforts and resources expended, so let the work begin now to better the lots of all those, on whose behalf we have accepted our positions of responsibility!

Alex Ogundipe mps,
Director, Policy & Strategy
National Agency for the Control of AIDS
NACA
December 2009

ACRONYMS AND ABBREVIATIONS

AFPAC	Armed Forces Program on AIDS Control
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Care
AONN	Association of OVC NGOs in Nigeria
APIN	AIDS Prevention Initiative Nigeria
BCC	Behavior Change Communication
CBOs	Community Based Organizations
CiSHAN	Civil Society Network for HIV/AIDS in Nigeria
CPT	Cotrimoxazole Preventive Therapy
CSOs	Civil Society Organizations
CTX	Cotrimoxazole
DFID	Department for International Development
DHIS	District Health Information System
DOTS	Directly Observed Treatment Short Course
FBOs	Faith Based Organizations
FCT	Federal Capital Territory
FGoN	Federal Government of Nigeria
FHI	Family Health International
FMoH	Federal Ministry of Health
FMWA & SD	Federal Ministry of Women Affairs and Social Development
GFATM	Global Fund to fight HIV/AIDS, TB and Malaria
GoN	Government of Nigeria
HAD	HIV/AIDS Division
HAF	HIV/AIDS Fund
HAPSAT	HIV/AIDS Program Sustainability Analysis Tool
HCT	HIV Counseling and Testing
HIV	Human Imm unodeficiency Virus
IBBSS	Integrated Biological and Behavioral Surveillance Survey
IDPs	International Development Partners
IDU	Injecti ng Drug Users
IEC	Information, Education, and Communication
IHVN	Institute of Human Virology Nigeria
IMNCH	Integrated Maternal, Newborn, and Child Health
IPs	Implementing Partners
JMTR	Joint Mid-Term Review
LACAs	Local Government Action Committee on AIDS
LAMIS	Lafiya Management Information System
LHPMIP	Logistics and Health Program Management Information Platform
M&E	Monitoring and Evaluation
MAP	Multi-Country AIDS Program
MARPs	Most-at-Risk Populations
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistant TB
MSM	Men who have Sex with Men
NACA	National Agency for the Control of AIDS
NAPEP	National Poverty Eradication Program
NARHS	National AIDS and Reproductive Health Surveys
NASA	National AIDS Spending Assessment
NASCP	National AIDS and STI Control Program
NBTS	National Blood Transfusion Service
NDE	National Directorate of Employment
NDHS	Nigeria Demographic and Health Survey

NGOs	Non-Governmental Organizations
NIBUCAA	Nigeria Business Coalition Against AIDS
NiDAR	Niger Delta AIDS Response
NNRIMS	Nigeria National Response Information Management System
NSF	National Strategic Framework
NTBLCP	National TB and Leprosy Control Program
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PABA	People Affected By HIV/AIDS
PATH 2	Partnership for Transforming Health Systems PhaseII
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLWHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
SACAs	State Action Committees on AIDS/State Agency for the Control of AIDS
SBTS	State Blood Transfusion Service
SDPs	Service Delivery Points
SMEDAN	Small and Medium Scale Enterprises Development Agency of Nigeria
SMoH	State Ministry of Health
SNR	Strengthening Nigeria HIV/AIDS Response
SOPs	Standard Operating Procedures
SPDC	Shell Petroleum Development Cooperation
SRH	Sexual and Reproductive System
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UBE	Universal Basic Education
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

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BACKGROUND

Nigeria Demographic and Socio-Economic Profile

Nigeria lies between latitudes $4^0$16' and $13^0$53' to the north of the equator and longitudes $2^0$40' and $14^0$41' to the east of the Greenwich Meridian. The country is located in the West African sub-region and is bordered by Niger in the north, Chad in the northeast, Cameroon in the east, and the republic of Benin in the west. To the south, Nigeria is bordered by approximately 800 kilometers of the Atlantic Ocean. The country is made up of 36 states and a Federal Capital Territory (FCT), which are grouped into six geo-political zones: North-Central, North-East, North-West, South-East, South-South, and South-West. Nigeria has about 374 identifiable ethnic groups, with the Hausa, Igbo and Yoruba as the dominant tribes.

The total population of Nigeria as reported by the 2006 census was 140,003,542; males are more in number than females with a population of 71,709,859 and 68,293,683 respectively. This population size ranks Nigeria as the most populous country in Africa and one of the ten most populous worldwide. Nigeria has a young population structure, with almost half of the population being under the age of 15 years. Young people, 15-24 years, constitute more than a quarter of the population. The median age of the Nigerian population, according to the United Nations Millennium Development Goal Monitor, was 17.6 years in 2007. Based on the result of the 2006 national population and housing census, the National Population Commission specified the growth rate of the country as 3.18 per annum. At this rapid growth rate, Nigeria is expected to double her population in about 22 years. The most populous states in the country are Kano (9,383,682) and Lagos (9,013,534), while the least populous are Bayelsa (1,703,358) and Nassarawa (1,863,275). The growth rate for the states varies from 2.7% for Abia, Edo, and Taraba to 3.5 in Yobe State and 9.3 per annum in the Federal Capital Territory.

With a land area of 923,768 square kilometers, Nigeria is the fourth largest country in Africa and the population density is approximately 152 persons per square kilometer currently. Wide variability is, however, encountered in terms of the spatial distribution of the population: Anambra, Akwa Ibom, Imo and Lagos are the most densely populated states while many of the states in the North have low population density. The population of Nigeria is predominantly rural, although rapid urban-rural migration is being continuously witnessed: at least three-fifths of the population is currently estimated to be rural dwellers. The most urbanized areas in the country are Anambra, Lagos, and Oyo whereas most of the states that are least urbanized are located in the northern part of the country.

The life expectancy rate in Nigeria, according to the 2009 World Population Data Sheet, is presently estimated at 47 years (47 years for males and 48 years for females). Nigeria's total fertility rate, as reported by the 2008 Nigeria Demographic and Health Survey, is 5.7 children per woman while the crude birth rate is 40.6 per 1,000 population. Rural-urban variation exists in the fertility pattern with the total fertility rate being 6.3 for rural area and 4.7 for urban area. The infant mortality rate for the 20042008 period, according to the 2008 NDHS, is 75 deaths per 1,000 live births while the under-five mortality rate is 157 deaths per 1,000 live births.

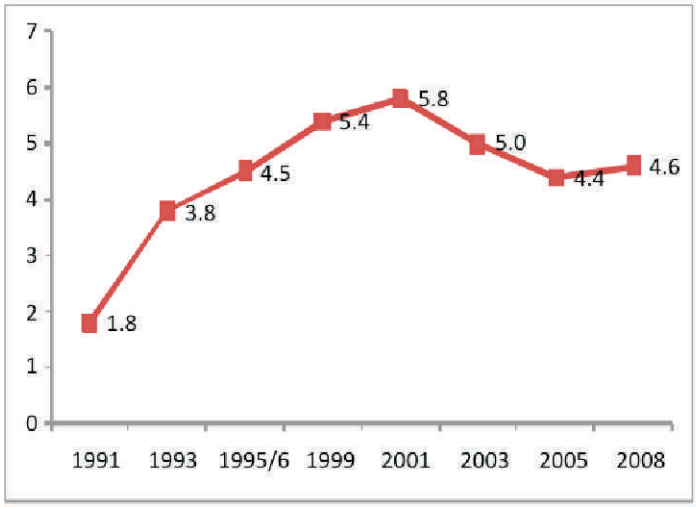
Most Nigerians are poor despite the status of the country as a crude oil producing country with high income. The gross domestic capital is US$1,166 and the annual GDP growth rate is 5.9 percent. According to the poverty profile published by the National Bureau of Statistics in 2004, 51.6 percent of Nigerians are living below the poverty line of US$1 purchasing power parity while the poverty incidence is 53.8 percent based on the national poverty standard. The poverty incidence varies significantly in the country with the rural areas and northern part of the country disproportionately affected. There is marked economic inequality in Nigeria, with a national Gini co-efficient of 0.4882 in 2004. The Gini coefficients for urban and rural areas

were 0.5541 and 0.5187 respectively. These high figures of Gini coefficients at all levels are manifestations of poverty and inequality of distribution of income.

HIV infection in Nigeria: trends and sources of new infections

In the decade 1991-2001, Nigeria progressively witnessed increases in its HIV prevalence level. The overall picture is that of significant increase within the period. The national HIV sero-prevalence level (Fig. 1), obtained through sentinel survey of antenatal care attendees, increased from 1.8 percent in 1991 to 5.8 percent in 2001 and then declined to 5.0 percent in 2003 and further to 4.4 percent in 2005. This decline was followed by a recent rise to 4.6 percent in 2008.

Figure 1
Trends in National HIV Sero-Prevalence Rate, Nigeria, 1991 - 2008



Source: NACA, 2009

The National Agency for the Control of AIDS (NACA) estimates there are about 2.95 million people living with HIV (PLHIV) in Nigeria in 2009, ranking the country third among countries with the highest burden of HIV infection in the world, next only to India and South Africa. Females constitute almost three-fifths (58.3%) of PLHIV in Nigeria: about1.72 million women and girls are infected with HIV. With the highest HIV prevalence rate of 5.6% in the age group 25-29 years, young people are disproportionately infected with HIV.

The leading route of HIV transmission in Nigeria is heterosexual intercourse, accounting for over 80 percent of the infections. Mother-to-child transmission and transfusion of infected blood and blood products are generally estimated as ranking next as common routes of infection; arguably, each of these two are believed to account for almost ten percent of infections. However, other modes of transmission such as intravenous drug use and same-sex intercourse are slowly growing in importance.

Key drivers of the HIV epidemic in Nigeria include: low personal risk perception, multiple concurrent sexual partnerships, intense transactional and inter-generational sex, ineffective and inefficient services for sexually transmitted infections (STIs), and inadequate access to and poor quality of healthcare services. Entrenched gender inequalities and inequities, chronic and debilitating poverty, and stubborn persistence of HIV/AIDS-related stigma and discrimination also significantly contribute to the continuing spread of the infection.

The HIV epidemiological picture shows considerable diversity across Nigeria's geographic landscape, both in terms of the level of infection and the trend. The 2008 national survey, for example, shows the HIV sero-prevalence level as ranging from 1.0 percent in Ekiti State (in South-West geo-political zone) to 10.6 percent in Benue State (North-Central geo-political zones). Seventeen states and the Federal Capital Territory (FCT) recorded sero-prevalence of at least five percent. Sero-prevalence level was seven percent or higher in seven states and the FCT; four of these are in the South-South geo-political zone while none was in the South-West and the North East zone.

Whereas urban population recorded higher prevalence than the rural in most states, the reverse is the case in nine states and the FCT. The geographic dissimilarities in the dynamics of the epidemic suggest that the

influence and contributions of various high-risk behaviors may vary in their relative importance in different communities and geographical settings within the country.

The most-at-risk populations (MARPs) for HIV infection include female sex workers (FSWs), intravenous drug users (IDUs), men who have sex with men (MSM), long-distance drivers, young people, and members of the uniformed services. The result of the mode of HIV transmission analysis in Nigeria carried out by the National Agency for the Control of AIDS (NACA) in 2008 showed that about 62% of new infections occur among persons perceived as practicing “low risk sex' in the general population including married sexual partners. The rest of the new infections (38 percent) are attributable to IDUs, FSWs, MSM and their partners who constitute about 3.5 percent of the adult population.

A SYNOPSIS OF THE NSF 2005-2009 RESPONSE ANALYSIS

Following nearly two and a half decades of the emergence of the HIV/AIDS as a significant public health challenge in Nigeria, HIV has spread to become a generalized and matured epidemic affecting all population groups and geographic areas of the country. Not only is the HIV/AIDS epidemic a continuing, persistent, and dangerous menace to the achievement of future national development targets including the Millennium Development Goals (MDGs) but is also contributing to the reversal of some hard-won development gains of the recent past such as playing pivotal roles in decreasing life expectancy at birth and worsening national health systems and care indicators.

Molded by variable combinations of social, cultural, traditional, economic, and religious factors of relative importance in different communities, the HIV/AIDS epidemiologic picture demonstrates great variability and diversity across the country. The 2008 national survey shows HIV-sero prevalence level of at least 5% in 17 states and the FCT with a range of 1.0% in Ekiti state (South-West geopolitical zone) to 10.6% in Benue State (North Central political zone). Urban-rural HIV prevalence differentials, once higher in the urban areas, is narrowing. However, the gender-face of the epidemic continues unabated: women and girls constitute nearly 60% of people living with HIV (PLHIV) in the country and bear the brunt of the socio-economic and care-giving impact of the disease.

Nigeria has been steadfast in its commitments to strengthen its response to the HIV and AIDS epidemic during the National Strategic Framework 2005-2009 period through the implementation of multisectoral comprehensive intervention programs broadly clustered around complementary thematic areas of Promotion of Behavior Change and Prevention of New HIV Infections; Treatment of HIV/AIDS and Related Health Conditions; Support and Care for people living with and affected by HIV/AIDS; Policy, Advocacy, Human Rights and Legal Issues; Institutional Arrangements and Resource Mobilization and Application for the national response; and Monitoring and Evaluation Systems including research and knowledge management.

Promotion of Behavior Change and Prevention of New Infections

That the intent of the NSF 2005-2009 to focus attention on HIV prevention as a top priority area with appropriate resources allocation is very clear. Anecdotal evidence from the implementation of the framework would, however, suggest expenditure on HIV/AIDS treatment was far greater than for prevention services. This may be a reflection of the fact that the unit cost of providing treatment services including drugs and laboratory services is far greater than that for HIV infection prevention services and therefore may not necessarily be a true reflection of the program level of effort.

The national survey of 2008 shows the overall HIV sero-positive prevalence rate of 4.6%, indicating that more than 90% of the population is free of HIV infection, down from 5.8% at the peak of the epidemic in 2001. Based on the 2008 HIV prevalence rate, the National Agency for the Control of AIDS (NACA), estimated 2.95 million people were living with HIV in that year. The number of new HIV infections, however, seems to show an increasing trend especially among adults: from an estimated 250,000 in 2005 to 323,000 adults in 2008. Sexual intercourse remains by far the commonest mode of HIV transmission (80%), followed by mother-to-child transmission (10%) and infected blood and blood products (10%).

The NACA commissioned HIV sexual transmission study analysis of 2008 showed that 62% of new infections occurred among persons perceived as practicing “low risk sex” in the general population including married sexual partners. The rest (38%) of the new infections is attributable to persons practicing

"high risk sex" including injecting drug users (IDUs), female sex workers (FSWs), and men who have sex with men (MSM) and their partners who constitute about 3.5% of the adult population.

The NSF 2005-09 identified a number of key and mutually re-enforcing strategies to prevent new HIV infections and promote behavior change. Broadly classified, these strategies include HIV Counseling and Testing (HCT); Prevention of Mother-to-Child Transmission (PMTCT) of HIV; Prevention of Biomedical Transmission of HIV; Early Detection, Treatment, and Control of Sexually Transmitted Infections (STIs); Condom Promotion); Communication Interventions targeting the general population on the one hand and most-at-risk populations (MARPs) on the other hand; and Integration of Sexual and Reproductive Health (SRH) and HIV Services.

HIV Counseling and Testing

By December 2008, HCT service delivery sites increased to 908; about 3.37 million people (men and women) had ever been counseled, tested, and received their test results by this date. The rate of increase of access to HCT services for both men and women is similar: from about 7% in 2003 to 11% in 2005 to 14% in 2007. These contrasts sharply with the intent of the framework targeting 50% of Nigerians to access quality HCT services by 2010 and falls far short of the country's commitment to universal access target of at least 80% by the same year. Coupled with the fact that the number of HCT services delivery points are woefully inadequate to meet the needs of the population, most services are still facility-based and located in secondary and tertiary health facilities, often inaccessible to hard-to-reach communities and have insufficient targeting of MARPs.

Even though the review did not find any specific evidence for poor quality of HCT services, there is the perception that this might exist especially when HCT commodities are inadequate and in quality-quantity conundrum situations where pressure to reach higher numbers of HCT clients are set in some donor-funded projects is great. The response analysis identified the need to further decentralize HCT services to primary care centers (this is partly being addressed under the GFATM Round 8 Health System Strengthening {HSS} grant), to identify and target MARPs with HCT services, and to focus on couple counseling with male involvement to address the challenge posed by increasing number of HIV discordant couples.

Strategic recommendations include increasing access to quality HCT services should be improved through integration of HCT into routine health care services at all levels to expand reach and access, expansion of community outreach/mobile HCT services targeting the grassroots and hard to reach areas, designing and implementing HCT to address the needs of different population groups including MARPs, promotion of couple counseling with the development of relevant materials and capacity building for service providers, and stronger emphasis on provider-initiated HCT to minimize missed opportunities

Prevention of mother to child transmission of HIV

Considerable efforts are being made by the national response to strengthen PMTCT interventions. The 11 experimental PMTCT sites in 2003 had increased to 640 by December 2008. According to WHO/UNAIDS/UNICEF (2008), a total of 207,107 pregnant women had been tested for HIV in 2007, an estimated coverage of 4%. The coverage of PMTCT services in Nigeria for 2007 was also reported as 7% for administration of ART prophylaxis during pregnancy, and 2% for administration of ART prophylaxis to infants born to infected mothers. According to NACA (2009), in 2008 about 675,550 pregnant women received HIV counseling and testing for PMTCT of which 21,478 (3.2%) received ARV prophylaxis. The National AIDS and STD Control Program (NASCP) of the Federal Ministry of Health (FMoH) reported uptake of PMTCT services nationally at 11%, as at July 2009 (Coker, 2009) up from 2% in 2004. The same NASCP report indicates the number of HIV exposed infants receiving ARV prophylaxis has increased from 516 in 2004 to 2,230 babies. Therefore, even if the PMTCT coverage was substantially increased before the end of the current NSF in December 2009, it will be impossible to reach the national PMTCT policy target of

reducing "the transmission of the HIV virus through mother-to-child-transmission by 50%, by the year 2010" and a far cry from the national target of Universal Access of 80% by 2015.

There are daunting but not insurmountable challenges to accelerating the scale-up of the PMTCT program. These include increasing access to PMTCT services by further decentralizing the services from tertiary and secondary facilities to primary care facilities, increasing access to early infant diagnosis (EID) facilities, and ensuring the operationalization of all 4 components of the PMTCT program (primary HIV prevention among women of reproductive age, prevention of unintended pregnancies among HIV positive women, prevention of HIV transmission from an infected pregnant woman to her child, and care and treatment for women, their children, and families). The analysis recognizes the need to significantly increase male and community involvement in PMTCT programs and institute policies on task-shifting of some responsibilities in PMTCT to lay people and volunteers on credible, scientific, and context-relevant evidences.
Strategic recommendations include accelerating the scale up of PMTCT services nationally especially at the grassroots with the development and/or adaptation of training and service manuals for PMTCT for PHC workers (community health practitioners), advocacy for PMTCT programs and implementation needs to be strengthened with special focus on demand generation, promotion of community involvement and ownership of PMTCT programs with local women groups as key targets; strengthen male and community involvement in PMTCT and broaden the focus of PMTCT services to be more comprehensive; and institute policies on task-shifting of some responsibilities in PMTCT to lay people and volunteers based on credible, scientific and context-relevant evidences

Biomedical transmission of HIV
Biomedical transmission of HIV is a distinctively avoidable risk under present knowledge and technologies. The prevalence of transfusion transmissible infections (TTIs) among blood donors in Nigeria are 2.1% for HIV, and 9.7% and 2.5% for Hepatitis B and Hepatitis C respectively. The National Blood Transfusion Service (NBTS) is working hard to improve the quality and availability of safe blood through routine screening for TTIs and a linkage program that ensures safe blood is available at all times in hospitals. Interventions undertaken to reduce the risk of biomedical transmission of HIV and other TTI during the NSF 2005-2009 period include establishing 17 centers nationwide for safer and effective blood banking, the development of policy guidelines and protocols on safer blood transfusion.

Many challenges remain in the quest to further reduce biomedical transmission of HIV. The blood transfusion service continues to be highly-fragmented, hospital-based, and unregulated, and is predominantly dependant on remunerated and family replacement donors. Insufficient blood supply and distribution logistics has the potential to compromise standards of safety practices and hemo-vigilance. Despite recent efforts, most health facilities operate inadequate environmentally acceptable healthcare waste management programs, with the attendant risk of increasing the risk TTIs including HIV. The response analysis stresses the need for an effective and efficient coordination and regulation of all blood transfusion services by the National and State Blood Transfusion Services, recommends the strengthening activities to promote voluntary blood donation, injection safety, and proper healthcare waste management.

Key recommendations include: ensure national coordination and regulation of all blood transfusion services by FMoH/NBTS and SMoH/SBTS; initiate upstream policy dialogue and advocacy for enactment of relevant legislations including development/dissemination of the national protocol on PEP, operationalization of the health care waste management plan and the dissemination/implementation of the health workers' injection safety guideline; advocacy for increased capacity building at personal and institutional levels on medical transmission prevention; strengthen BCC activities to promote voluntary blood donation, injection safety and proper treatment and disposal of health care waste as a key part of HIV prevention activities; develop national programs targeting injecting drug users on safety practices to avoid HIV transmission; and carry out operations research with special focus on incidence studies taking advantage of regular voluntary blood donors.

Sexually Transmitted Infections

Evidence abounds that sexually transmitted infections (STIs) facilitate HIV transmission. Early detection, treatment, and control of STIs is therefore a key strategy under NSF 2005-09 for HIV prevention. However, sufficient attention and resources have not been placed on early detection and treatment of STIs in the context of national response to HIV/AIDS epidemic. The poor focus on STIs has been linked to the overshadowing of STI control by HIV control at the level of implementation. Syndromic management of STIs is nearly universal at all primary care facilities but the frequent stock-out of STI drugs compromises the quality of the service. However, free STI treatment services are provided for PLHIV only.

The magnitude and extent of contribution of specific STIs to the HIV scourge is not accurately known due to the paucity of such data. Great efforts are being made to improve linkages between and integrate STI control and family planning services especially at some primary care centers. While such integration has the potential to improve the scope and quality of care leading to enhanced program effectiveness, efficiency and cost-effectiveness, differences in policy and operational procedure between HIV prevention and Sexual and Reproductive Health (SRH) services is a major challenge as services are mostly free in HIV control activities while they have to be (nominally) paid for in SRH services.

Strategic recommendations include: strengthen policy guidelines and frameworks for integration of HIV and reproductive health activities; strengthen the use of syndromic management of STIs across all states as part of HIV prevention; expand the practice of syndromic management of STI to the informal sector by training and monitoring the practice of patient medicine store and chemist operators; ensure accessibility to quality services with special focus on MARPs and the provision of youth friendly STI services, and develop a systematic data collection on STI at all levels and encourage more operation research activities.

Condom promotion

The NSF 2005-2009 place much premium on condom promotion and use as a dual mechanism for reducing HIV and other STI transmission as well as preventing unwanted pregnancies. Informed opinions indicate that condom distribution has been going up during the NSF 2005-09 period despite strenuous efforts by some religious groups to proscribe it; voluntary limitations on condom advertising are in place. This notwithstanding, in 2007 alone, nearly 180 million condoms were distributed through workplace programs, community mobilization, awareness events, health clinics, and through the private sector social marketing programs. Awareness of the male condom is quite high (71%); not so much is known about the female condom (13%). Ironically and worryingly, only 49% of those who engaged in sex with a non-marital partner in the preceding 12 months before the 2007 National Reproductive Health Survey (NARHS) survey used a male condom.

Alas, knowledge and awareness about condoms has not translated into correct and consistent use. Several misconceptions about condoms in general exist and challenges regarding the availability, accessibility, affordability, and user-friendliness of the female condom continue to prevent its widespread use. The response analysis noted the great reach and effectiveness of condom social marketing especially in urban areas and recommends it as an innovative communication tool to promote as well as address potential impediments to condom use. Many MSM use condoms as the primary means of preventing HIV transmission; the efficacy of this practice should be further enhanced by the concurrent use of lubricants with the condom.

Strategic recommendations are: extensive social marketing efforts and innovative communication interventions to promote condom use and address potential impediments to its use; appropriate interventions need to be put in place to increase awareness, acceptance and use of the female condom nationwide including targeted advocacy efforts to leadership of faith-based organizations; ensure increased availability and non discriminatory access across the country including making subsidized condoms available at non-

traditional outlets and increase integration with other SRH/HIV services to expand reach.; provision of lubricants to improve condom efficacy among MSM; and increase priority on social research to inform better designs and delivery of condom programs.

Communication Interventions

The NSF 2005-09 placed much emphasis on the fact that communication interventions, including information, education and communication (IEC) and behavior change communication (BCC), hold a vital and indispensable place in HIV prevention interventions. Awareness of HIV/AIDS continues to be above universal levels 87.7% in 2003 and 93.8% in 2007 but comprehensive knowledge of HIV transmission continued to be low (24%). Relevant policy and program related documents on communication interventions have been developed including the National Behavior Change Communication Strategy 2009-14, which proposes a minimum package of strategic interventions for several vulnerable groups; and a 3-Year Prevention Plan which aims at according greater attention to HIV prevention. Greater stakeholder participation and involvement in communication interventions have enabled the provision of improved IEC through innovative and non-traditional approaches targeting the general and specific population segments.

Private sector companies including those from the communication and banking sector provided information communication technology-based IEC on HIV/AIDS for technology savvy youth using computer and telephone systems whilst an increasing number of members of the Nigerian Business Coalition Against AIDS (NIBUCAA) provided workplace programs. Enter-educative IEC programs providing both entertainment and education targeted at the general population and also at MARPs were aired on television, radio, and in the print media. Local language content (Yoruba, Hausa, and Ibo) improved access and comprehension to many viewers.

A NARHS survey of 2007 among MARPs (MSM, FSW, IDU, transport workers, armed forces, and police) on knowledge and exposure to HIV interventions was uniformly poor except for the armed forces that fared better than the other MARPs. Despite the avalanche of IEC on HIV/AIDS, there is concern that behavior change continues to lag significantly leading some practitioners to question the effectiveness of and evidence for the continuation of some communication interventions. The response analysis emphasized the urgent need to respond to the unmet HIV prevention needs of special groups including students at higher institutions of learning, persons with physical and mental disabilities, and MARPs especially MSM and IDUs.

Strategic recommendations include: develop the capacity of workers in the communication field for evidence-based programming; develop prevention interventions to meet the needs of MARPs including sexual minorities; strengthen linkages between drug demand reduction and linkages to HIV prevention; actively promote the use of female condom and other new prevention technologies as they may emerge; increase focus on basic research about the social drivers of HIV transmission and the development and evaluation of communication interventions at different levels and for different groups of vulnerable population; increase use of local languages and community involvement including local women's groups and networks in message and media material development for wider audience reach; and engage the media as key stakeholder in HIV related activities to subsidize media coverage costs at all levels.

Treatment of HIV/AIDS and Related Health Problems

The NSP 2005-09 period coincided with increased availability and use of cost-effective anti-retroviral drugs (ARVs) for the treatment of HIV/AIDS (ART). Significant sources of funding and technical assistance for the treatment program is provided by the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the GFATM in support of the very modest investment the government commits to the treatment program. This support has enabled the provision of comprehensive care and support services in all 36 states and the Federal Capital Territory through an increasing number of ART facilities from 85 in 2005 to 296 in 2008; this is a mere 9% of facilities that could potentially provide ART services.

By the end of 2008, about 289,500 PLHIV have ever received ART; this translates to about 55% of the NSF target of putting 520,000 PLHIV on ART based on 2005 estimates. In reality this approximates to 35% using recent more robust estimates indicating the number of PLHIV eligible for ART is 833,000, far higher than the 2005 estimate. The number of children on pediatric ART is unknown, but informed opinions suggest this is about 5% of the total.

The mutually reinforcing and symbiotic relationship existing between PLHIV dually infected with TB and HIV was recognized during the NSF 2005-2009 period and immediate steps were taken to address the problem through collaboration with the National TB and Leprosy and Control Program (NTBLCP). HIV/TB collaborative activities were started. By 2008, about 62% of 56,000 TB patients received HCT, about 31% tested HIV positive, and have been placed on Cotrimoxazole Preventive Therapy (CPT). Nearly half (49%) of the 289,500 ART patients also receive Cotrimoxazole prophylaxis. Other Opportunistic Infections (OIs) abound in PLHIV and often negatively affect the quality of care for PLHIV. Significant under-resourcing critically affects the quality of OIs services.

These achievements were made possible by strengthening and improving the capacity of service providers with standardized nationwide training based on national curriculum and training manuals, development and review of national guidelines, and standard operating procedures (SOPs) in use in facilities, and establishment of National Technical Working Groups for ART (adult and pediatric) and RH-HIV. The "cluster model" of HIV service delivery adopted under GFATM Round 5 grant has significantly improved access to services.

Despite these significant achievements, there are still considerable gaps to be bridged. These include challenges with variations in the quality of care; wide geographical, gender and age inequities as well as ensuring continuum of quality care through mentorship and referral networks. Other challenges include poor infrastructure, insufficient trained service providers, poor supply chain management of essential commodities, inadequate reporting of adverse drug reactions. Attempts at decentralizing ART services to some primary care facilities is a welcome step in the right direction since this will improve access but will likely burden the human resource and supply chain management systems if these are not simultaneously addressed.

Experiences from the NSF 2005-2009 implementation shows that the country can achieve its universal access targets if the response rededicates its efforts and commitments to providing substantially increased resources that are effectively and efficiently harmonized, aligned to, and coordinated within the national strategy by all partners including the public sector, the private sector, civil society, development partners, and the UN system. Ongoing National Health System Strengthening (HSS) efforts will provide opportunity to decentralize services such HCT, PMTCT, management of OIs and ART drug refill to Primary Health Facilities. This will contribute to the move towards universal access.

The following strategic recommendations will further increase access and quality of treatment services:

i. *Community involvement:* Enhancing community involvement in HIV and TB prevention, treatment, care and support has clear value. Community volunteers as well as home-based TB/HIV care providers have been shown to support case detection, provide support for DOTS and ART treatment. Collaborative linkages are to be established between existing village health committees in LGAs, networks of *PLHIV* support groups, and public and private health facilities (hospitals, clinics and community pharmacies etc).
ii. *Data collation:* The M&E framework needs to be evaluated and reviewed. All existing recording and reporting tools of both NTBLCP and NASCP will need to fully integrate indicators to effectively monitor performance and quality of program activities. In addition, there should be adequate support for operational research, documentation, archiving, and knowledge management.

iii. *Diagnostic framework/Referral network:* A major platform for accomplishing quality care and treatment is the diagnostic framework. This requires the existence of appropriate mechanisms for patient identification using the necessary tools for tracking and referrals within a continuum of care. Multipoint HIV testing could also help patient identification particularly in pediatric settings. Diagnosis of HIV+ smear negative TB could be improved through training of providers on use of appropriate screening algorithms, better access to chest x-rays and sputum acid-fast bacilli (AFB) culture. Standard of care should include diagnosis and treatment of OI. Provision of referral centers with polymerase chain reaction (PCR) facility and resistance testing to diagnose and manage treatment failure should be looked in to. Viral load estimation to all patients at least twice annually should be considered.

iv. Establish a clear mechanism to ensure patient retention in care through a *good tracking system* to prevent and manage loss to follow up

v. Ensure *infection control measures* in health care and congregate setting*:* Each health care and congregate setting should have and implement a TB infection control plan, supported by all stakeholders, that includes administrative, environmental and personal protection measures to reduce transmission of TB

vi. Define standards of care and treatment including OI diagnosis and treatment: Harmonize and standardize all training curricula, guidelines, and SOPs.

vii. Strengthen system for *Adverse Drug Reaction (ADR) monitoring, evaluation and reporting of adverse reactions of medicines for HIV, TB and OIs (pharmacovigilance) and s*trengthen reporting of adverse drug events (pharmacovigilance)

viii. Strengthen *quality assurance* and *quality improvement* in HIV care, treatment and laboratory services

ix. Strengthen *logistics and supply chain management* for pharmaceutical and laboratory commodities.

Care and Support of people infected and affected by HIV/AIDS including OVC

The NSF 2005-2009 period witnessed the gradual change in perception and reality of HIV/AIDS as an invariably terminal disease to a chronic illness requiring regular and sustained care and support. The national response included systematically developing policies and guidelines that promote a minimum package and standards of care and support services and provide a common policy framework for the operations of all key stakeholders including federal, state, and local government. The policies and guidelines promote the continuum of care strategy for PLHIV and their families and link specialist and professional care to community and home-based care (HBC). Civil society organizations (CSOs) including non-governmental organizations (NGOs), faith-based organizations (FBOs), community-based organizations (CBOs), and associations, networks, and support groups of PLHIV rose up to the challenge.

In partnership with government and significant technical assistance and funding from development partners, the CSOs are the driving force and mainstay of providing care and support services for nearly 3 million people living with HIV, the several millions more affected by HIV/AIDS (PABA), and the 17.5 million orphans and vulnerable children (OVC) nationwide, many of who are orphaned or made vulnerable by HIV/AIDS. Accurate and unified numbers of PLHIV, PABA, and OVC benefiting from the care and support services are not available, in part, because of an inadequate national response focus and the multitude of services provider organizations (and donors) using M&E systems and tools that are neither harmonized with nor aligned to the Nigeria National Reporting Information Management System (NNRIMS), the one national M&E system.

Even though stigma and discrimination remain formidable obstacles to the national HIV/AIDS response and great impediments to accessing care and support services, tremendous but often uncoordinated efforts have continued to address these issues. PLHIV and key stakeholders have been mobilized and empowered to challenge this at institutional and community levels as well as decrease self-stigmatization and improve self-

esteem of PLHIV. Registered PLHIV support groups have grown tremendously from 35 in 2005 to more than 500 in 2009 and the political will to capture women's aspirations and mitigate the impact of AIDS on women and girls led to the formation of a National Women's Coalition on AIDS (NAWOCA) in 2007.

By 2009, fifteen states and the Federal Capital Territory (FCT) had attained the status of functional State Agency for the Control of AIDS (SACAs), which entitles them to state government on-budget support to enable them improve care and support services for PLHIV and their families in the states. Meanwhile, care and support services have continued to diversify and broaden their support sources. The USAID PEPFAR project is a critical source of this support. Others include the GFATM, the British government Department for International Development (DFID), the UN family, and the World Bank Multi-Country AIDS Program (MAP).

The national HIV/AIDS response adopted a comprehensive, holistic, and inclusive OVC programming framework irrespective of the causes of orphaning and vulnerability. The OVC National Plan of Action (NPA) 2006-10, coordinated by the Federal Ministry of Women Affairs and Social Development, provides more explicit strategies for OVC programming than the NSF 2005-09. The Ministry has played and continues to play leadership roles in the OVC response including spearheading the National Situation Assessment and Analysis of OVC (2008), the development of the OVC Vulnerability Index (2008), and the National Priority Plan for OVC 2009-10.

Other important sector policy frameworks targeting OVC are the National Health Sector Plan 2005-09, which proposes strategic response for addressing critical challenges in the health sector including issues of HIV/AIDS and OVC and the National Education Sector HIV/AIDS Strategic Plan 2006-10, which recognize the rights of OVC to education. The formation of the Association of OVC NGOs in Nigeria (AONN), an umbrella organization for OVC-focused NGOs, has great potential to enhance OVC programming by harmonizing and aligning the work of its membership with the national response and improving access to quality care and support services for OVC.

Since 2005, PEPFAR has been the single largest supporter of OVC programs in the country; to PEPFAR has enabled more than 100,000 OVC and their facilities to access single or multiple care and support services through assistance to education, health, protection, nutrition, shelter, economic empowerment, and psychosocial support programs. Other important direct supporters of OVC programs in the country include the GFATM and the United Nations Children's Fund (UNICEF).

Strategic recommendations include the following:

i. Strengthen linkages between delivery sites to support referrals among and within HIV prevention, orphan and vulnerable children programs, palliative care, and treatment sites.
ii. Increase funding for care and support services**:** Financial resources for care and support services should be provided through a specific budgetary line
iii. Create a comprehensive data-base*:* In order to ensure that the response to the Care and Support for PLHIV and PABA is evidence-based, there is need to develop a management information system (MIS) that can be coordinated at state and national levels.
iv. Enhance focus on poverty and food insecurity**:** There is a crucial need for applied research to identify what is happening to rural poverty and food insecurity, and what can be done to strengthen policy and program assistance for affected populations.
v. Develop a national policy on OVC and ensure that government policy cover the needs of OVC by mainstreaming OVC programs into all national developmental programs and ensure the implementation of OVC NPA at all levels.
vi. Initiate a Universal Social Protection Agenda and legal framework to guide care and support of OVC derived from existing national policy documents, Child's Rights Act and the OVC NPA provisions.

vii. Build capacity of older OVC to be part of decision making and service delivery at the community level. The capacity of family members and community operatives also needs to be built to effectively respond to meeting the needs of OVC and to be able to provide home-based care and support for OVC. Capacities need to strengthen at the community level to identify, address and monitor issues of OVC related to stigma and discrimination. Volunteers who are the backbone of service delivery to OVC need to be adequately trained and supported through provision of stipends to support the work they do and reduce attrition rate.

Viii. Create and strengthen linkages between available services for OVC such as UBE, NAPEP, and NDE; and promote the provision of integrated social services to support the OVC in their communities.

ix. Mobilize Resources for OVC: Resources need to be efficiently mobilized from relevant bodies that can legally and through corporate social responsibilities allocate resources for service delivery for OVC.

x. Scale-up quality OVC services: Scale-up must be coupled with service provision that makes a measurable difference in the lives of OVC and caregivers.

Policy, Advocacy, Human Rights, and Legal Issues

Nigeria has a glut of policies and guidelines on the rights of people infected and affected by HIV/AIDS. The draft 2009 HIV Policy is perhaps the most ambitious and comprehensive. The country is also a signatory to many regional and international commitments and covenants on human rights. Yet, minimal progress, if any, has been made in addressing the human rights and legal issues surrounding HIV/AIDS. This stems principally from the fact that, in Nigeria, official policy documents do not constitute law and cannot be enforced in courts of law. They are merely administrative tools and guidelines that provide direction for governmental action.

However, these policy documents can and may elaborate and specify the goals, values, and standards to which existing laws aspire and may be useful in interpreting the latter as well as guiding programmatic interventions by the government. The problem is that, at the moment, there are no HIV/AIDS specific laws on the statutes.

As legal reforms have been notoriously slow in coming and without the backing of the law, government policy documents can only be inspirational in wishing for an effective national HIV/AIDS response that respects the rights of PLHIV and PABA.

Currently, the 1999 Nigerian constitution and international treaties ratified by the country have provided the major sources of human rights for PLHIV and PABA in the country. However, as none of these treaties or the constitution specifically addresses the situation of PLHIV and PABA, the case of their applicability often has to be made through advocacy and lobbying. Thus, although PLHIV have human rights to be respected and protected, it is the tendency of the society to have pervasive prejudices and to overtly and covertly stigmatize and discriminate against PLHIV and PABA. A constitutional provision that does not speak HIV/AIDS contexts specifically does not do much to help the situation of the rights of PLHIV. And the protection of the rights of PLHIV and PABA are not on the priority radar screen of law enforcement agencies.

The NARHS (2007) found reluctance on the part of many Nigerians to relate with PLHIV who are not members of their family. Only 24% of respondents were willing to share meals with infected persons and only 16% were willing to buy food from a shopkeeper known to be HIV infected. Just about two-fifths were willing to work with an infected colleague, allow an infected student in school, and allow an infected female teacher in school.

The absence of explicit laws leaves PLHIV extremely vulnerable to the violation of their rights as available evidence demonstrates. The national HIV/AIDS response needs to do more to advance the intent and aims of a number of policies and guidelines in the context of the rights of PLHIV and PABA through intensive and consistent advocacy and lobbying. Illustrative among these are the following:

1. *Women and the right to prevention from HIV infection:* Human rights are a critical component in reducing the risk of acquiring infection among those whose vulnerability is determined by inequalities and stigma associated with a host of attributes including gender. Women are particularly vulnerable to the infection because of factors relating to their reproductive role and subordinate position in society. They typically lack equal access to education, health, training, independent income, property and legal rights, with these having serious implications for their right to access to knowledge on HIV/AIDS, the measures that can be taken to prevent transmission of the HIV infection, as well as their ability to protect themselves from infection.
2. *Mandatory HIV testing for those regarded as "at risk" and the right to privacy*: When the HIV pandemic first broke out, one of the early official responses was to impose mandatory testing on those regarded as "at risk" including commercial sex workers. In spite of an array of guidelines prohibiting mandatory testing, this persists in the form of pre-marriage and pre-employment tests required by some clergy and employers respectively. The pre-marriage testing mandated by a church or mosques constitutes a violation of the right to privacy and is often a violation of the right to marry and found a family. The National Workplace Policy strongly discourages against mandatory pre-employment testing because of the tendency to use the information derived prejudicially against those who are HIV positive. Unfortunately, many employers, unrestrained in the absence of explicit laws, carry out mandatory HIV testing. Mandatory testing takes place pre-employment as it does during employment.

Key recommendations are:

1. The coalition of Civil Society Organizations such as Civil Society Network on HIV/AIDS in Nigeria (CiSHAN), Nigerian Youth Network on HIV/AIDS (NYNETHA) and Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) should have their capacities strengthened to spearhead advocacy efforts to government to substantially increase budgetary support for the national HIV/AIDS response
2. All HIV/AIDS stakeholders should work together for the passage of the HIV-AIDS anti discrimination bill through intensification of advocacy
3. The HIV/AIDS program should facilitate utilization of HIV/AIDS policies and guidelines by stakeholders by putting a robust system in place to monitor the implementation of national policies and guidelines at all level
4. The capacity of the national human rights institutions such as National Human Rights Commission and Public Complaints Commission should be strengthened to protect the rights of PLHIV and PABA
5. Advocate for the establishment of a legal frame and bill that will protect prospective employees and people intending to marry from mandatory HIV testing; rather they should be encouraged and supported to access voluntary counseling and testing services.

Institutional architecture, systems, coordination, and resourcing

Institutional architecture

National Agency for the Control of AIDS (NACA) is at the apex of linked institutions in the multisectoral HIV/AIDS response architecture; it is mandated to provide overall coordination of the national response while State Action Committee on AIDS (SACA) and LGA Action Committee (LACA) ensures same at state and local government levels respectively. NACA transformed from "committee" to an autonomous agency in 2007. Similarly, SACAs in 15 states and FCT have also become agencies. While NACA's financial; management and human resource systems have been reengineered to enhance performance, capacity is still weak in some technical areas and in terms of internal audit system. Also the agency lacks a strategic plan. There are critical shortfalls in technical and managerial capacities in most SACAs and all LACAs. Poor funding of SACAs remains a pernicious and recurring issue. Political interference in coordination structures distorts relationships and linkages of institutions at several levels.

The key recommendations include: strengthen NACA's technical and management capacity to proactively lead the National Response; facilitate the transformation of all State Action Committees on AIDS to State Agencies for the Control of AIDS and build their capacity to operate effectively; and review, redefine and resuscitate all LACAs.

Coordination

Coordination responsibility regarding the National Response entails establishing and sustaining relationships with a diverse state and non-state actors at multiple levels. Currently, NACA interfaces in five domains: NACA-SACA, NACA-Civil Society organizations (CSOs), NACA-private sector, NACA- public sector and NACA-development partners. NACA has established interactive platforms with SACAs and provided technical, financial and managerial oversight to SACAs for World Bank HAF projects in several states. Technical Working Groups were established to coordinate Joint Planning and technical support for critical issues.

NACA facilitated the formation, funding and capacity building of CSOs and CSO networks into constituent coordinating entities that provided viable platforms for program activities. However, the capacity of many CSO service delivery institutions to provide data and poor data quality is still low. There is absence of coordination mechanisms and platform to facilitate CSO/public sector, CSO/Donors and CSO/Private sector interaction at state levels. Other challenges include limited transparency and accountability and good governance practices among CSO and their networks as well as complacency, lack of resource mobilization drive and donor dependency. Public-Private Partnership Forum has been established to leverage the vast pools of private sector resources and competencies available in the private sector but the engagement and response had been limited to mostly multinationals. Furthermore, there is limited or insignificant private sector response in many states.

NACA has also forged partnerships with development partners to leverage multi donor resource for the national response. NACA-Donor interaction platform and “Donor Coordination Group” have been established and Joint Funding Agreement is proposed to streamline and track funding and strengthen resource application. There are challenges in terms of excessive fragmentation of donor activities, resulting in increased transaction costs, and donors' reporting practices to National Planning Commission that exclude NACA from the information sharing loop. Poor coordination and weak collaboration mechanisms result in duplication and non-equitable resource allocation and inadequate coverage of some states and rural areas. Transparency issues on donor/national institutions divide generate mutual distrust and constrain viable collaboration.

Strategic recommendations are: Strengthen capacity of CSO to diversify and leverage domestic and external sources of support through partnerships; expand engagement of community based and faith organizations to increase ownership and strengthen sustainability; expand private sector and CSO partnership; and streamline CSO activities to promote transparency and accountability.

Resource mobilization and application

Full implementation of NSF was estimated to cost $3.76billion with the total cost of all HIV/AIDS services planned for 2009 estimated at US$450 million. Thirty-five percent of the cost relates to treatment while only 12 percent relates to prevention. Overall, it is difficult to state with certainty the total funds inflows from all sources. It is even more difficult to track and document outflows through various funding agencies and program management channels due to weak tracking system, inadequate coordination and lack of financial transparency on the part of many players. Political and resource commitment by states to HIV/AIDS remains extremely weak and in many cases has deteriorated as budgeted funds are seldom released. Zero allocation to HIV/AIDS response appears to be the norm at LGA level.

In general, government entities at all levels appear reluctant to implement 1% budget allocation to HIV/AIDS approved nationally. Private sector contributions remain largely untapped and are negligible in most states. Overall, the national response is donor-driven and donor-dependent; this poses considerable challenge to the sustainability of the response particularly in the face of global financial meltdown. Another challenge is the weak linkages between HIV/AIDS response and other development efforts particularly poverty reduction initiatives. Program management efficiency is sub-optimal and financial management is poor at many levels of HIV/AIDS program implementation.

Key recommendations include:

1. Institutionalize funding arrangements to ensure allocation of dedicated budget lines to HIV/AIDS funding by federal, state and local governments and their agencies.
2. Explore alternative domestic funding sources and diversify resource mobilization including cost recovery mechanism, taxes, and tariff waivers to engage more competitive players to reduce commodity and service costs. .
3. Explore and advocate for HIV/AIDS derivation fund, comparable to ecological fund, to be source directly from Federation Account, or HIV/AIDS tax.
4. Strengthen partnership with the private sector to achieve increased contribution of financial, skills, competencies and other resources from that sector to national HIV/AIDS response.
5. Institutionalize arrangements that strengthen community, local council and state ownership of HIV/AIDS response.

Health Sector Response: Health Systems, Procurement, Logistic, and Human Resources.

The infrastructure and health systems strengthening goals of the NSF lag well behind its service delivery achievements. Recent rapid scale up of various HIV/AIDS interventions poses enormous procurement and logistic challenge; there is shortage of staff skilled in commodity quantification, supply planning and procurement management and sub-optimal warehousing and storage facilities and practices including standard of practice, storage/warehouse conditions, equipment and inventory management. The surge of donor funds, unfortunately, does not guarantee continuous commodity financing; differences in institutional funding cycles which are usually short-term often do not translate to long-term commodity procurement support.

Strategic recommendations include creating an enabling environment for HIV/AIDS commodities supply chain management including incentives for importation, duty waivers for essential/donated products; supporting local production of commodities; monitoring and ensuring strict adherence to SOPs on Logistic Management Information Systems; developing National HIV/AIDS Commodities Security Plan and delink funding cycles and commodity procurement; strengthen Central, Regional and Peripheral Medical Stores systems; and strengthen relationships and collaborations with Reproductive Health Commodity Logistic Management Security System to achieve synergy and ensure greater cost-effectiveness of operations.

Monitoring and Evaluation, Research, and Knowledge Management

Monitoring and Evaluation

Notable achievements in Monitoring and Evaluation for the period under review include development of a National M&E Operational Plan (2007-2010), efforts at harmonization of tools and indicators, joint review of the World Bank MAP I Project, and the end-of-project assessment of the HIV/AIDS Fund. Other achievements include the development of national Universal Access targets and joint mid-term review of the NSF. Integrated Biological and Behavioral Surveillance Survey (IBBSS) and the first national population based sero-prevalence survey, the National AIDS Pending Assessments, and the Sustainability Analysis of HIV/AIDS services in Nigeria were among the numerous studies conducted during the period.

The performance of the national M&E system has shown evidences of continuous improvement as the capacity of the staff continues to be strengthened. However, the human capacity for M&E response appears insufficient in comparison to the scope of work that is expected to be accomplished; existing resource gap seems to have militated against the attainment of a critical mass in the required human capacity (quantity and quality). Consequently, a number of activities are not executed in a timely manner. Nevertheless, the fundamentals now seem to have been put in place to enable a rapid scale-up in the performance of the national M&E system though a gap in the adoption and implementation of a systems approach to the delivery of the national M&E system still exists. There are also challenges in terms of weaknesses in processes for generating accurate, actionable strategic information regarding the financing of HIV/AIDS services, which makes it currently impossible to get a comprehensive picture of how and where resources are being expended in the HIV/AIDS response.

Research and knowledge management

A draft National HIV/AIDS Research Policy has been developed with the intention of strengthening research promotion and utilization of results in strengthening policies and programs. Capacity development has taken plan place in the area of research ethics, with the establishment of two National Health Research Ethics Committees and Operational Guidelines for Research on Human Subject developed and operationalisation of training activities. As mentioned in the M&E section, Nigeria has witnessed a number of major national research initiatives with potentials to strengthen the platform for evidence-based policy and programming.

A compilation of abstracts of presentations made by Nigerians at national and international HIV/AIDS conferences has been undertaken and disseminated by the National Institute of Medical Research. The organization of National HIV/AIDS Conferences by Nigerian HIV/AIDS Research Network and other stakeholders had provided an avenue for knowledge sharing.

Existing challenges include lack of national priority research funding and coordination framework, poor dissemination and utilization of research outputs, poor involvement of stakeholders in research activities, particularly at community level, and low priority accorded by various stakeholders, including international development agencies, in their projects and plans.

THE NSP 2010-2015 DEVELOPMENT PROCESS

The National HIV/AIDS Strategic Plan (NSP) 2010-15

The NSP 2010-15 is the third in a series of national HIV/AIDS strategic plans which started with the HIV/AIDS Emergency Action Plan (HEAP) 2001-04. Gains from the Emergency Plan informed the development of the second HIV/AIDS Strategic Plan, the National Strategic Framework (NSF) 2005-09, which ushered in a period of significant scale-up of HIV/AIDS services especially access to HIV treatment. This NSP 2009-2015 is six years long and is coterminous with two important international commitments that Nigeria has signed on especially the Millennium Development Goals and the Universal Access (UA) to HIV/AIDS prevention and care and treatment services. The overarching priority of the NSP 2010-15 is to reposition HIV prevention as the centerpiece of the national HIV/AIDS response.

Key NSP development timelines

Following the midterm review of the NSF 2005-09, Nigeria initiated low intensity activities and processes to better inform the development of the NSP 2010-15. Some of these activities and processes have been captured in the successful proposal (Scaling-up Gender Sensitive HIV Prevention, Treatment, Care and Support for Adults and Children in Nigeria) that Nigeria submitted in May 2009 to the Global Fund Round 9. Intensive NSP development activities commenced in earnest in June 2009 with preparatory planning activities followed by a participatory process for documenting the NSF 2005-09 HIV/AIDS Response and the development of the NSP 2010-15 using a bottom-up consultative and interactive approach. Key NSP development timelines are shown in the table below.

	Process	Duration	Comment
1.	National HIV/AIDS 2005- 2009 Response Analysis and development of Strategic Framework for NSP 2010-2015	23 September 2009 to 30 October 2009	NSF 2005-2009 Response Analysis Report compiled and drafted by a 12-member team of consultants who also designed the framework for the development of the NSP 2010-2015.
2.	Validation of Findings of the NSF 2005-2009 Response Analysis and Reaching Consensus on the draft framework for NSP 2010-2015	22-27 October 2009	More than 250 participants drawn from the public, private, and civil society sector and from Nigeria's development partners validated the findings of the NSF 2006-2009 Response Analysis and approved the framework for developing the NSP 2010-2015.
3.	NSF 2005-2009 HIV/AIDS Response Analysis and Development and Validation of NSP 2010-2015 by States, MDAs, and CSO Networks	1st November 2009 – 30 November 2009	A team of consultants provided technical assistance to 34 states and the FCT, 19 Ministries, Departments and Agencies (MDAs), and 6 Civil Society Organization Networks to carry out response analysis of their 2005-2009 HIV/AIDS programs and develop their 2010-2015 strategic plans.
4.	Collation and harmonization of validated States, MDAs, and CSO networks strategic plans into one National Strategic Plan (NSP) 2010-2015	30 November 2009 – 5 December 2009	Integration of all States, MDAs and CSO Network Plans into the Draft NSP 2010-2015.
5.	Drafting of NACA Strategic Plan 2010-2015; Draft of NSP 2010-2015 shared with development partners – multilateral, bilateral, and UN agencies	December 2009	Representatives from development partner organization participated in various processes of the development of the NSP. Others provided written comments which were incorporated into the draft NSP.
6.	Finalization of the NSP 2010-2015	19 Dec 2009 – 21 Dec 2009	Draft NSP 2010-2015 document harmonized and aligned with key aspects of NACA, States, MDAs, and CSO Networks specific strategic plans 2010-2015. Preliminary costing of key interventions and major activities of the draft NSP undertaken.
7.	Launch of the NSP 2010-2015	March 2010	Public Presentation of the document in the presence of Government representatives (Federal, States & Local), International & National Partners and Civil Society representatives.

Context, Considerations, and Principles and Commitments

The overarching priority of the NSP is to reposition prevention of new HIV infections as the centerpiece of the national HIV and AIDS response. Thus greater focus will be placed on scaling-up HIV prevention services that enable individuals to maintain their HIV negative status as well as improve access to quality treatment and care services for PLHIV including positive health, dignity and prevention (PHDP) interventions that reduce their transmitting HIV to others.

The Context of the NSP

The NSP 2010-15 is developed in the context of:

1. The 1999 Constitution of the Federal Republic of Nigeria that affirms the national philosophy of social justice and guarantees the fundamental right of every citizen to life and freedom from discrimination
2. Complementary government documents that provide the basis for the NSP include:
   The NACA Act that empowers NACA to facilitate engagement of all tiers of government and all sectors on issues of HIV/AIDS prevention, care, and support, advocate for mainstreaming HIV / AIDS in all sectors of society, and formulate policies and guidelines for HIV/AIDs; National Economic Empowerment and Development and Strategy, (NEEDS) I & II, which assert HIV/AIDS as a major social and health problem that threatens the country's productivity and economy; and the President's 7-Point Agenda on cross-cutting issues including gender and HIV/AIDS.
3. Nigeria's commitment to various international conventions: Economic, Social, and Cultural Rights (1977); Convention on Elimination of All Forms of Discrimination Against Women (CEDAW); Millennium Development Declaration (2000), which targets 2015 for halting and reversal of the HIV epidemic; the Abuja Declaration and Framework for Action for the Fight against HIV,TB, and related diseases in Africa (April 2001); and the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (June 2001) at which countries committed to ensure an urgent, coordinated, and sustained response to HIV and AIDS and the National Gender Policy (2006).

Considerations of the NSP

The key considerations that inform the development of this NSP are:

1. *The burden of HIV/AIDS*: The heavy burden of HIV/AIDS on about three million Nigerians infected with the virus, their families, communities, and the country
2. *Public health challenge of HIV/AIDS:* HIV/AIDS is a one of the greatest public health challenges in the country; it is reversing many health and development gains of the recent past including maternal and under-five mortality rates and placing unprecedented stress on an already overburdened health care system
3. *Comprehensive HIV/AIDS services:* Comprehensive HIV prevention, treatment, care and support services as mutually reinforcing elements on the continuum of a holistic, effective, and efficient HIV/AIDS response
4. *Feminization of HIV epidemic and strategy for gender mainstreaming*: Females constitute almost three-fifths (58.3 percent) of the infected persons in Nigeria a total of 1.72 million infected women and girls. The burden of care and support for PLHIV and OVC rests disproportionately on women and girls. Gender mainstreaming is a key strategy for making women's as well as men's concerns and experiences an integral part of the political, economic, and social dimensions of the national HIV response so that women and men benefit equally and inequality is not perpetuated.
5. *Young people and HIV/AIDS*: The prevalence of HIV in the country peaks in the age group 25-29 years with a sero-prevalence level of 5.6%. Young people especially females are disproportionately infected with the virus.
6. *The most-at-risk-populations (MARPs)*: These include female sex workers (FSWs), intravenous drug users (IDUs), men who have sex with men (MSM), long-distance drivers, the youth, and members of the uniformed services.
7. *Modes of HIV transmission*: The leading route of HIV transmission in Nigeria is heterosexual sex, accounting for about 80 percent of infections. Mother-to-child transmission and transfusion of infected blood and blood products are generally estimated as ranking next as common routes of infection; arguably, each of these two are believed to account for almost ten percent of infections. However, other modes of transmission such as intravenous drug use and same-sex intercourse are slowly growing in importance.
8. *Drivers of HIV epidemic*: The drivers of the HIV epidemic in Nigeria include low personal risk

perception for contracting HIV, multiple concurrent sexual partnerships, informal transactional and inter-generational sex, lack of effective services for sexually transmitted infections (STIs), and poor quality of health services. Gender inequalities, poverty and HIV/AIDS-related stigma and discrimination also significantly contribute to the continuing spread of the infection.

9. *Stigma and discrimination*: HIV/AIDS related stigma and discrimination remain pervasive and PLHIV are discriminated against and denied access to compassion, care, support and social services.
10. *Culture, traditions and religion*: These have a strong influence of behaviors, attitudes, and practices of majority of Nigerians. As such traditional and faith-based institutions, as gate keepers of attitudes and behaviors, are critical assets in the fight against the disease.
11. *Human rights of PLHIV*: Effective response to HIV/AIDS requires respect for and protection and fulfillment of all human rights (civil, political, economic, social, and cultural) and upholding the fundamental freedoms of all people in accordance with the country's constitution and existing international human rights principles, norms and standards.
12. *Multisectoral partnership*: The involvement of government, the private sector, the civil society, the UN system, and development partners will continue to be the cornerstone of the national HIV and AIDS response.

Guiding principles and commitments

The NSP interventions are premised on the following *principles and commitments:*

1. *Leadership and stewardship of the national response*: Strong political leadership and stewardship of the national HIV/AIDS response and commitment to transparency and prudent management of financial and other resources at all levels of the response.
2. *Multisectoral HIV response*: Commitment to forge consistent and effective partnership and collaboration with development partners, the private sector, and civil society through harmonized and aligned ways of working to support the HIV/AIDS response at all levels
3. *Rights of PLHIV*: Protection and promotion of the rights and access of PLHIV to comprehensive prevention, treatment, care and support services as well as reduction of stigma and discrimination and ensuring meaningful involvement of PLHIV (MIPA) in the HIV/AIDS response at all levels.
4. *Rights of vulnerable groups*: Commitment to promote and protect the rights of women, children, young people, and marginalized groups and reduce their vulnerability to HIV.
5. *Addressing gender factors that increase female vulnerability to HIV*: Commitment to address social, economic, and cultural factors responsible for disproportionate vulnerability of women and girls to HIV infection.
6. *Enhanced focus on MARPs*: Commitment to accelerate the scale up HIV prevention among MARPs
7. *Delivery of integrated services:* Commitment to strengthen linkages and optimize synergies between HIV/AIDS programs and poverty alleviation initiatives to break the vicious cycle of the disease and its relationship with economic disempowerment.
8. *Evidence-based HIV/AIDS programming:* Commitment to evidence-based approach to planning and implementing interventions

HIV/AIDS Thematic Areas of the NSP 2010-15

The key HIV/AIDS thematic areas of the NSP 2010-15 correspond to the thematic areas identified by the National HIV/AIDS Policy 2010-15. Gender issues related to the various thematic areas are addressed under the specific thematic activities as well as in the indicators. The thematic areas are:

1. Promotion of Behavior Change and Prevention of New HIV Infections
2. Treatment of HIV/AIDS and Related Health Conditions
3. Care and Support of PLHIV, PABA, and OVC
4. Policy, Advocacy, Human Rights, and Legal Issues
5. Institutional Architecture, Systems, Coordination, and Resourcing
6. Monitoring and Evaluation Systems comprising M&E, Research, and Knowledge Management

The NSP targets are ambitious. This conforms to the advice given by the Universal Access (UA) commitment encouraging countries to set ambitious country specific targets that can be used to plan and monitor progress towards UAs. It is also based on Nigeria's experience of increasing access to ART from near zero to 35% between 2005 and 2009 with limited resources. The targets are premised upon the commitments to secure significantly increased resources (human, material, financial, and technical) for the national HIV/AIDS response from both domestic and external sources.

A number of broad interventions have been identified as critical for the success of the NSP. They are therefore important components that must be addressed in all six HIV/AIDS thematic areas. These interventions include gender mainstreaming, advocacy at all levels, and capacity building including training and skills development, increased access to material goods, technical assistance, and sustainable funding.

PROMOTION OF BEHAVIOR CHANGE AND PREVENTION OF NEW INFECTIONS

Rationale

Prevention remains the most important strategy and the most feasible approach for reversing the HIV epidemic since there are no vaccines and no medical cure. The majority of Nigerians are HIV-negative and keeping them uninfected is critical for altering the epidemic trajectory. This underscores the importance of prevention as a cornerstone of the national HIV and AIDS response. Furthermore, persistent HIV-risky behavior in spite of high level of HIV awareness requires continuous and concerted focus on effective preventive interventions that will address specific needs key population segments and stimulate adoption of appropriate behavior that reduces the risk of HIV transmission. Communication holds a vital and indispensable place in HIV prevention interventions. It has the potential to increase demand for HIV prevention services and have an impact on knowledge, attitudes, behaviors, and practices influencing the spread of HIV. Hence in the quest for the effective control of HIV and AIDS communication for behavioral change is of critical importance.

Goal

The goal of this thematic focus and indeed the National Strategic Plan is to reduce the incidence of HIV/AIDS.

Objectives

The objectives for the sub-thematic areas are:

HIV Counseling and Testing

1. At least 80% of sexually active adults (including discordant couples and people in concurrent multiple partnerships) accessing HCT services in an equitable and sustainable way by 2015
2. At least 80% of most at-risk-populations accessing HIV counseling and testing by 2015

Sexually Transmitted Infections

3. At least 80% of sexually active Nigerians have access to quality gender responsive STI services by 2015
4. STI treatment & prevention services integrated into HIV prevention services by 2015

Prevention of Mother-to-Child Transmission of HIV

5. At least 80% of all pregnant women have access to quality HIV testing and counseling by 2015
6. At least 80% of all HIV positive pregnant women access to more efficacious ARV prophylaxis by 2015
7. At least 80% of all HIV exposed infants have access to ARV prophylaxis by 2015
8. At least 80% of HIV positive pregnant women have access to quality infant feeding counseling
9. At least 80% of all HIV exposed infants have access to early infant diagnosis services

Communication Interventions

10. At least 80 % of all Nigerians have comprehensive knowledge on HIV and AIDS by the year 2015
11. At least 80% of young people 15-24 years adopting appropriate HIV and AIDS related behavior
12. At least 80% of Most-At-Risk Populations (MARP) reached with group-specific interventions and adopting appropriate HIV and AIDS related behavior.
13. At least 80% of registered organizations engaging in HIV communication interventions address gender inequalities and comply with national standard/guidelines by 2015

Condom Promotion

14. At least 80% of men and women of reproductive age (MWRA) have knowledge about dual protection benefit of condoms
15. At least 80% of sexually active males and females use condoms consistently and correctly with non-regular partner by 2015.
16. At least 80% of MARPs use condoms consistently and correctly by 2015

Integration of Sexual and Reproductive Health (SRH) and Other Relevant Health Issues into HIV Prevention Program

17. SRH services integrated into all HIV prevention programs at all levels by 2015
18. Integrate drug demand reduction and other substance use control services into 80% of HIV prevention programs by 2015

Prevention with Positives

19. At least 80% of people living with HIV/AIDS (PLHIV) have access to Positive Health, Dignity and Prevention (PHDP) interventions 2015.

Prevention of Biomedical Transmission of HIV

20. At least 80% of all private and public health institutions practicing universal safety precautions and procedures by 2015
21. All (100%) donors of blood, blood products and organs for transplant including sperm for assisted reproductive technology are screened for HIV and other transfusion transmissible infections (TTIs) according to relevant national protocol, standards and guidelines by the year 2015.
22. At least 80% of drug dependant persons (IDUs and non-IDUs) have access to quality prevention programs/services in accordance with national guidelines by 2015.
23. At least 80% of traditional medical practitioners adopt universal safety precaution by 2015
24. At least 80% of health facilities provide post-exposure prophylaxis (PEP) to relevant health workers and survivors of rape in line with national protocols by 2015

Key Interventions

The key interventions for achieving these objectives include:

1. Adapt, disseminate, and/or implement national policies, standards, protocols and guidelines for HIV prevention services
2. Institutional/human technical capacity building for organizations and institutions involved in HIV prevention
3. Accelerate the scale up of quality service provision with special focus on MARPs
4. Advocacy to critical stakeholders
5. Demand creation for and utilization of HIV prevention services
6. Promotion of evidenced based approach to HIV prevention programming with special focus on strategic behavior change communication (SBCC)
7. Integration of HIV prevention into other health related services especially SRH
8. Resource mobilization and fund allocation
9. Public private partnerships and multisectoral collaborative activities
10. Operation research/ documentation and dissemination of best practices

Other interventions include: Regular supply of drugs, commodities and consumables; Improve referral/linkages; Operationalize/strengthen Family Life and HIV Education (FLHE) curriculum implementation in schools; and undertake policy dialogue for the enactment and/or /enforcement of relevant legislations especially those directly impacting on biomedical transmission of HIV.

Major Activities for NACA and the States

A total of thirty-four states including the FCT have developed multisectoral state specific HIV/AIDS strategic plans 2010-2015. The major activities include:

1. Implementation of policies, standards, protocols and guidelines

NACA will provide appropriate policies and guidelines for HIV prevention interventions. Many of the states will adapt, review, produce, disseminate and operationalize available national policies, plans, guidelines, protocols and standards of practice. These include the National Healthcare Waste Management Policy, Plan, and Guidelines; the National Blood Transfusion Policy and Guideline; implementation of the Policy and Guideline on Safety of Blood and Blood Products; National Policy on Universal Safety Precautions; HCT Protocol; National Protocol on Post Exposure Prophylaxis (PEP) and Health Workers Injection Safety Guidelines; National Protocol on Voluntary Non-Remunerated Blood Donors (VNRBD); National SBCC Strategy Document; National Drug Control Master Plan; PMTCT Guidelines; ART Guidelines; Guidelines on the Syndromic Management of STIs and implementation of the FLHE curriculum. A few states will develop guidelines for the provision of positive health, dignity and prevention (PHDP) interventions; implementation of the national protocol on VNRBD; and integration of drug demand reduction and substance abuse control into other health related activities.

2. Implementation/provision of HIV/AIDS prevention services

The focus is on service provision that is gender sensitive and specifically designed and implemented to appropriately respond to the special needs of various population sub-groups including vulnerable populations, MARPs and PLHIV using appropriate media. The major activities are:

i. Institutional and human technical capacity building include:

a. Training/re-training, orientation and skills development of service providers in both private and public institutions, and CSOs on the various policies, plans, standard of practices, protocols, and guidelines. Other areas include providing training in peer education, FLHE, advocacy, and logistics and commodity management.
b. Material resources: Expansion of service delivery points including mobile teams for outreach services; equip these facilities and provide test kits, drugs, commodities and consumables; and also establish and sustain a functional supply chain management system to prevent stock-outs
c. Financial resources: The States plan to leverage resources especially from public private partnerships, mobilize resources from the government and development partners; and ensure appropriate allocation and tracking of funds, and timely reporting.

ii. Accelerate scale up of quality HIV prevention services by:

a. Improving universal access to quality, affordable and accessible services especially at the facility and community levels. Consequently, many states have plans to establish and equip more service delivery points and mobile community teams to provide outreach services especially in hard to reach communities. A few states are also developing a directory of service delivery points in their states in the hope to further strengthen the hitherto weak referral system
b. Integration of HIV prevention services into other health related programs such as sexual and reproductive health, drug demand reduction, blood transfusion services and family life education etc. to improve access, strengthen collaboration, improve synergy and impact of prevention programs. A few states are advocating for a trained desk officer on SRH in SACA to encourage integration.
c. Demand creation/utilization of HIV prevention services through relevant evidenced based HIV communication interventions including development of culturally-appropriate IEC & SBCC materials.

iii. Advocacy

Meetings and wide consultations with key policy/decision makers and community/religious gatekeepers at all levels to improve service provision and increase uptake of HIV prevention

services. Targeted advocacy includes those to the media to promote safer sexual behavior targeting all population and population sub-groups especially MARPs and HIV prevention services; to the National Association of Patent Medicine Dealers (NAPMED) to improve referrals to health facilities and to the National Institute of Medical Research (NIMR) to support research activities.

3. Coordinating Functions

The responsibility of coordinating, monitoring and evaluating state-wide HIV/AIDS response lies with SACA and LACA at the local government levels. These bodies have the mandate to facilitate the engagement of all sectors on prevention within the state, mobilize resources, and coordinate equitable applications for HIV/AIDS activities within the state, and coordinating state-wide reports of the states' HIV/AIDS response.

Major Activities for the MDAs

Nine-teen (19) MDAs have developed sector-specific HIV/AIDS plan 2010-15. Key sector plans include those of the Ministries of Health, Education, Women Affairs and Social Development, Communication, Transport, Labor, Police, Prison Services, Immigration, and the National Youth Service Corps (NYSC). All MDAs will engage in awareness creation, sensitization, behavior change communication, establishing linkages with and referrals to other services. The major activities for the MDAs include:

1. **Coordination and supervision:** The MDAs coordinate and supervise sector-wide HIV/AIDS response by constituting and supervising the relevant committees for the implementation of national policies, guidelines, protocols, plans, and standard of practice. MDAs conduct organizational assessments; gap analysis and site selections of both private/public health institutions for service provision, hold annual review meetings involving all stakeholders and develop structured two-way referral forms for use in the sites.

2. **Policy & Guidelines:** Develop/review and disseminate sector specific policies, plans, guidelines, and protocols, standard of practice and training manuals. These include HCT/PMTCT guidelines, training manuals and standard operating procedures (SOPs); national guideline on the syndromic management of STIs; national guideline on reproductive health/HIV integration; early infant diagnosis (EID) training manuals, job aids, forms and flow charts; national protocol on PEP and guideline on health workers injection safety.

3. **Advocacy:** Meetings and wide consultations with key policy/decision makers and gatekeepers at all levels to increase uptake of HIV prevention services. Targeted advocacy include those to the FMoH for health care delivery systems strengthening and capacity building, Federal Ministry of Women Affairs and Social Development (FMoWA &SD) for developing and implementing HIV prevention programs for vulnerable population within the ministry's purview, Federal Ministry of Education (FMoE) for promotion of school based HIV/AIDS prevention programs and the Federal Ministry of Information and Communication to provide sustained accurate and culturally appropriate information on HIV/AIDS as well as report and project challenges and responses by other sectors and stakeholders in HIV prevention

4. **Capacity building:**
   a. Training and skills development: Training of health care providers in both public and private facilities on the implementation of the national policies, protocols and guidelines, training of trainers on HCT/PMTCT, training of peer educators and school counselors on ARH/HIV/AIDS.
   b. Material resources: Improved access to material goods including equipments, drugs, commodities and consumables.
   c. Financial resources: Mobilization, allocation and ensure accountable expenditure of funds released for HIV prevention activities

5. **M&E, Research and Knowledge Management:** To strengthen quality of program management, MDAs will conduct regular monitoring and mentoring to program sites to ensure proper program reporting, conduct quarterly DQA and site impact assessments. The MDAs are to ensure wide dissemination of findings from operations research to all stakeholders as well as the documentation of best practices

6. **Reporting:** All MDAs will produce sector-wide annual reports

Major Activities for the CSO Networks

Six (6) CSO networks (Coordinating Entities) have developed sector-specific HIV/AIDS plans 2010-2015 to expand and strengthen CSO participation in HIV prevention. Key plans include those of the Nigerian Business Coalition Against AIDS (NIBUCAA); Civil Society Network on HIV/AIDS in Nigeria (CiSNHAN), Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), Nigerian Youth Network on HIV/AIDS (NYNETHA), and the Nigerian AIDS Research Network (NARN). The major activities for the CSO network include:

1. **Coordination and supervision**

   The Networks facilitate networking and coordination arrangements among NGOs to avoid duplication and increase impact and national coverage of HIV prevention programs on the one hand, and enhance collaboration between NGOs and government on the other hand to ensure their representation in advisory bodies of HIV/AIDS agencies and structures at all levels. They also identify, map out and supervises support groups and constituencies at all levels and mobilize/ strengthen the capacity of members at community levels to improve referrals, linkages and service uptake.

2. **Policy and guidelines**

   The CSO networks develop/review/produce advocacy plans and materials and actively engage in the distribution of national policies, plans, protocols, guidelines and standard of practice

3. **Advocacy**

   These coordinating entities organize meetings and wide consultations with key policy/decision makers, the private sector and gatekeepers at all levels to mobilize resources and garner support for the promotion/uptake of HIV prevention services. Targeted advocacy include those carried out by NYNETHA for the scale up of youth friendly services and the development/production of youth friendly SBCC materials and to NIBUCAA for IEC adoption, production/information dissemination and organization of family oriented/gender sensitive programs for the business sector. Targeted advocacy by NEPWHAN to strengthen support groups and organize awareness creation on HIV prevention services including PMTCT and infant feeding and by CiSNHAN to support state networks/constituency to strengthen the implementation of FLHE at primary/secondary levels and scale up/ increase uptake of HIV prevention services.

4. **Capacity building**

   Principally the networks will actively engage in training member organizations in various aspects of HIV prevention within their mandate. These include capacity building in development of advocacy skills/conduct of media activities, integration of SRH/HIV programming and strengthening the capacity of network members to develop, implement, and manage culturally appropriate youth friendly and gender sensitive SBCC programs

5. **M&E and Research**

   All the networks monitor and evaluate the work of its members. Research work is principally within

the purview of the Nigeria AIDS Research Network (NARN). It provides a platform for exchange of information between the different networks/organization active in health research for development and is involved in defining national research priorities such as the focus on incidence studies in this NSP, coordinating research efforts, documentation and dissemination of research findings.

6. Reporting

All CSO networks will produce annual reports and send these to NACA as well as disseminate the reports widely within the network and elsewhere.

HIV PREVENTION RESULT FRAMEWORK

Indicators	Baseline value (Year)	Mid-term (end of 2012)	End of program (2015)	Means of Verification	Comments
HIV Counseling & Testing					
Objective 1: At least 80% of adults accessing HCT services in an equitable and sustainable way by 2015					
Percentage of men and women aged 15yeras and older that received HCT	14% (2007)	50%	80%	NARHS NDHS	Disaggregate data by sex, age, and geographic location (zones and states)
Objective 2: At least 80% of MARPs accessing HCT by 2015					
Percentage of MARPs who accessed HCT	44% (brothel-based FSW) 2007) 21% (Transport workers)	62% 51%	80% 80%	IBBSS	Disaggregate data by sex, age, and groups
Sexually Transmitted Infections					
Objective 3: At least 80% of sexually active persons in Nigeria with access to quality and gender responsive STI services by 2015					
% of sexually active males and females with STI symptoms who accessed quality and gender responsive treatment services	65% (males, 15-24 years, 2007) 47% (females, 15-24 years, 2007)	78% 70%	90% 90%	NARHS (or secondary analysis of NARHS data)	Disaggregate data by sex and age Baseline was obtained from secondary analysis of NARHS 2007 data
% of male and female with symptoms of STI seeking treatment who used orthodox health facilities	35%	60%	80%	NARHS	Orthodox health facilities is defined as health centers, clinics and hospitals but exclude pharmacies and patent medicine stores
% of health facilities providing STI treatment services according to national guidelines	To be determined at the beginning of the NSP **(TBD)**			NASCP, FMOH Reports Reports of Service Surveys	Disaggregate data by level of care
Objective 4: STI treatment & prevention services integrated into HIV prevention services by 2015					
% of HIV prevention programs providing treatment for other STIs	TBD	50%	80%	NASCP, FMOH Reports NACA M&E/ \ Reports Reports of Service Surveys	Disaggregate data by level of care
Prevention of Mother-to-Child Transmission of HIV					
Objective 5: At least 80% of all pregnant women have access to quality HCT by 2015					
% of pregnant women counseled and tested for HIV and received results according to national guidelines	11% (2008)	46%	80%	NARHS NDHS	Disaggregate data by level of care age of client and location (Rural/urban).
Objective 6: At least 80% of all HIV positive pregnant women access ARV prophylaxis by 2015					
% of HIV + pregnant women who received ARV prophylaxis according to national guideline	8% (2008)	50%	80%	NASCP, FMOH Reports NACA M&E/ Annual Report	Disaggregate by age of client and location (urban/rural)
Objective 7: At least 80% of all HIV exposed infants have access to ARV prophylaxis by 2015					
% of HIV exposed infants that received ARV ylaxis proph	TBD	40%	80%	NASCP, FMOH Reports NACA M&E/ Annual Report	Disaggregate by sex and location (urban/rural)

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Objective 8: At least 80% of HIV positive pregnant women have access to quality infant feeding counseling					
% of HIV+ pregnant women that received infant feeding counseling according to national guidelines	TBD	50%	80%	NASCP, FMOH Reports NACA M&E/ Annual Report	Disaggregate by age and location (urban/rural)
Objective 9: At least 80% of all HIV exposed infants have access to early infant diagnosis (EID) services					
% of HIV exposed infants that received EID services according to national guidelines	TBD	50%	80%	NASCP Report NACA M&E/ Annual Reports	Disaggregate by sex and location (urban/rural)
Objective 10: At least 80 % of all persons in Nigeria have comprehensive knowledge on HIV and AIDS by the year 2015					
80 % of persons in Nigeria that have **comprehensive knowledge** * of HIV and AIDS by the year 2015.	24.2%	52%	80%	NARHS NDHS	3 major ways of preventing HIV and 2 common misconceptions. Disaggregate by sex, age, and location
Objective 11: At least 80% of young people 15-24 years adopting appropriate HIV and AIDS related behavior					
% of males and females aged 15-19 years who have ever had sex	Age at first sexual debut 22.2% (males, 2007) 42.9% (females, 2007)	17% 33%	12% 23%	NARHS NHDS	Disaggregate data by age and sex
% of schools where family life & HIV education (FLEH) curriculum is implemented	32% (2006)	60%	80%	Federal Ministry of Education reports	Disaggregate data by type of school, zone, and state
% of in-school adolescents exposed to FLHE	TBD	50%	80%	Federal Ministry of Education reports	Disaggregate data by age, sex, type of school, and state
% of out-of-school youths (male and female) receiving life skills education	TBD	TBD	TBD	Partner reports, Federal Ministry of Women Affairs reports	Disaggregate by sex and location (rural and urban)
% of sexually active young people who used condom with last non-marital partner	Males, 15-19 years: 47.8% (2007) Females, 15-19 years: 28.7% (2007) Males, 20-24 years: 54.2% (2007) Females, 20-24 years: 38.7% (2007)	67% 67% 67% 67%	80% 80% 80% 80%	NARHS NDHS	Disaggregate data by age and sex and zones
Objective 12: At least 80% of Most-At-Risk Populations (MARPs) reached with group-specific interventions and adopting appropriate HIV and AIDS related behavior.					
% of MARPs that are exposed to safer sex education in the past 12 months	24.5% (transport workers, 2007) 23.7% (Police, 2007) 36.8% (brothel-based FSW) Prisoners Armed Forces MSM	60% 60% 60%	80% 80% 80%	IBBSS	
% of MARPs that are engaging in casual sex	9.2% (transport workers, 2007) 21.1% (Police, 2007)	7% 15%	5% 10%	IBBSS	
% of MARPS with STI symptoms who	76.3% (brothel-based FSW, 2007)	83%	90%	IBBSS	

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Objective 13: At least 80% of registered organizations engaging in HIV communication and/or Workplace interventions address gender inequities and comply with national standard/guidelines or					
% of registered organizations undertaking HIV communication interventions that address gender inequities and adapt national guidelines in programming	TBD	50%	80%	Reports of special surveys; Annual reports of service providers; NACA M&E and A nnual Reports	National standards are as reflected in the National HIV Strategic Comm. Plan and the National HIV Prevention Plan documents
% of registered organizations undertaking HIV communication interventions who complied with national standards in programming	TBD	50%	80%	Reports of special surveys NACA M&E/ Annual Reports	National standards are as reflected in the National HIV Strategic Communication and the national HIV Prevention Plans document
Proportion of organizations with gender sensitive HIV/AIDS Workplace policy	TBD	40%	80%	Reports of organizations with workplace programs	Disaggregate by type of workplace (public/private)
% of organizations with HIV/AIDS workplace programs	TBD	40%	80%	Reports of organizations with workplace programs	Disaggregate by type of workplace (public/private)
Condom Promotion					
Objective 14: At least 80% of men and women of reproductive age (MWRA) have knowledge about dual protection benefit of condoms					
% of MWRA who know condoms to be effective in preventing unplanned pregnancy and STIs including HIV	Females: 42.7% (2007) Males: 64.7% (2007)	67% 80%	90% 90%	NARHS NDHS	Disaggregate data by age and sex
Objective 15: At least 80% of sexually active males and females use condoms consistently and correctly with non-regular partner by 2015.					
% of sexually active males and females who used a male or female condom with non regular partner in last 12 months -	Females: 35.3% (2007) Males: 54.2% (2007)	60% 77%	80% 80%	NARHS NDHS	Disaggregate data by age, sex and condom type (male or female condom)
Objective 16: At least 80% of MARPs use condoms consistently and correctly by 2015 with non-marital partners					
% of MARPs that reported consistent condom use with casual partners in the last 12 months	64.8% (brothel -based FSW, 2007) 46.6% (transport workers, 2007)	78% 64%	90% 80%	IBBSS	Results are to be disaggregated by sex and age-group
Objective 17: SRH services integrated into HIV prevention programs at all levels by 2015					
% of HIV prevention programs with integrated SRH services	TBD	50%	100%	Reports of special surveys FMOH Reports (RH Unit/Family Health) NACA M&E/ Annual Reports	
% of HIV prevention programs that provide linkages or referrals to other SRH services	TBD	TBD	TBD		
Objective 18: Integrate drug demand reduction and other substance use control services into 80% of HIV prevention programs by 2015					
% of HIV prevention programs providing drug and substance abuse control services	TBD	TBD	TBD	Reports of special surveys NACA M&E/ Annual	

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% of HIV prevention programs that provide linkages or referrals to other drug and substance abuse control services	TBD	TBD	TBD	Reports of special surveys NACA M&E/ Annual Reports	
% of drug and substance abuse control services that have integrated HIV prevention activities	TBD	TBD	TBD	NDLEA reports NACA M&E/ Annual Reports	
Objective 19: At least 80% of PLHIV have access to Positive Health, Dignity and Prevention (PHDP) interventions by 2015					
% of HIV programs providing PHDP services % of PLHIV that have access to PHDP services	TBD	50%	80%	Report of Special Surveys Facility survey reports NACA M&E/ Annual Reports	Disaggregate by sex
% of all private and public health facilities practicing universal safety precautions and procedures by 2015	20%	50%	80%	Facility survey Survey of health workers NACA M&E/ Annual Reports	Disaggregate by location
Objective 21: All (100%) donors of blood, blood products and organs for transplant including sperm for assisted reproductive technology shall be screened for HIV and other transfusion transmissible infections (TTIs) according to relevant national protocol, standards and guidelines by the year 2015.					
% of donors of blood, blood products, organs for transplant including sperm donors that are screened for TTIs disaggregated by specific screening tests	32%	70%	100%	NBTS Reports FMOH Reports	
Objective 22: At least 80% of drug dependant persons (IDUs and non -IDUs) have access to quality prevention programs/services in accordance with national guidelines by 2015					
% of national/state programs targeting IDUs and non- IDUs	TBD	50%	80%	Reports of special surveys NACA M&E/ Annual Reports	
% of IDUs and non -IDUs accessing prevention programs	TBD	TBD	TBD	Reports of special surveys NACA M&E/ Annual Reports	
Objective 23: At least 80% of traditional medical practitioners adopt universal safety precaution by 2015					
% of traditional practitioners that practice universal safety precautions	TBD	40%	80%	Reports of special surveys NACA M&E/ Annual Reports	
Objective 24: At least 80% of health facilities provide post-exposure prophylaxis (PEP) to relevant health workers and survivors of rape in line with national protocols by 2015					
% of health facilities offering PEP according to national guidelines	TBD	50%	80%	Facility survey; Survey of health staff; NACA M&E/ Annual Reports	Disaggregate data by level of health care
% of persons who are biomedically exposed to HIV transmission risk who received PEP	TBD	50%	80%	Survey of health workers NACA M&E/ Annual Reports	Disaggregate data by level of health care

TREATMENT OF HIV/AIDS AND RELATED HEALTH CONDITIONS

Rationale

Over the last five years, the national response to the HIV epidemic has made significant strides with approximately 300,000 people accessing ART. This number, however, represents only about a third of those eligible for ART. Also, there is wide variation in quality as well as access to services between urban and rural communities. Although the effects of Opportunistic Infections (OIs) account for most of the ill health associated with HIV infection, a minimum package for diagnosis, prophylaxis and treatment is yet to be defined to ensure standardization and equitable access to these services. Furthermore, the increasing incidence of TB among PLWHIV and associated increased morbidity and mortality necessitates the scale up of TB/HIV collaborative activities. Compounding the problem further is the fact that the diagnostic algorithm for TB in Nigeria does not detect extra-pulmonary TB whereas many HIV positive TB patients have extrapulmonary TB. Thus, more needs to be done not only to diagnose and provide equitable access for eligible adults and children to ART, OIs, and TB/HIV co-infection services but also to ensure quality of these services.

Goal

All eligible PLWHIV to receive quality treatment services for HIV/AIDS and opportunistic infections (OIs) as well as TB treatment services for PLWHIV co-infected with TB

Objectives

1. At least 80% of eligible adults (women and men) and 80% of children (boys and girls) are receiving ART based on national guidelines by 2015
2. At least 80% of PLHIV are receiving quality management for OIs (diagnosis, prophylaxis, and treatment) by 2015
3. All states and local government areas (LGAs) are implementing strong TB/HIV collaborative interventions by 2015
4. All TB suspects and patients have access to quality and comprehensive HIV and AIDS services by 2015
5. All PLWHIV have access to quality TB screening and those suspected to have TB, to receive comprehensive TB services.

Key Interventions

The key interventions for achieving treatment of HIV, OI and TB/HIV collaboration objectives include:

1. Advocacy to relevant stakeholders
2. Institutional and human capacity building
3. Establishment of new and upgrading of existing service delivery facilities
4. Improved commodities logistic management system
5. Quality assurance and quality improvement mechanisms for clinical and laboratory services
6. Integration and linkages of HIV/AIDS, TB and other related services
7. Monitoring and Evaluation system

Major Activities for the States

Major activities include:

1. **Advocacy:** Production of advocacy tools and materials and undertaking advocacy to relevant stakeholders to ensure support for effective funding and system strengthening
2. **Training and skills development:** Training of master trainers and health workers on adult ART, paediatric ART, laboratory services, referral, adherence/referral/drug refill issues; training of PLHIV, support groups and other community-based support system personnel on drug literacy and adherence
3. **Procurement of medical commodities and drugs:** including ARV drugs, drugs for OIs and TB, Isoniazid and cotrimoxazole for preventive therapy, and laboratory consumables/reagents
4. **Provision and maintenance of equipment** such as laboratory equipment (including those for haematology, chemistry, CD4 count, PCR machines, and early infant diagnosis facilities)
5. **Provision of treatment-related services:**

a. Establishment and activation of new service delivery point and /centres including construction and renovation of service centers and provision of furniture
b. Integration and linkage of HIV/AIDS services (ARV and management of OIs) with other related health problems including TB, RH, and malaria
c. Laboratory services
d. Pharmacovigilance and drug monitoring
e. Development of effective referral system

6. Monitoring and supervision of the quality of services

Other activities: These include establishing of public-private partnerships to improve access to treatment services, community sensitisation and establishment of support groups to promote adherence

Major Activities for government Ministries, Departments, and Agencies (MDAs)

Only three out of the twenty-three MDAs had activities on their plans under the treatment thematic area. These are Ministries of Health and Defense and the Police Force.

The common activities for the three MDAs include:

1. Capacity assessment to identify areas of gaps in service delivery
2. Training, including those focusing on ART management and adherence counselling
3. Procurement of medical commodities and drugs
4. Upgrading service facilities, including physical infrastructure and equipment
5. Provision of integrated services for HIV/AIDS and related health problems
6. Monitoring and supervision of quality of services

Other activities: These include provision of computers to improve logistics information management system, establishment of committee on monitoring and maintenance of medical commodities and equipments.

Major Activities for CSO Networks (Coordinating Entities)

The common activities for the networks include:

1. Advocacy: including those focusing on improved access to treatment and improvement in the quality of services
2. Training to improve skills in areas such as effective advocacy, counselling, adherence literacy promotion, partnership building and monitoring and education
3. Monitoring of access to and quality of services

Results Framework for Treatment Thematic Focus

Indicators	Baseline-Value (National)	Mid-term (End of 2012)	End of program (2015)	MOV	Comments
ARV Treatment					
Objective 1: At least 80% of adults (men and women) and all (100%) of children (boys and girls) have access to comprehensive quality HIV and AIDS treatment by 2015					
By the year 2015, 80% of women and men in need of HIV treatment are receiving treatment	32%	56%	80%	FMoH & NACA Reports	Disaggregate by: Age groups, sex Health facility (HF) level//State
By the year 2015, 80% of eligible children (boys and girls 0 –14yrs) are receiving HIV treatment	13%	56%	80%	FMoH & NACA Reports	Disaggregate by: Age groups (≤18 months; 19 months - 5years; 6-9 years; 10-14years), sex HF level /LGA/state
Opportunistic Infections (OIs)					
Objective 2: At least 80% of adults (men and women) and all children (boys and girls) on ART have access to quality management of OIs by 2015					
% of male and female PLHIV on ART that received OI prophylaxis (Cotrimoxazole prophylaxis)	54%	67%	80%	FMOH Report	
% of PLHIV (male and female) that received OI treatment	17%	40%	80%	FMOH Report	Disaggregate by sex, age, health facility (HF), LGA and State
TB and & HIV/AIDS					
Objective 3: To establish and strengthen TB and HIV/AIDS collaboration in all states and LGAs by 2015					
Proportion of states with functional and gender inclusive TBHIV TWG	23 of the 36 states and FCT	31 States	36 States and FCT	FMOH reports	Reports of meeting
Proportion of LGAs with functional and gender inclusive TBHIV TWG	TBD	At least 50%	774 LGAs	FMOH reports	Quarterly TBHIV data
Objective 4: To ensure all TB patients have access to quality comprehensive HIV and AIDS services by 2015					
Proportion of TB patients screened for HIV	62% (2008)	90%	95%	FMOH reports Facility TB and ART register	Disaggregate by : Sex Age Health facility level/LGA/State
Proportion of the TB/HIV patients receiv ing ART	45% (2008)	60%	80%	FMOH reports Facility TB and ART register	
Proportion of the TB/HIV patients receiving CPT	26% (2008)	70%	80%	FMOH reports Facility TB and ART register	
Proportion of the TB/HIV patients referred for HIV care	TBD	50%	80%	FMOH reports Facility TB and ART	
Objective 5: To ensure all PLHIV have access to quality comprehensive TB services by 2015					
Proportion of PLHIV on care screened for TB	87% (2008)	90%	100%	FMOH reports ART Registers	Disaggregate by : Sex Age State, LGA Health Facility, and level
Proportion of PLHIV with active TB referred for TB treatment	100% (2008)	100%	100%	Facility level ART registers FMOH reports	
Proportion of PLHIV receiving IPT	TBD	50%	100%	- FMOH reports	

CARE AND SUPPORT OF PLHIV, PABA, & OVC

Rationale

Over the last 5 years and buoyed by increasing access to effective ART, there has been a gradual change from the perception that HIV infection condemns one invariably to death to the reality that HIV/AIDS is a chronic illness requiring regular and sustained care and support. As the number of people infected and affected by HIV/AIDS rises, the burden of the epidemic on individuals, families and communities is increasingly evident, exacerbated by wide spread poverty. Some of the critical indicators of the social consequences of the epidemic are the increasing numbers of orphans and other vulnerable children (OVC) and a general stigmatization of and discrimination against PLHIV. Also, access to anti-retroviral treatment (ART) means that more PLHIV ar having longer and improved lives. This is a big challenge to the nation to provide the increasing care and support including palliative care for infected and affected persons. This challenge will continue for a very long time even when the epidemic is brought under control.

There are about 3 million PLHIV and 17.5million OVC, many of which are AIDS-related. There are millions more who are affected by the disease. Government recognizes not only the detrimental social and economic consequences of HIV/AIDS to the nation but also attaches great importance and is committed to providing care and support to PLHIV and to OVC, future of the nation. Civil society, especially community-based and faith-based organizations, has been the bedrock for the provision of care and support services to PLHIV, PABA, and to OVC. The continuation of civil society in this role is pivotal and will be strengthened during this NSP.

Goal

The goal of this thematic focus is to promote the survival and improve the quality of life of PLHIV and people affected by HIV/AIDS (PABA) especially OVC.

Objectives

The Objectives of the Care and Support services are:

1. To improve access to quality care and support services (as defined by national guidelines) to at least 50% of PLHIV by 2015
2. To link at least 50% PLHIV and PABA, especially females (women and girls) and marginalized and people with special needs, to IGA and poverty alleviation programs by 2015
3. To reduce stigma & discrimination targeted at PLHIV and PABA by at least 60% on baseline value by 2025
4. To support effective referral and linkages within and between relevant health care facilities and community-based care services improved by 80% by 2015
5. To create an enabling environment for the legal protection of OVC by 2015
6. To provide integrated comprehensive social support (as defined by national guidelines) to at least 30% OVC of most vulnerable OVC by 2015.
7. To strengthen the capacity of 30% of older OVC (especially girls) households to mitigate the impact of HIV/AIDS by 2015
8. To establish functional gender-responsive OVC coordinating mechanism at all levels by 2015

Key Interventions

The key interventions (strategies) for achieving PLHIV, PABA, and OVC objectives include:

1. Advocacy to relevant stakeholders, behavior change communication, community participation
2. Review/develop and disseminate national policies, standards and protocols for care and support services.

3. Institutional and human capacity building for States, MDAs and CSOs providing care and support services
4. Provision of integrated care and support services to PLHIV and quality services to OVC as contained in the OVC National Plan of Action.
5. Resource mobilization and fund allocation
6. Capacity building of service providers, policy makers, decision makers program planners, households, caregivers, and OVC
7. Capacity building on IGA programs targeted at PLHIV and PABA especially women, young girls and persons with special needs infected with HIV
8. Networking, coordination and collaboration
9. Policy Enforcement on Rights of PLHIV

Major Activities for NACA and States

Major Activities: Thirty-five (35) States and the FCT have developed their specific HIV/AIDS strategic plans for 2010-2015. The major activities for the states include:

1. **Coordination and supervision:** Coordination and supervision of the state HIV/AIDS care and support response activities
2. **Policy & Guidelines:** Support the implementation of national policies and guidelines on PLHIV, PABA, and OVC and operationalize guidelines for the provision of integrated services on health (Malaria, TB, STI, MCH, and RH services) and social needs (Health, Education, Psychosocial Support, Food and Nutrition, Protection, Shelter and IGA).
3. **Advocacy:** Meetings and consultations with key policy/decision makers and gatekeepers at State, LGA and community levels. Targeted advocacy at the state level include those to Ministry of Finance for budgetary support; Ministry of Women Affairs for OVC programming; the MDG Fund and State Poverty Eradication Project for poverty alleviation; State Directorate of Employment for employment opportunities; Ministry of Agriculture and Water Resources for support in agriculture and water supply; and Human Rights Commission, Police, and State Ministry of Justice for protection.
4. **Capacity building**
   a. Training & skills development: Training of service providers, community leaders, PLHIV, PABA, caregivers, OVC and volunteers especially on palliative care and OVC programming.
   b. Material resources: Improved access to material goods and infrastructure including equipment, food, medicines, and others
   c. Financial resources: Mapping, mobilization, allocation, tracking, and reporting
5. **Provision of HIV/AIDS HBC and palliative care:** SACA and partners will provide leadership and guidance for HBC and palliative care whilst the Ministry of Women Affairs and Social Development will do the same for social services. All States will engage in awareness creation, sensitization, behavior change communication, establishing linkages with and referrals to other services.
6. **Reporting:** All states will produce state HIV/AIDS Reports and forward these to NACA as well as widely disseminate the reports within the states.

Other Activities: These include establishing effective supply chain management systems; identification of and partnering with other stakeholders especially viable CSOs; making grants to CSOs and other implementers, and study tours to successful care and support projects.

Major Activities for the MDAs

Nineteen MDAs have developed sector- specific HIV/AIDS strategic plans for 2010-15. Key sectors with Strategic Plans include Ministries of Health, Education, Women Affairs and Social Development (responsible for OVC), Agriculture and Water Resources; and Defense and Police.

The *Major activities* for the MDAs include:

1. **Coordination and supervision:** Coordination and supervision of sector-wide HIV/AIDS care and support response
2. **Policy & Guidelines:** Develop/review sector policies and guidelines on PLHIV, PABA, and OVC; develop/review guidelines for the provision of integrated health services (Malaria, TB, STI, MCH, and RH services) and social services including Education, Psychosocial support, Food and Nutrition, Protection, Shelter and Income Generating Activities.
3. **Advocacy:** Meetings and consultations with key policy/decision makers and gatekeepers at national and other levels as appropriate. Targeted advocacy include those to Federal Ministry of Finance for budgetary support, FMoWA for OVC programming, MDGs and NAPEP for poverty alleviation, NDE for employment initiatives, FMA&WR for support in agriculture and water supply, Human Rights Commission, Police, NAPTIP and Federal Ministry of Justice for protection.
4. **Capacity Building:**
   a. Training & skills development: Training of Trainers especially on palliative and OVC care.
   b. Material resources: Improved access to material goods including equipment and other goods
   c. Financial resources: Mapping, mobilization, allocation, tracking, and reporting
5. **M&E**: Impact of HIV/AIDS on the specific sectors especially health, education, and security agencies.
6. **Provision of HIV/AIDS HBC and Palliative Care**: FMoH and Ministry of Defense will provide leadership and guidance for HBC and palliative care whilst the Ministry of Women Affairs and Social Development will do the same for social services. All MDAs will engage in awareness creation, behavior change communication, and establishing linkages with and referrals to other services.
7. **Reporting:** All MDAs will produce sector-wide reports and send these to NACA as well as widely disseminate the reports within the sector.

Major Activities for the CSO Networks

Major activities include:

1. Coordination and supervision of members and networking with other stakeholders.
2. Policy and guidelines development for care and support response for PLHIV, PABA and OVC.
3. Advocacy to donors and partners, government representatives, and communities at all level.
4. Capacity building for network members on care and support for PLWHAs, PABA and OVC.
5. Resource mobilization
6. M&E of programs and members response to Care and Support.
7. Reporting on CSO network response to HIV/AIDS to NACA as well as widely disseminating the reports among the networks.

Other activities include mapping of relevant CSOs in Care and support response for PLWHA, PABA and OVC and organizational capacity and need assessment of members.

CARE AND SUPPORT RESULTS FRAMEWORK

Indicators	Baseline Value (National)	Mid-term (End 0f 2012)	End of Program (2015)	MOV	Comments
Objective 1: To improve access to quality care and support services (as defined by national guide lines) to at least 50% of PLHIV by 2015					
% of PLWHIV receiving quality care and support services (as defined in national guidelines)	TBD	30% increase on baseline value of PLHIV receiving care and support	60% increase on baseline value of PLHIV receiving care and support	Reports of CSOs, support groups, and other service providers	Desegregated by sex
Proportion of states providing quality care and support services	TBD	40% of the LGAs are covered with C&S services.	80% of the LGAs are covered with Care and support services.	State Reports; Reports of Ministry of Women Affairs; Lists of location of service outlets	Geographical distribution of service outlets
% of caregivers providers trained to provide care and support	TBD	40% of caregivers trained to provide care and support	At least 80% of caregivers trained to provide care and support	Reports of CSOs, support groups, and other service providers	Care providers include health care and non health care workers as well as community volunteers, NGOs and CBOs
National care and support policies, standards, and protocols reviewed/developed and disseminated by 2012	TBD	Policies, standards, and protocols developed and disseminated		Copies of Standards and protocols developed and disseminated	Guidelines, action plans or strategic framework etc
% of service outlets adhering to national standards and protocols	TBD	At least 40% of service outlets adhere to national protocol and standards	At least 80% of service outlets adhere to national protocol and standards	M&E reports, client satisfaction forms	Operational Research
% of PLHIV and PABA especially women, marginalized groups and people with special needs with improved source of livelihood	TBD	At least 20% target groups have skills and accessing microcredit.	At least 40% target groups have skills and accessing microcredit.	National studies reports	Source of data can be from NARHS, Human Development Reports
Objective 2: To link at least 50% PLWHIV and PABA, especially females (women and girls) and marginalized and people with special needs, to IGA and poverty alleviation programs by 2015					
% of PLWH, PABA especially women, marginalized groups and people with special needs enrolled for skill acquisition programs	TBD	At least 15% of target groups graduate from IGA skills training	At least 40% of target groups graduate from IGA skills training	Training Reports with participants List of beneficiaries disaggregated by sex. Copies of Certificates of participants trained	
% of PLHIV, PABA especially women, marginalized groups and people with special needs linked with IGAs and poverty reduction programs	TBD	At least 25% of target groups linked with IGAs services and poverty reduction programs	At least 50% of target groups linked with IGAs services and poverty reduction programs	Reports of IGA service providers and poverty reduction programs	Disaggregated by sex
Objective 3: To reduce stigma and discrimination targeted at PLWHIV and PABA by at least 60% on baseline value by 2015					
% of PLHIV and PABA who report suffering stigma and discrimination	TBD	30% reduction on baseline value	At least 60% on baseline value	National Surveys and analysis of M&E reports	Mid term and End of Term reports; IBSSS
% health facilities with effective referral and linkages with community based care programs for PLHIV and PABA.	TBD	40% health facilities have effective referral and linkages with community based health care programs for PLHIV and PABAs	80% health facilities have effective referral and linkages with community based health care programs for PLHIV and PABAs	Health facility records and reports of community based programs for PLHIV and PABA -	

CARE AND SUPPORT RESULTS FRAMEWORK

Objective 4: To improve effective referral and linkages within and between relevant health care facilities and community - based care services by 80% by 2015					
To support effective referral and linkages within and between relevant health care facilities and community-based care services improved by 80% by 2015		40% health facilities have effective referral and linkages with community based health care programs for PLHIV and PABAs	80% health facilities have effective referral and linkages with community based health care programs for PLHIV and PABAs	Health facility records and reports of community based programs for PLHIV and PABA	40% health facilities have effective referral and linkages with community based health care programs for PLHIV and PABA
Objective 5 To create an enabling environment for the legal protection of OVC by 2015					
OVC legal framework revised or developed	TBD	Legal framework developed and implemented			Existence of legal frameworks
Proportion of OVC requiring legal protection provided with legal aid	TBD	15% increase on baseline value	15% increase on baseline value	Legal records. Reports of service organizations; Reports of Ministry of Women Affairs	Disaggregate by sex and age and type of services.
Proportion of OVC services provider organizations trained on and using legal documents by 2015	TBD	20% increase on baseline value	At least 60% on baseline value	Reports of OVC services provider organizations National surveys	Disaggregate by type of service provider
Objective 6: To provide integrated comprehensive social support (as defined by national guidelines) to at least 30% of most vulnerable OVC by 2015)					
% of OVC who have access to integrated comprehensive care and support services	TBD	15% increase on baseline value	30% increase on baseline value	Service records and reports of service providers; Reports from Min of Women Affairs	Disaggregate by sex, type of support, and types of orphanhood and vulnerability.
Objective 7: To strengthen the capacity of 30% of older OVC (especially girls headed households) to mitigate the impact of HIV/AIDS by 2015					
% of households with OVC whose capacity has been strengthened	TBD	15% increase on baseline value	30% increase on baseline value	Service records and reports of service providers; Reports from Min of Women Affairs	Disaggregate by household heads-sex, age, marital status
% of primary caregivers economically empowered	TBD	15% on baseline value	30% on baseline value	Record of activities and reports	Disaggregate by sex, age & type of empowerment
% of community based initiatives economically empowered	TBD	15% on baseline value	30% on baseline value	Record of activities and reports of CBOs	Disaggregate by type of initiative.
Objective 8: To establish and/or strengthen OVC coordination structures at all levels					
Proportion of OVC coordination structures established/strengthened	TBD	5% increase on baseline	5% increase on baseline	Report of LGAs/states/Min of Women Affairs	Disaggregate by type and level
Proportion women in the coordination structure	TBD	At least 35% of women	At least 35% of women	List of members	Disaggregate by sex

POLICY, ADVOCACY, HUMAN RIGHTS, & LEGAL ISSUES

Rationale

Despite compelling evidence that reducing stigma, promoting and protecting human rights, promoting greater involvement of PLHIV and gender mainstreaming strengthen HIV/AIDS control; Nigeria's achievements in this regard remain slow and hesitant. More than two decades after the identification of the first case of HIV in Nigeria, violation of human rights of persons infected and affected is still rampant and stigma remains pernicious and pervasive. This situation is compounded by attitudes and practices which discriminate against widows and persons orphaned by AIDS. Furthermore, the approach of the national response under the last NSF appears to accentuate the differential access to information, services and participation by marginalized segments of the population and those with high vulnerability to HIV infection including women, young people, and persons who engage in transactional sex or same sex relationships. These situations call for stronger focus on advancing human rights in the context of the national response, demanding, among others, vigorous promotion of relevant policy and legal frameworks.

Goal

To protect the rights of PLHIV and PABA and empower them and other groups made vulnerable by HIV/AIDS so as to reduce their cultural, legal, and socioeconomic vulnerabilities and ensure their full participation in the national HIV/AIDS response and other development initiatives.

Objectives

1. Protection of the rights of and empower PLHIV
2. Ensure equitable increase in participation of PLHIV in decision making processes at all levels.
3. Protect women, children and other socially vulnerable and marginalized groups from HIV Infections
4. Advocate for the progressive increase in government's funding of HIV/AIDS response at all levels to at least 30% by 2015
5. Ensure compliance with existing guidelines on ethical standards on HIV/AIDS issues

Key interventions

1. Capacity building on strengthening program linkages between HIV and human rights issues
2. Advocacy to stakeholders
3. Sensitization and public education
4. Partnership-building and networking
5. Development of policy framework

Major Activities for NACA and States

Major activities: The major activities for the states include:

1. Capacity building: includes training on research ethics and those aimed at improving skills in linking HIV programming and human rights issues, enhance gender-responsiveness in programming, and ensure transparency and accountability in resources management,
2. Advocacy: focusing, among others, on enhancing the capacity of NACA, SACAs and LACAs; sustained political support for and increased budgetary allocation and release to SACAs, LACAs and other implementing structures under the state jurisdiction; progressive increase in government funding of HIV/AIDS response at state and LGA levels; institutionalization of transparency and accountability monitoring mechanisms; passage of relevant laws, including anti-discrimination bills; and increasing development and economic opportunities for PLHIV and PABA including

building linkages with NAPEP and NDE. Advocate to MDAs to implement the policy of dedicating 1% ofannual budgetary allocation to HIV/AIDS activities.

3. Development of policy and guidelines on human rights issues and establishment of committees for enhancing policy implementation; translate National HIV Policy into local languages including Hausa, Yoruba, Igbo, and Pidgin English.
4. Establishment and funding of regular periodic meeting of relevant committees and structures, including partnership forums, research and ethics committee and gender-related bodies.
5. Sensitization seminars for religious and traditional leaders and media houses to encourage removal of cultural and traditional barriers/practices that impede access to relevant HIV/AIDS-related information/services or practices that violate the human right of PLHIV and PABA

Other Activities: These include provision of economic support for PLHIV, promotion of family life and HIV education for young people, and support of youth-friendly centers, and production of educational materials.

Major Activities for the MDAs

Nineteen MDAs have developed sector- specific HIV/AIDS strategic plans for 2010-15. Key sector plans include those of the Ministries of Health, Education, Women Affairs and Social Development, Defense, Agriculture and Water Resources; Information, and National Youth Service Corps

The *major activities* for the MDAs include:

1. Develop capacity building plan, based on the results of needs assessment and gap analysis
2. Training of relevant stakeholders on
3. Developing information, education and communication (IEC) materials
4. Sensitization programs on human rights and policy issues, including workshops and seminars
5. Production and dissemination of the existing national guidelines on ethical standards and practices regarding HIV/AIDS
6. Establish research ethics board at MDA level
7. Organize periodic meetings of relevant partnership forums
8. Advocacy: at sectoral and multi-sectoral level, including those targeted at NAPEP, NDE and Microfinance institutions to enhance employment and economic opportunities for PLHIV

Other activities include production of media-based sensitization programs and production of relevant policy documents on workplace stigma and discrimination issues

Major Activities for the CSO Networks

Major activities include:

1. Advocacy to relevant key stakeholders at various levels to: increase and sustain political support for coordinating structures; increase support for human rights issues and HIV/AIDS-related policies and program implementation; and domestication/passage of relevant laws including the domestication of the protocol on African Charter on the Rights of Women, and Anti-discrimination bill.
2. Training of trainers, focusing on network members, to advance policy, legal and human rights issues
3. Development of advocacy tools and materials.
4. Sensitization of members and public education.
5. Monitoring and reporting on CSO network response with regards to policy advocacy and human rights issues.

Other activities include facilitation of inclusion of economic empowerment issues for PLHIV in various stakeholders' programs and organizing annual dialogue on HIV/AIDS response

POLICY, ADVOCACY, HUMAN RIGHTS, AND LEGAL ISSUES RESULTS FRAMEWORK

Indicators	Baseline value (National)	Mid-Term (end of 2012)	End of program (2015)	MOV	Comments
Objective 1: To advocate for the protection of the rights of and empower PLHIV					
% PLHIV networks who report their rights are protected and they are empowered	TBD	TBD	100%	NARHS and NDHS reports; Reports of other national surveys	
Objective 2: To facilitate the greater involvement of PLHIV on HIV/AIDS decision making bodies at all levels of the national response					
Proportion of HIV/AIDS decision making bodies with PLWHIV representation	TBD	TBD	100%	Reports of stakeholder organizations; Reports of special surveys	
Objective 3: Protect women, children and other socially vulnerable and marginalized groups from HIV Infections					
% Decrease in HIV new infections among vulnerable groups	TBD	25% on baseline	50% on baseline	NARHS and NDHS reports; Reports of other national surveys	
Objective 4: To advocate for the progressive increase in funding HIV/AIDS response at all levels of government					
% of government contribution to total HIV/AIDS spending	7%	15%	30%	National AIDS Spending Assessment (NASA) Report	
Proportion of sector policies that provide response for the mitigation of impact of HIV/AIDS	TBD	50%	100%	Sector policies documents	
Objective 5: To advocate for compliance with ethical standards on HIV/AIDS					
Proportion of organizations complying with ethical standards	TBD	TBD	100%	Reports of service provider organizations; Reports of special studies	

INSTITUTIONAL ARCHITECTURE, SYSTEMS, AND RESOURCING

Rationale

Despite achievements towards control of HIV/AIDS the epidemic continues to pose significant challenges to national development. While the response has experienced increased inflow of resources from government and development partners, significant funding and resource gaps still exist. Also, the national response is largely donor dependent and for most part, donor driven. At the state level, political commitment remains consistently weak; many states seldom provide financial allocation to HIV/AIDS activities, beyond the counterpart funding to World Bank MAP funds. Many federal ministries, parastatals and agencies are also very much dependent on World Bank funds for their HIV/AIDS programs. The global financial meltdown signals reduction in financial contributions by development partners. As such, Nigerian governments and citizens should assume greater responsibility for scaling up and sustaining HIV/AIDS response. Present realities compel urgent review and realignment of the institutional framework, coordination mechanisms and resource mobilization and application for the national response.

Besides financial resources and physical infrastructure, availability and capability of human resources are pivotal to sustainability of HIV/AIDS response. Although it is generally agreed that Nigeria has a good supply of health professionals, compared with other countries in the sub-region, there are wide regional disparities and the vast majority are urban-based. It is also true that the HIV/AIDS epidemic has significantly increased pressures on health care delivery systems that are already overstretched. While, in general, the numerous strands of human resource needs of the national HIV/AIDS response are appropriately addressed within thematic areas, critical elements of the human resource needs are at once generic and cross-cutting.

The gender dimensions of Nigeria's HIV/AIDS epidemic is well articulated and though the NSF mainstreams gender in all thematic areas, personnel with expertise in gender mainstreaming and the use of rights-based approaches are few. The need to institute Gender Management Systems in all SACAs, LACAs, line Ministries and other coordinating bodies (following the example of NACA) cannot be over-emphasized.

Goal

The goal of the thematic focus is to **s**trengthen structures and systems for the coordination of a sustainable and gender-sensitive multisectoral HIV/AIDS response in Nigeria. The NSP will focus on strengthening

1. Institutional arrangements and coordinating mechanisms
2. Human Resources
3. Procurement and logistics management systems
4. Financial Resources

1. **Institutional Arrangement and Coordination Mechanisms**

Objective 1:

NACA, SACAs and LACAs capacity to effectively coordinate sustainable and gender-sensitive and age-responsive multisectoral HIV/AIDS response at National, State and LGA respectively strengthened.

This objective responds to critical organization capacity, alignment of roles and responsibilities and the capacity of public sector institutions with coordination mandate to effectively lead HIV/AIDS responses in

their constituencies. Also it seeks to address critical capacity shortfalls in these entities in particular at the states and local levels where the roles of LACAs which are the weakest links in the national response should be reviewed, redefined and resuscitated.

Key Interventions

Key Interventions for the achievement of this objective focus are two pronged. The first level of initiatives shall strengthen the capacities of NACA, SACAs LACAs. In this regard key interventions include capacity assessment and development of institutional capacity building plans by these entities. Also, it includes the upgrade of SACAs to agencies and the establishment of LACAs in local government councils where they do not exist. The second level of interventions is designed to strengthen program, financial, gender and other management systems at all levels. Significantly all States are to strengthen capacity of LACAs which presently are the weakest links in the national response. The third level of interventions shall establish, maintain and sustain interactive platforms that positions NACA, SACAs and LACAs to effectively coordinate their constituency stakeholder activities

Major Activities for NACA

The major activities for NACA include coordinating the HIV/AIDS national response including activities of SACAs and LACAs, the MDAs, Development Partners, the private sector, and the CSO networks. Additionally, NACA will provide leadership and coordination for the development of HIV/AIDS related policies and guidelines and resource mobilization at the national level as well as coordinate and supervise the implementation of the GFATM Rounds 5 and 9 HIV grants for which it is the principal recipient and manage the World Bank Multi-Country HIV/AIDS Program (MAP) funds.

Major Activities for the States

Major Activities by States include trainings in key HIV program and financial management for LACA, monitoring and supervision of LACA, and institution of regular SACA/NACA meetings, collaborative meetings between SACA, LACA and CSOs to conduct capacity needs assessment.

Other activities include advocacy to stakeholders including policy makers, media, corporate organizations, and development of tools.

Major Activities for the MDAs

Major Activities by 23 MDAs, including the Nigerian Armed Forces, Police, Customs, Prisons and Immigration include, capacity assessment, development of organizational capacity building plans, strengthening of program and gender mainstreaming capacities and cascade staff trainings to improve HIV/AIDS programs in their institutions.

Major Activities for CSO Networks

Major Activities include development or review of capacity building plans and manuals, provision of technical assistance to national, zonal and state offices to implement capacity building plans. Also it includes advocacy to facilitate the establishment of network permanent office complexes at national, state and LGAs. Furthermore, networks shall conduct advocacy to policy makers in state where SACA have not transformed into agencies.

Other activities are training of constituencies on program and financial management and the establishment and coordination of regular CSO meetings with NACA, SACA, and LACA.

Objective 2

Strengthened coordination mechanisms of development partners at all levels, National State and local government to harmonize support to the national response.

This objective seeks to improve coordination of the multisectoral, multilevel, and diverse activities in the national response by clarifying roles and responsibilities of development partners to optimize comparative

advantages of all stakeholders and forge synergies that enhance their contributions to HIV/AIDS service delivery.

Key Interventions
Key Interventions include creation of partnerships and interactive platforms, advocacy to partners, the establishment of communication and information sharing networks at multiple levels, and structured meetings with development partners.

Major Activities for NACA
The major activities for NACA include creating partnerships at the national level and facilitating the creation of partnerships at the state and LGA levels by SACAs and LACAs respectively. At the national level, important partnerships include those with the private sector through Nigeria Business Coalition Against AIDS (NIBUCAA), the HIV/AIDS Development Partners Group, and the CSO networks.

Major Activities for the States
Major Activities include development of partners' forum, establishment of and support for technical working groups, and quarterly meetings with development partners.

Major Activities for MDAs
Major Activities include commitment to develop database of sector specific partners at all operational points, develop and disseminate terms of reference for partnership forum and conduct meetings of same.

Major activities for CSO Networks
The only common activity in this regard is the strengthening of CSO Constituency Coordinating Entities (CCE) coordination platforms.

Objective 3
Strengthened coordination mechanisms of CSO at all levels, National State and Local Government and position CSO for enhanced services
The overarching aim of this objective is to strengthen collaboration between civil society organizations and critical institutions of state and non-state players in the national HIV/AIDS response.

Key Interventions
The first level of interventions is designed to establish or re-organize existing framework for program interfaces between CSO and coordination institutions at all levels. Specifically, they include structured interactive platforms; namely, NACA/CSO, SACA/CSO and CSO/ Line ministries platforms and the creation of framework for SACA/LACA-CSO partnerships to promote integration of CSO activities into state and LACA programs. The second level of interventions support capacity building of CSO, mobilizes funds for collaborative activities and institute mechanisms for monitoring CSO activities.

Major Activities for NACA
The major activities for NACA are to facilitate the strengthening of the coordination functions of CSO networks and enhancing HIV/AIDS services delivery by CSO networks' affiliates at the state and LGA levels through capacity building (training, resource mobilization, and funding). NACA will focus greater attention to gender-focused CSO networks such as the National Women Coalition against AIDS (NAWOCA)

Major Activities for States
Major Activities are establishment of technical working groups for CSO and interactive platforms between CSO and SACAs including quarterly review meetings.

Major Activities for CSO Networks

Major activities include the development and dissemination of a national database on CSO, training for CSO on effective project reporting, joint state proposal development meetings and advocacy to governments to enhance financial support for CSO activities. Other activities are review meetings between CSO and organized stakeholder groups including development partners, PLHIV Support groups, and with SACA/Line Ministries and SACA/CSO Networks

2. Human Resources

Rationale

Besides financial resources and physical infrastructure, availability and capability of human resources are pivotal to sustainability of HIV/AIDS response. Although it is generally agreed that Nigeria has a good supply of health professionals, compared with countries in the sub-region, there are wide regional disparities and the vast majority of healthcare providers are urban based. It is also true that the HIV/AIDS epidemic has significantly increased pressures on health care delivery systems that are already overstretched. In general, the numerous strands of human resource needs of the national HIV/AIDS are appropriately addressed within other themes of the response. However, critical elements of human resource gaps are at once generic and cross-cutting.

The HIV Policy assigns the cardinal role of facilitating and coordinating human resource development for the national response to NACA, and by interpretation to SACAs and LACAs. These structures are mandated to:

Build and strengthen human capacity for effective management of national response.

Build human resource capacity at all levels to leverage and effectively manage resources for service delivery.

Objective 4

Ensure that at least 80% of HIV/AIDS programs have adequate number of appropriately skilled and gender and age-responsive personnel

The aims of this objective are to build and support systems for training a critical mass of skilled staff for effective HIV/AIDS service delivery and address the high attrition rate of health personnel. To the extent possible, these interventions shall address shortage of trained health professionals, strengthen capacities at the state and local government tiers and reduce regional disparities in human resource capacity.

Key Interventions

Overall, interventions for the achievement of this objective are designed to strengthen healthcare delivery systems at many levels. Specifically the interventions are:

(i) ensure that at least 80% of HIV programs have adequate number of appropriately skilled gender responsive personnel,
(ii) develop sustainable system for training and re-training staff,
(iii) develop retention strategy and task-sharing approaches for trained HIV/AIDS personnel,
(iv) develop innovative and sustainable capacity building mechanisms to link HIV/AIDS with other related health programs,
(v) develop and implement human resource plan for the sector and build sustainable systems for human resource capacity building in management and leadership (vi) develop human resource management information systems.

Major Activities for NACA
NACA will collaborate with and support stakeholder organizations providing HIV/AIDS healthcare services in the country i.e. Ministries of Health and Defense and the Police Force as well as private-for profit and private-not-for-profit service providers operating health facilities that provide HIV/AIDS services in the country.

Major Activities for the States
The States shall train SACAs and LACAs and civil society organizations, health service providers and establish HRIMS and build capacity of these entities to use HRMIS.

Major Activities for the MDAs
Key institutions with strategic and ramifying constituents across the country such as; Armed Forces, Customs, Immigration, and Prisons Services are critical for the achievement of this objective Activities of these critical institutions include: human capacity needs assessment, development of human resource plans, development of training tools and curricula which integrate HIV/AIDS into pre-service trainings of non-health workforce and multiple cascade trainings. It also includes review and modification of policies as well as the development of advocacy plans and appropriate advocacy to decision makers.

Major Activities for the CSO Networks
Networks shall create database on membership and activities and standardize, harmonize and distribute training curricula at all levels. Also they shall develop training plans based on assessment, and training including trainings on research methodology, program management and gender mainstreaming and rights based approach to HIV/AIDS programs.

3. Procurement & Logistics Management Systems

Rationale
Nigeria's HIV/AIDS response has undergone quantum expansion in recent times to the extent that the surge of donors, the geographic spread and the complexity of programs continue to exert unprecedented pressure on already weak Procurement and Supply Management (PSM) systems. For the most part, the deluge of donor initiatives has not guaranteed continuous commodity financing. Furthermore, differences in funding cycles of key development partners seldom translate to long-term commodity security. Presently, diverse and often disparate programs across the country have generated fragmented and unsustainable parallel logistics systems.

The HIV/AIDS policy objective is to strengthen logistics management system to facilitate sustainable supply of drugs, laboratory materials, and other commodities.

Objective 5
Efficient and sustainable logistics systems for uninterrupted supply of ARVs, drugs for the management of opportunistic infections and other HIV/AIDS-related commodities operational by 2015

This objective responds to weak coordination mechanisms between national and state governments in the management of centrally funded commodities, poor product forecasting, limited evidence base of procurement decisions and poor warehouse infrastructure. It also addresses procurement cycles which are dependent on donor procurement practices. In all, these challenges have limited access of rural and underserved communities to drugs and other HIV/AIDS commodities.

Key Interventions
Key interventions designed to address these challenges include: survey and review of national forecasting and quantification systems, establishment of a national HIV/AIDS procurement and supply management steering committee and technical working group, rehabilitation of central and peripheral medical warehouses, multiple level logistics management trainings and the development of a unified HIV/AIDS commodities distribution system.

Major Activities for NACA
NACAs major activities include maintaining a robust national forecasting and quantification system, set-up national steering committees and technical working groups (TWGs), and facilitate the rehabilitation of warehouses and the unification of HIV/AIDS commodities distribution system especially for the ART program..

Major Activities for the States
The States are committed to establish and support national steering committee and technical working group on HIV/AIDS commodity procurement and logistics management. Other activities are advocacy to key development partners and suppliers to adopt unified HIV/AIDS commodities distribution system and needs assessment and upgrade or establishment of central warehouse in all states. Other activities are development of training tools for training various cadres of logistics managers and the development of logistic management information systems.

4. Financial Resources

Rationale
Despite recent improvements in federal government financial contributions, HIV/AIDS response remains largely donor dependant. For example, PEPFAR supported 83 percent of ART provision in 2007. Furthermore, it is estimated that full implementation of the national HIV/AIDS program in 2009 would cost $453.6 million. Of this amount, the resource need of $342.1 million was met, leaving a shortfall of $111.1 million, a resource gap that shall significantly increase over the next five years. Yet, domestic sources account for only 5 % of resources needed; with vast pools of private sector resources still largely untapped. It is noteworthy that many states actually made zero allocation for HIV/AIDS activities in 2009 and it is extremely difficult to track public sector contributions in the absence of comprehensive financial data.
The overarching aim of this objective is to leverage increased political and resource commitment to the national response by all stakeholders while ensuring stewardship, transparency and accountability for all resources allocated for the national response.

Objective 6
Increase in the financial contribution of governments at all levels to at least 30% of financial resources required for HIV/AIDS interventions by 2015

Key Interventions
The key interventions include advocacy efforts allocate and approve increasing amounts of annual budgetary support to HIV/AIDS activities to federal, state, and local governments and to ensure all budgeted allocations are released in a timely manner for the approved activities.

Major Activities for NACA, SACAs, and LACAs
Carry out advocacy engagements to create awareness and sensitize key ministries and officials with decision making powers for financial allocations and budgetary control to understand the need and allocate funding for HIV/AIDS activities at the federal, state, and LGA levels through dedicated HIV/AIDS budget lines: Legislators and Senators, Ministry of Finance, State Governance, and LGA Chairmen

Objective 7

To mobilize additional financial resources from non-government sources in support of the implementation of the national HIV/AIDS response

Key Interventions

Key interventions are partnership building including strengthening public-private partnerships, strengthening resource mobilization mechanisms and operationalizing the Joint Funding Agreement.

Major Activities for NACA

At the national level, NACA will spearhead the strengthening of the public-private sector partnerships, establishment of partnerships with development partners (bilateral and multilateral agencies and the UN system) including operationalizing the Joint Funding Agreement (JFA) with development partners, and leading the development of HIV/AIDS proposals for funding by the Global Fund.

Major Activities for the States

The major States activity towards achievement of this goal is to strengthen existing partnership with development and private sector partners on mobilizing additional resources. Other activities include establishment of advocacy units and engage advocacy staffs.

Objective 8

To progressively improve the effectiveness of HIV/AIDS resource tracking and enhance the efficiency of fund management for HIV/AIDS programs

Key Interventions

Key Interventions are (i) capacity building on financial management (ii) establishment of pro-active budget tracking methods(,iii)documentation and dissemination of resource tracking results (iv) advocacy to key political and decision makers so that budget tracking outcomes improve financial management and (v) integration of HIV/AIDS issues into budgetary process.

Major Activities for NACA

NACA will support the capacity building efforts for SACAs; develop and institutionalize HIV/AIDS budget tracking tool for use by all stakeholders, undertake HIV/AIDS Program Sustainability Analysis (HAPSAT), and carry out National AIDS Spending Assessment (NASA).

Major Activities for the States

States shall conduct advocacy to Executive Council and the Ministry of Finance for budget and planning and decision makers of other key ministries and institutions. Furthermore, they shall advocate for integration and tracking of costs for HIV/AIDS activities into line ministries' budgets.

Major Activities for the MDAs

These entities shall develop budget tracking tools and support activities budget tracking committees. Also, MDAs shall compile, document and disseminate resource tracking outcomes and conduct advocacy to decision makers at national, state and local levels.

Major Activities for the CSO Networks

Networks shall develop comprehensive database on HIV/AIDS resources, create budget tracking tools, conduct trainings on budget tracking and financial and management and train budget tracking focal persons at all levels,. Also they shall constitute task teams to track budget implementation and conduct advocacy to key institutions. They shall also conduct stakeholders meetings with corporate organization on funding opportunities. In addition networks dialogue with key development partners.

INSTITUTIONAL ARCHITECTURE, SYSTEMS, & RESOURCING RESULTS FRAMEWORK

Indicators	Baseline Value (Year)]	Mid-term (End of 2012)	End of program (2015)	Means of Verification	Comments
Institutional Coordination Mechanism					
Objective 1: NACA, SACA and LACAs capacity to effectively coordinate sustainable and gender - sensitive multi-sectoral HIV/AIDS at National, State and LGA respectively strengthened					
% of NACA's annual operational funds that is provided by the government	TBD	TBD	TBD	NACA Reports NASA Reports	
% of states that have coordinating body as agency	33%	67%	80%	NACA Reports	Disaggregate membership of coordinating body by sex
% of SACAs that received at least 80% of government budgeted funds for HIV annually	TBD	40%	80%	SACA Reports	
Proportion of women and men occupying decision making positions in the coordination structures (NACA, SACA, LACA etc)	TBD	At least 35% women in line with the National Gender Policy	At least 35% women National Gender (Policy)	Staff list Organogram	Desegregate by sex and position
Proportion of SACAs, LACAs, line Ministries and other coordinating bodies with Gender Management Systems (GMS) established and functional	NACA; Some SACAs and MDAs have Gender Focal points	25%	50%	SACA, LACA, and MDA Reports	Desegregate by the type of coordinating body
% of LGAs that have functional LACAs	19.5%		50%	80%	Disaggregate data by States
Objective 2: Strengthened coordination mechanisms of development partners at all levels (national, state, and local government levels) to harmonize support to the national response.					
% of SACAs and line ministries submitting report to NACA at least twice a year	TBD	50%	100%	NACA Reports	
% of civil society constituency coordinating entities submitting report to NACA at least twice a year	TBD	50%	100%	NACA Reports	
% of LACAs submitting reports to SACA at least twice a year	TBD	50%	100%	State Reports	
% of international development partners submitting report to NACA at least annually	TBD	40%	80%	NACA Reports	
% of development partners that are operating in line with the Joint Financing Agreement	TBD	30%	80%	NACA Reports	
Objective 3: Strengthened coordination mechanisms of CSO at all levels					
Proportion of CSO coordinating entities implementing at least 80% of annual work plan.	TBD	TBD	TBD		Disaggregate data by federal, state and local government.
Human Resources					
Objective 4: Ensure that at least 80% of HIV/AIDS programs have adequate number of appropriately skilled and gender - responsive personnel					
% of health facilities offering HIV/AIDS services that have adequate human resources according to set national standards	TBD	40%	80%	Facility survey report NACA report	Disaggregate data by sex, level of care, types of HIV/AIDS-related services, and states
Proportion of partners' reports reflecting gender sensitive programming	TBD	50% of all reports	80% of all reports	NACA report, partners' reports	Desegregated by sex and type of partners
Proportion of key NACA, SACA, LACA, key partners' staff trained in Gender and HIV/AIDS programming.	TBD	40%	80%	NACA report, Partners' report	Desegregated by sex and type of organization
Logistics Management System					
Objective 5: Efficient and sustainable logistics systems for uninterrupted supply of ARVs, drugs for the management of opportunistic infection and other HIV/AIDS-related commodities operational by 2015.					
% of facilities that experienced no stock-out of ARVs annually	TBD	60%	At least 80%	Health facility reports	

INSTITUTIONAL ARCHITECTURE, SYSTEMS, & RESOURCING RESULTS FRAMEWORK

% of facilities that experienced no stock -out of drugs for management of opportunistic infections annually	TBD	60%	At least 80%	Health facility reports	
% of facilities that experienced no stock -out of male and female condoms	TBD	60%	At least 80%	Health facility reports	Disaggregate data by level of care and types of condom
Financial Resources					
Objective 6: Increase in the financial contribution of governments at all levels to at least 30% of financial resources required for HIV/AIDS interventions by 2015					
% of government's contribution to total HIV/AIDS spendi ng annually	7% (2008)	15%	30%	National AIDS Spending Assessment (NASA) report	Disaggregate by federal, state, and local government
Objective 7: To mobilize adequate financial resources in support of the implementation of the national HIV/AIDs response					
% of the annual funds required by the costed National Strategic Plan that is realized	TBD	TBD	TBD	National AIDS Spending Assessment (NASA) report	Disaggregate data by the sources for fund – government, private enterprises, and international development partners
Proportion of HIV/AIDS budgets addressing gender gaps			At least 60%		Desegregated by donor and location
Objective 8: To progressively improve the effectiveness of HIV/AIDS resource tracking and enhance the efficiency of fund management for HIV/AIDS programs					
% of HIV/AIDS-related funds that is expended in program management	TBD	TBD	TBD	National AIDS Spending Assessment (NASA) report	Disaggregate data by type of organization and level of government
% of HIV/AIDs program implementers whose funds management is tracked annually	TBD	TBD	TBD	National AIDS Spending Assessment (NASA) report	Disaggregate data by type of organization and level of government

MONITORING & EVALUATION SYSTEMS

Context and Rationale

A functional and effective monitoring and evaluation (M&E) system serves to provide the data needed to guide the planning, coordination, and implementation of the HIV response; assess the effectiveness of the HIV response; and identify areas for program improvement. It also enables enhanced accountability to those infected or affected by HIV/AIDS, as well as the funders. However, the effectiveness of the M&E system is itself dependant on the seamless and systemic integration of the components of its organizing framework. Twelve components, including HIV evaluation, research and learning have been recognized in this respect. The M&E system of the NSF and NSP thereby covers both the "M&E" and the "Research and Knowledge Management" thematic areas of the National HIV/AIDS Policy (2010-15).

The implementation of the Nigeria National Response Information Management System (NNRIMS) Operational Plan (2007-2010) has resulted in improved functionality of the national HIV M&E system. There are, however, still gaps regarding human capacity for ensuring good data quality, the use of M&E data for decision-making, and funding. Also, the infrastructure to underpin the national and sub-national M&E databases, routine HIV program monitoring, program evaluation, and research are still weak. Furthermore, the national response still contend with a proliferation of M&E sub-systems which are mostly donor-driven and not responsive to NNRIMS; for instance, each program area such as OVC, ART, and PMTCT has its own routine information system which respond primarily to the need of program funders. Also, the low participation of the private sector, especially the private-for-profit players, in the submission of information using NNRIMS platform is another critical issue. These as well as the other findings of a response analysis had informed the development of the strategic objectives and interventions of the M&E system thematic area of the NSP.

Goal

The goal of the thematic focus is to strengthen and embed a sustainable systems based approach to delivering a cost-effective, multidimensional and gender sensitive monitoring and evaluation system which supports the continuous improvement of the national response

Objectives

1. To enhance the leadership and managerial competencies and effectiveness of Federal, State and Local Government Areas' authorities for the delivery of the one national M&E system by 2015
2. To improve the coordination, and cost-effectiveness of data collection, analysis and use of program data and information to inform program planning and decision-making by HIV/AIDS Stakeholders at all levels of HIV/AIDS response by 2015
3. To improve the HIV evaluation, research and learning agenda, and use the information to continuously enhance national response
4. To continuously improve data quality and supportive supervision at all levels by 2015
5. To improve the efficiency and effectiveness of the delivery of the costed national multi-sectoral HIV M&E plan through a systems management approach
6. To strengthen and regularly update an integrated, appropriate to local context, National HIV/AIDS database(s) to capture, verify, analyze and present program monitoring data from all levels and sectors by 2015.

Key Interventions

1. Review and clarify the competencies and accountability structures for M & E, and strengthen their alignment to organizational strategies at State/LGA/Project /Service delivery point/levels
2. Review and enhance the organizational culture for sustainable human competency development and adequate budgetary provision and timely release of funds for the M&E system
3. Develop/strengthen appropriate, fully funded mechanisms for coordination and review of M&E activities at all levels.
4. Advocate for an enhanced commitment to the HIV M&E system ball stakeholders by 2015
5. Review and strengthen the effectiveness and efficiency of coordinating mechanisms for design and implementation of HIV evaluation, research and surveillance
6. Create an enabling environment to promote continuous identification, sharing and learning from best practices', and promote timely presentation of Nigeria HIV/AIDS Experience in State/National and International Conferences by 2015
7. Review and strengthen capacity building for the design, execution, analysis and use of information from surveys/ surveillance and other evaluation and research studies
8. To review and strengthen a national documentation system for HIV evaluation, research and learning
9. Review and strengthen the implementation of national guidelines and Standard Operating Procedures on data quality auditing at all the service delivery points, intermediate aggregation levels and national M&E unit
10. Enforce/Promote One harmonized national data collection and information flow structure
11. Periodically review and strengthen national/state capacity to design and maintain databases used in the national/state response by 2015

Major Activities for NACA

NACA will establish a podcast capability, build capacity to improve M&E systems, improve the provision of strategic information through upgrading NACA data management center including video conferencing, web portal etc. and establishing a helpdesk. NACA will also support special studies such as the NARHS and IBBSS, compile a bibliography of AIDS research, and engage intensely with the media to promote its work and results. Other activities NACA plans to carry out are submitting timely reports on the country's UNGASS, UA, and MDGs commitments and to launch and carry out a midterm review and end of program evaluation of the NSP.

Major Activities for the States

Major activities: The major activities for the states include:

1. **Advocacy** to generate greater support for effective funding and sustained political support for M&E activities
2. **Capacity development**: including:
   a. Capacity assessment of human, material and other resources for M& E system
   b. Human capacity development through training, study tours, and mentoring, conference participation on issues of generation, management, reporting, and use of appropriately disaggregated (for example, by gender and age)
   c. Institutional capacity development and strengthening through development of functional organogram and terms of reference for M & E units, development of costed annual M & E plan at state and LGA level,
   d. Material resources: Provision and upgrading of sustainable equipment such as computer and software to improve data collection
3. **Increased availability of MIS tools**: Adoption/adaptation, printing and distribution of M & E-related tools and job aids, including forms, manuals, and guidelines
4. **Support M& E coordinating structures**: Establish and hold regular meeting of M&E coordinating structures such as Technical Working Group and meetings of State and LGA M&E officers

5. **Improved availability of state-specific data** through the development and continuous update of state HIV/AIDS database
6. **Undertake quality assurance and continuous quality improvement** exercises through:
   a. Regular supervisory visit
   b. Data quality audits
   c. Data triangulation
7. **Conduct special surveys and relevant research** to improve the availability of state-specific data, including operations research, evaluation studies such as the midterm and final review of the implementation of the State HIV/AIDS strategic plan, and secondary analysis of some national HIV-related dataset, such as Nigeria Demographic and Health Survey (NDHS) and National HIV/AIDS and Reproductive Health Survey to obtain state-specific and state-relevant information
8. **Wide dissemination of M&E-related information** including summary of service data and research outputs; in particular state will produce and widely disseminate annual HIV/AIDS reports
9. **Reporting:** States and LGAs will comply with relevant data reporting procedure as specified by government, including submission of state's report to NACA and other designated national institutions
10. **Use of data for decision-making**, including the use of service data and state HIV targets for the development of costed plans and budgets

Other activities: include development of inventory of ongoing and completed state-specific HIV studies and establishment of M&E-related networks and partnership

Major Activities for the MDAs

The *major activities* for the MDAs include:

1. **Advocacy:** Advocacy visits and meetings with relevant key stakeholders to increase funding and support for M & E activities
2. **Training & skills development**: Training of Trainers and step-down training on M&E issues, including quality data generation, data utilization for decision-making, and research methods.
3. **Provision of MIS-related equipment** including computers and software,
4. **Development/review/update of relevant management information system (MIS) tools and job aids**, including data-collection forms, manuals, and guidelines
5. **Development of research-related policies and guidelines, agenda and activities**, including ethical standards for community research and use of information and sector-specific HIV research
6. **Monitoring visits, supervision and data quality audits** to ensure quality and effectiveness of the M&E system.
7. **Surveys and evaluation studies** to determine the impact of HIV/AIDS at key sectoral level, the trajectory of the epidemics, and the effectiveness of response, including mid-term (2012) and final (2015) evaluation of the sectoral HIV/AIDS plan, financial flow and support to M&E and research activities, and identification of best practices.
8. **Dissemination of M&E and research information:** this will be carried out through various information-sharing media including print and electronic means, dissemination meetings, and MDA websites
9. **Data reporting**: Submission of relevant data to NACA and other designated national authorities

Major Activities for the CSO Networks

Major Activities include:

1. Training of network members on data generation, reporting and utilization
2. Adaptation of relevant national forms, formats, and guidelines regarding M&E
3. Advocacy to relevant stakeholders
4. Provision of MIS equipment to improve data generation, collation, and dissemination

5. Data collection and collation from network members
6. Reporting on CSO network response to HIV/AIDS to NACA and other relevant national agencies
7. Research on HIV/AIDS issues relevant to network focus
8. Annual evaluation of network activities
9. Dissemination of reports of network's activities, research and M&E information through various channels including presentation at conferences.

Other activities include the organization of National HIV/AIDS conference and networking with other stakeholders and partners at international, national, and sub-national levels on research and information sharing.

HIV/AIDS PROGRAM MANAGEMENT ILLUSTRATIVE INDICATOR DATASET

Background and Introduction

Following the review and development of the Nigeria National Strategic Framework and National Strategic Plans 2010-15, and in line with international best practices and standards aimed at strengthening the national HIV Monitoring and Evaluation systems (the third one), the NACA has reviewed its indicator sets for the National HIV/AIDS response.

There is a shift towards enabling all stakeholders and implementing partners to collect, collate and report relevant data which will enable the national response to ensure improved coverage of quality HIV/AIDS services towards achieving the overall goal of the national response.

The illustrative indicator datasets presented in the Table below shows the recommend indicators to be collated centrally. However, the Service delivery points (part of the national response systems) are expected to collect additional data for program management as well as to enable the computation of some relevant national outcome indicators. Implementing partners, irrespective of the source of funding will be expected to report their data primarily through the relevant Service delivery point that they are supporting. They may however also send copies of the collated data to their funders as an adjunct process. The suggested list of such input, process and output indicators are presented in the National HIV/AIDS Indicators Reference Guide. Also, the Indicators Reference Guide contains the complete description of the indicators shown in the table below including the definition, rationale, measurement criteria etc.

The standard M&E classification typology of Output, Outcome and Impact have been used to classify the recommended national illustrative datasets.

Impact-level Indicator

Performance indicators at the impact level specify the expected medium- to long-term impact at program, subsector, or sector level to which the present project, several other projects, and initiatives described in the NSP will contribute. Hence, the impact level indicator includes targets beyond the scope of the project. NACA and other relevant international agencies, e.g. UNAIDS will be responsible for measuring these indicators.

Outcome-level Indicator

The outcome or end-of-NSP/end-of-project indicator defines the project's immediate effect on or the behavioral change of beneficiaries, and improvements to systems or institutions. They are the performance targets that the project takes full accountability to deliver and they are the basis by which the project will be judged a success or a failure. The responsibility for monitoring and measuring the outcome indicators lies with the NACA/SACA.

Output-level Indicator

Output indicators are the easiest to define. They specify the key tangible goods and services the project will deliver. They define the NACA/SACA/LACA /project management's terms of accountability that have to be achieved by the end of national/state response/project implementation. It is the SACA/project management's responsibility to monitor the performance indicators at output level.

Further classification of all the suggested indicators, including the aggregation levels and data flow will be presented in the National Indicator Reference Guide.

HIV/AIDS PROGRAM MANAGEMENT ILLUSTRATIVE INDICATOR DATASET

NSP Thematic Area	NSP Sub-thematic area	Indicator ID #	Indicators	Methods/Data Sources	Frequency of Collection	Indicator Type	Reference
All		1	Percentage of young women and men aged 15 -24 years who are HIV -infected	HIV sentinel surveillance and population -based survey	Annually	Impact	UNGASS #22; GF
		2	Percentage of most-at-risk populations who are HIV -infected	Second-generation surveillance	Annually		UNGASS #23; GF
		3	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ant -retroviral therapy	Program Monitoring	Annually		UNGASS #24; GF
		4	Percentage of infants born to HIV -infected mothers who are infected	Intermittent: Modeling at UNAIDS HQs based on program coverage, survey, special study	Annually		UNGASS #25; NNRIMS, PEPFAR, WHO
		5	Percentage of children under 18 years who are orphans	Population-based survey	Every 3-5 years		GF
		6	Percentage of men and women aged 15 -49 who received counseling and HIV test in the last 12 months and who know their results	Intermittent: Program, population - based survey, special study	Every 2-5 years		UNGASS #7; GF
Behavior Change and Prevention of New HIV Infections	Counseling and Testing	7	Percentage of most-at-risk population who received counseling and HIV test in the last 12 months who know their results	Intermittent: Program, survey, special study	Every 2 years		UNGASS #8; WHO;
		8	Percentage of sexually active young women and men aged 15 -24 years who received an HIV test in the last 12 months and know their results	Population-based survey			Additional recommended indicator #5; WHO; GF
		9	Number (and percentage) of health facilities that provide HIV counseling and testing services; disaggregated by level of facility: primary, secondary, tertiary; by LGA; by State	Intermittent: Program, survey, special study			UNAIDS, WHO, UNICEF, PEPFAR, NNRIMS
		10	Percentage of HIV Testing and Counseling sites with Quality Assurance (QA) systems for HIV counseling service delivery (non -test elements)	Intermittent: Program, survey, special study			
		11	Percentage of the patient population aged 15 and older who received HIV C&T and received their results through provider-initiated services in the past 12 months	Intermittent: Program, survey, special study			
		12	Percentage of people with a sexually transmitted infection (STI) a ged 15 and older who received HIV C&T and received their results through provider -initiated services in the past 12 months; disaggregated: by sex: Male and Female; Age: 15 24, 25 49, 50 64, 65 and over	Intermittent: Program, survey, special study			

HIV/AIDS PROGRAM MANAGEMENT ILLUSTRATIVE INDICATOR DATASET

13	Number of individuals who received counseling and testing for HIV and received their test results Disaggregated by Sex: Male, Female; by age: <15, 15 -24; 25-49; 50-64; >65; by test result: positive, negative; by type of counseling/test: individual, couple and group	Routine Program Monitoring	Quarterly and annually	Output	PEPFAR (P11.1.D); WHO; GF, NNRIMS
14	Percentage of pregnant women who were counseled and tested for HIV and know their results	Program Reports	Quarterly and Annually	Outcome	GF, PEPFAR, WHO, Additional recommended indicator #7
15	Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission; disaggregated by prophylactic regimens: S ingle Dose Nevirapine only, prophylactic regimens using a combination of 2 ARVs, prophylactic regimens of 3 ARVs; ART)	Program Reports	Quarterly and Annually		UNGASS#5; PEPFAR, WHO
16	Percentage of infants born to HIV-infected women who receive an HIV test within 12 months; disaggregated into virological testing at <2months, 2 -12 months or antibody testing at 9 -12 months	Program Reports			GF, PEPFAR, WHO, Additional recommended indicator #8
17	Percentage of infants born to HIV-infected women started on Cotrimoxazole prophylaxis within 2 months of birth	Program Reports	Quarterly and Annually		GF, PEPFAR, Additional recommended indicator #9
18	Percentage of donated blood units screened for HIV in a quality assured manner	Routine NBTS reports	Quarterly or annually		UNGASS #3
19	Percentage of health facilities with no stock outs of new sterile syringes (standard or safety) in the prior 6 months	Intermittent: Survey (population or facility) or assessment			WHO/SIGN
20	Percentage of health facilities with no stock outs of safety boxes in the prior 6 months	Intermittent: Survey (population or facility) or assessment			WHO/SIGN
21	Proportion of women and men age 15 -49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package	Intermittent: Survey (population or facility) or assessment			WHO/SIGN
22	Percentage of health facilities with HIV Post -exposure prophylaxis (PEP) available; disaggregated by type: Occupational and Non -Occupational	Intermittent: Facility survey, special study	Every 2-3 years		UNAIDS Additional #1; GF Prevention #HIV-P15
23	Percentage of young women and men aged 15 -24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Intermittent: Survey, special study	Every 2-5 years		UNGASS #13, GF, PEPFAR
24	Percentage of Most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Intermittent: Survey, special study	Every 2years		UNGASS #14, GF
25	Percent of never-married young people aged 15-24 who have never had sex	Intermittent: Survey, special study			UNGASS #15, GF Prevention #HIV - 01
26	Percentage of young women and men aged 15 -24 who have had sexual intercourse before the age of 15	Intermittent: Survey, special study			UNGASS #16
27	Percent of women and men aged 15 -49 who have had sexual intercourse with more than one partner in the last 12 months reporting the use of a condom their last sexual intercourse	Intermittent: Survey, special study			UNGASS #17
28	Percentage of women and men aged 15-49 with more than one ongoing sexual partnership at the point in time six months before the interview	Intermittent: Survey, special study			UNAIDS Reference Group on Estimates, Modeling and Projections

HIV/AIDS PROGRAM MANAGEMENT ILLUSTRATIVE INDICATOR DATASET

29	Percent of men and women aged 15-49, who have two or more concurrent partners within the past twelve months	Intermittent: Survey, special study			UNAIDS Reference Group on Estimates, Modeling and Projections
30	Cross-generational sex: Percentage of women respondents aged 15 -19 who have had non-marital sex with a man 10 years or more older than themselves in the last 12 months, of all those who have had non-marital sex in the last 12 months	Intermittent: Survey, special study			UNAIDS 2000 Young People #7
31	Sexually active in past year: Percentage of young never married people (15 -24) who have had sex in the last 12 months	Intermittent: Survey, special study			2000 UNAIDS Youth #2
32	Percentage of youth who have ever had sexual intercourse	Intermittent: Survey, special study			Prevention TWG
33	Percentage of young people (aged 15-24) who used a condom the first time they ever had sex, of those who have ever had sex, disaggregated by age groups (15 -19, 20-24) and gender	Intermittent: Survey, special study			2000 UNAIDS Youth #6
34	Percentage of young women and men aged 15-24 who report they could get condoms on their own	Intermittent: Survey, special study			UNAIDS additional #11
35	Condom use at last premarital sex, last sex: Percentage of young never married people (aged 15 - 24) who used a condom at last sex, of all young single sexually active people surveyed	Intermittent: Survey, special study			2000 UNAIDS Youth #3
36	Percentage of adults who are in favor of young people being educated about the use of condoms in order to prevent HIV/AIDS	Intermittent: Survey, special study			Youth Guidance Determinant #7
37	Number of adults and children with advanced HIV infection newly enrolled on ART; disaggregated by Sex: Male and Fe male; By Age: <1, <15, 15+; Pregnant women	Program Reports		Output	PEPFAR
38	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]; disaggregated by Sex: Male and Female; By Age: <1, <15, 15+	Program Reports	Quarterly or annually	Outcome	UNGASS #4; GF; PEPFAR
39	Number of adults and children with advanced HIV -infection who ever started on ART; disaggregated by Sex: Male and Female; By Age: <15 and 15+	Program Reports		Output	PEPFAR
40	Percentage of health facilities that offer ART; disaggregated by level of service: primary, secondary, tertiary; by type of site: public, private -for-profit and private-not-for-profit	Intermittent: Facility survey, special study			PEPFAR
41	Percentage of health facilities providing ART using CD4 monitoring in line with national guidelines/policies on site or through referral	Intermittent: Facility survey, special study			Additional recommended #4; GF, PEPFAR
42	Number of eligible adults and children provided with a minimum of one care services; disaggregated By Sex: Male and Female; By Age: <18 and 18+	Routine Program			PEPFAR, Partially GF Care Support
43	Percent of ART sites that have pain management programs	Intermittent: Facility survey, special study			Care & Support TWG

HIV/AIDS PROGRAM MANAGEMENT ILLUSTRATIVE INDICATOR DATASET

44	Percent of health care facilities that have the capacity and conditions to provide advanced level HIV/AIDS care and support services, including provision of ART	Intermittent: Facility survey, special study	WHO/UNAIDS Care & Support Guide (2004) indicator CS7
45	Percent of health care facilities that have the capacity and conditions to provide basic -level HIV testing and HIV/AIDS clinical management	Intermittent: Facility survey, special study	WHO/UNAIDS Care & Support Guide (2004) indicator CS6
46	Percent of HIV-positive patients who are given cotrimoxazole preventive therapy	Intermittent: Facility survey, special stud y	GF Care & Support #HIV-CS1
47	Quality of life for people living with HIV/AIDS (PLHIV)	Periodic special studies: Cohort study (MOS - HIV scale, SF 12, which includes both physical and mental domains)	Care and Support M & E Working Group/ World Bank
48	Percent of TB patients who had an HIV test results recorded in the TB register	National TB Registry	UNAIDS additional #6
49	Percent of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Intermittent: Facility survey, special study	UNGASS #6
50	Percent of HIV-positive patient who were screened for TB in HIV care or treatment settings	Intermittent: Facility survey, special study	Partially GF collaborative activities #TB/HIV-1
51	Percent of infants born to HIV-positive pregnant testing services for infant diagnosis for HIV exposed infants, on site or through Dried Blood Spots (DBS).	Intermittent: Facility survey, special study	UNAIDS additional #9, GF prevention #HIV-P15
52	Percent of health facilities that provide virological testing services for infant diagnosis for HIV exposed infants, on site or through Dried Blood Spots (DBS).	Intermittent: Facility survey, special study	PMTCT Guide Additional #2
54	Total health expenditures per capita	Intermittent: NHA	WHO
55	Proportion of all deaths attributable to HIV	National mortality statistics, Sample Vital Registration with Verbal Autopsy (SAVVY)/DSS	
56	Ratio between the median price paid by the country for each ARV in the last 12 months t o the median international price	SCMS/AMD	Partially WHO
57	Proportion of generic to branded drugs procured	SCMs, National Pharmacy Records	PEPFAR HSS TWG
58	Percentage of health facilities providing ART that experienced stock -outs of ARV in the last 12 months	Intermittent: SCMS, Facility survey, special study	UNAIDS Additional #3; GF Treatment #HIV-T3
59	Monitoring policy reform and development of PEPFAR supported activities (Required for partnership Framework Countries)	National Policy Review; NCP	PEPFAR Partnership Framework
	National Composite Policy Index (NCP)	Intermittent: NCPI	UNGASS #2
60	Existence of national costed HIV implementation plan	Intermittent: NCPI	Partially WHO

HIV/AIDS PROGRAM MANAGEMENT ILLUSTRATIVE INDICATOR DATASET

61	Existence of effective civil society or ganizations	WB: Worldwide Governance indicators; NCP	Partially WHO
63	Existence of one agreed upon M & E plan for overall national monitoring and evaluation	NCPI	UNAIDS
64	Percent of health facilities with record -keeping systems for monitoring HIV/AIDS care and Support	FMoH Reports; NACA Reports	WHO/ UNAIDS Care & Support Guide (2004) indicator CS - A2
65	Percent of ARV distribution nodes that report on inventory consumption, quality, losses and adjustments on a monthly basis	SCMS, National Pharmacy Records	WHO 3x5
66	Existence of national and sub -national databases that enable stakeholders to access relevant data for policy formulation and program management and improvement	FMoH Reports; NACA Reports	WHO
67	Existence of a designated and functioning institutional mechanism charged with analysis of health statistics, synthesis of data from different sources and validation of data from population and facility sources.	FMoH Reports; NACA Reports	Partially WHO
68	Availability o f HIV prevalence data for relevant surveillance population published within 12 months of preceding year	FMoH Reports; NACA Reports	Partially WHO and GF
69	Existence of a nationally coordinated multi -year disease Monitoring and Evaluation plan with a schedule for survey implementation and data analysis prepared and implemented	FMoH Sector Reports; NAC Reports	WHO
70	Availability of maternal and child mortality data	FMoH Reports; National Mortality Registration; Mortality Surveillance	WHO

COSTING THE NSP 2010 - 15

The two key parameters for costing the NSP are the number of activities, goods, and services to be procured and the unit cost of the activities, goods, and services. Capacity building is the major activity identified as common to all the six HIV/AIDS thematic areas in the NSP and comprises personnel, institutional, and organizational capacity building, which involves training and financial and material resource mobilization and allocation. Other major activities common to most or all HIV/AIDS thematic areas include advocacy; development or review of policies, guidelines, and standard operating procedures (SOPs), and printing, disseminating and distributing the final documents; meetings; and supervision and monitoring of and reporting on program activities. The goods are mainly of medical nature and include HIV test kits; drugs; laboratory equipment, reagents, and consumables; and vehicles to improve supply chain and logistics management. Other issues include providing new and improving existing physical infrastructure to provide HCT, PMTCT, and ART services.

Determining the targets

Targets for capacity development, advocacy, development or review of policies, guidelines, and standard operating procedures (SOPs), and printing, disseminating and distributing the final documents; meetings; and supervision and monitoring of and reporting on program activities are informed by the self-reported needs of key stakeholders from the States, the MDAs and the CSO Networks. *Appendix1* shows the major strategic interventions for the HIV/AIDS thematic areas and their objectives that have informed the costing of the NSP.

HCT, PMTCT, and ART targets required to reach the NSP coverage are calculated from estimates of the number of people eligible to receive the service: i.e. the service estimates are based on populations needing the service and the coverage. The *Spectrum Model* developed by the Futures Group with financial support from USAID and used to support strategic planning and for similar purposes in many countries in Africa and elsewhere was used to generate the targets for HCT, PMTCT, and ART targets required to achieve Universal Access by 2015. The *Spectrum Model* uses trends in adult HIV prevalence from surveillance data to estimate the number of new HIV infections among adults and children, the number of those in need of treatment, the impact of treatment in extending life, and the annual number of AIDS death. The following critical issues in determining the targets for the NSP are noted:

1. Population projections: The UNFPA population estimate for Nigeria compares favourably with the Nigeria Population Council 2006 census figure and estimates
2. Future HIV prevalence based on UNAIDS Estimates and Projection Package projections and the *Spectrum Model* projections using results of previous ANC prevalence figures
3. HIV progression: 50% of adults infected with HIV will require treatment in 9 years
4. Survival on ART in first year ≤ 90% for adults
5. HIV prevalence in Nigeria reflects that seen in a countries with generalized epidemic
6. *Table 1A, 1B, and 1C* show the projections for HCT, PMTCT, and ART respectively for the NSP.

Determining the unit cost of goods and services

Although unit costs of goods and services are known to vary, in some cases substantially, across the country, the costing of the NSP did not take into consideration these variations. The unit costs used are in the upper part of the ranges of costs known for the goods and services. Cost of goods and services procured directly from vendors in Nigeria were obtained from the vendors and those imported were obtained from available data from suppliers and those within the country who regularly procure the goods and services. Some unit

costs were obtained from the costing templates of the recently approved Round 9 Global Fund proposal.

Key budget assumptions

Capacity building made up a substantial proportion of the activities in the NSP. For training activities at the national and zonal levels, it was assumed that facilitators and consultants have to travel by air to the training location while at the state level facilitators and consultants are assumed to be sources within the state and would not have to travel. Most step down training activities at the LGA and community levels are assumed to be facilitated by trainers who have been trained and are not therefore paid as consultants.

M&E activities were not vetted by the National M&E Technical Working Group and were also no sufficiently delineated for costing purposes. The M&E TWG will deliberate intensely on these interventions as part of the developing the M&E Plan for the NSP in early 2010. These activities may then be costed if stakeholders so desire. In the absence of the concrete activities, the NSP has adopted the GFATM suggestion that M&E for programs should be about 10% of the sub-total cost of other non-M&E program activities. The NSP therefore includes a 10% of the sub-total cost line item to cater for M&E and Research.

Annual workplans and budgets will be prepared by all implementers to better reflect the cost of activities. A review of the NSP objectives, strategic interventions, major activities and their costing will be undertaken in at the beginning of the 3rd year to better inform progress on the NSP and to address any major changes in cost of activities that may have occurred since the implementation of the NSP began.

Key challenges of costing the NSP

Assumptions have to be made on several unit costs relating to costs that will be determined after assessments that are programmed into the plan. Such costs include cost of rehabilitation of laboratories, clinics etc. Assumptions had to be made on the values of the different types of support to be provided to program beneficiaries such as OVC, caregivers, etc. Setting targets for activities in years 3-6 is a big challenge particularly in the absence of evidence-based data to inform projection of needs. Costing of training activities was a big challenge: implementers at state, MDAs, and CSO networks levels identified very many types of stand-alone training needs separate for each thematic area; as much as practicable implementers should have integrated training activities but this was not done. This has the potential to increase the cost of training significantly.

Table 1A: NSP 2010-2015 - HIV Counseling and Testing (HCT) Targets

Year	Total population	Population Aged 15-80+	Population Aged 15-80+ (Females)	Population Aged 15-80+ (Males)	Percent of population reached overall in the year (cumulative)	Percent of population newly reached in year	Target coverage by year (Females)	Target coverage by year (Males)	Target coverage by year (Both sexes)
Source	Spectrum	Spectrum	Spectrum	Spectrum					
2008	152,767,378	86,811,235	43,564,937	43,246,298	15%				
2009	156,402,089	89,118,354	44,698,193	44,420,162	15%				
2010	160,067,966	91,488,369	45,863,160	45,625,209	20%	5%	**2,293,158**	**2,281,260**	**4,574,418**
2011	163,763,892	93,920,226	47,058,678	46,861,549	30%	10%	**4,705,868**	**4,686,155**	**9,392,023**
2012	167,471,310	96,421,259	48,288,217	48,133,042	45%	15%	**7,243,233**	**7,219,956**	**14,463,189**
2013	171,184,458	98,988,187	49,549,930	49,438,257	60%	15%	**7,432,490**	**7,415,739**	**14,848,228**
2014	174,905,892	101,626,552	50,846,330	50,780,222	70%	10%	**5,084,633**	**5,078,022**	**10,162,655**
2015	178,624,179	104,345,723	52,181,975	52,163,747	80%	10%	**5,218,198**	**5,216,375**	**10,434,572**
							31,977,578	**31,897,507**	**63,875,085**

Table 1B: NSP 2010-2015 PMTCT Targets

Year	Total population	Total number of births (Women needing PMTCT)	Total target coverage for PMTCT	Total number to be reached with PMTCT	Total number of HIV pregnant women (requiring ART prophylaxis)	Presumed adult population HIV prevalence	Level of coverage for ARV prophylaxis	Total number of HIV pregnant women (to be reached with ART prophylaxis)
	Spectrum	Spectrum	NSP	Calculation	Spectrum	EPP/Spectrum	NSP	Calculation
2005	138,656,809	5,893,964			194,001	3.6		
2006	141,643,667	5,977,816			196,342	3.5		
2007	144,681,572	6,083,805			200,007	3.5		
2008	147,762,203	6,177,557	12%	741,307	204,109	3.5	5%	10,205
2009	150,870,149	6,245,735	12%	749,488	209,045	3.6	5%	10,452
2010	153,990,737	6,286,861	30%	1,886,058	215,001	3.7	15%	32,250
2011	157,123,528	6,330,332	50%	3,165,166	222,300	3.7	25%	55,575
2012	160,252,294	6,356,730	70%	4,449,711	229,320	3.8	35%	80,262
2013	163,371,288	6,378,169	80%	5,102,535	236,130	3.9	50%	118,065
2014	166,478,759	6,394,983	80%	5,115,986	242,391	4.0	60%	145,435
2015	169,561,453	6,392,287	80%	5,113,830	247,375	4.1	80%	197,900

Table 1C: NSP 2010-15 Anti-Retroviral Treatment (ART) Targets

	Total population - (Total)	HIV population (Males)	HIV population (Females)	HIV population (Total) (Males + Females)	Total need for ART (15+) - (Total) (Males + Female)	Children needing ART (Total) (Males + Female)	Total needing ART	Targeted coverage for adults	Targeted coverage for children	Targeted number for adults	Targeted number for children	Total targeted
	Spectrum	Spectrum	Spectrum	Spectrum	Spectrum	Spectrum	Spectrum	NSP	NSP	Calculations	Calculations	Calculations
2006	145,657,946	1,161,932	1,679,205	2,841,137	699,502	97,870	797372					
2007	149,180,477	1,194,688	1,724,823	2,919,512	726,477	99,447	825924					
2008	152,767,378	1,230,831	1,775,743	3,006,574	760,420	101,355	861775					
2009	156,402,089	1,278,273	1,844,019	3,122,292	801,931	104,555	906486	**35%**	**35%**	**280,676**	**36,594**	**317,270**
2010	160,067,966	1,336,888	1,928,923	3,265,811	853,217	105,961	959178	**40%**	**40%**	**341,287**	**42,384**	**383,671**
2011	163,763,892	1,402,744	2,024,291	3,427,035	915,526	107,640	1023166	**50%**	**50%**	**457,763**	**53,820**	**511,583**
2012	167,471,310	1,473,106	2,126,021	3,599,127	986,728	109,253	1095981	**60%**	**60%**	**592,037**	**65,552**	**657,589**
2013	171,184,458	1,545,431	2,230,284	3,775,716	1,064,691	110,752	1175443	**70%**	**70%**	**745,284**	**77,526**	**822,810**
2014	174,905,892	1,618,624	2,335,400	3,954,024	1,147,782	112,093	1259875	**80%**	**80%**	**918,226**	**89,674**	**1,007,900**
2015	178,624,179	1,691,965	2,440,380	4,132,345	1,234,683	113,084	1347767	**80%**	**80%**	**987,746**	**90,467**	**1,078,214**

NSP Budget Summary for States by Thematic Area and Cost Type

Thematic Area	2010	2011	2012	2013	2014	2015	
Thematic Area 1: Prevention	40,485,106,710	36,722,209,351	20,295,866,683	21,728,464,919	23,632,193,066	24,855,127,507	**167,718,968,237**
Thematic Area 2: Treatment	33,732,211,829	43,050,593,326	53,235,814,717	65,632,782,118	79,097,171,514	84,294,843,700	**359,043,417,204**
Thematic Area 3: Care & Support	14,932,870,383	17,905,450,767	7,891,063,200	9,873,721,200	12,094,800,000	12,938,563,200	**75,636,468,750**
Thematic Area 4: Policy	5,157,173,200	4,069,760,200	1,603,067,800	1,529,262,800	1,339,947,800	1,320,212,800	**15,019,424,600**
Thematic Area 5: Institutional Arrangement	2,182,606,000	2,179,366,000	2,098,936,000	2,098,936,000	2,098,936,000	2,098,936,000	**12,757,716,000**
Sub total	**96,489,968,122**	**103,927,379,643**	**85,124,748,400**	**100,863,167,037**	**118,263,048,381**	**125,507,683,207**	**630,175,994,790**
Thematic Area 6: M&E and Research (10% of Sub- total)	9,648,996,812	10,392,737,964	8,512,474,840	10,086,316,704	11,826,304,838	12,550,768,321	**63,017,599,479**
TOTAL	**106,138,964,934**	**114,320,117,608**	**93,637,223,240**	**110,949,483,741**	**130,089,353,219**	**138,058,451,527**	**693,193,594,269**

Cost Type	2010	2011	2012	2013	2014	2015	
A. Human Resources	128,629,667	144,909,667	105,480,000	105,480,000	113,620,000	113,620,000	**711,739,333**
B. Infrastructure/Equipment	12,423,157,767	10,606,044,489	7,401,772,096	8,012,541,109	8,614,867,430	8,586,394,216	**55,644,777,107**
C. Training/Planning	15,834,365,683	15,311,892,639	7,369,260,436	7,442,087,335	7,112,561,800	6,779,316,902	**59,849,484,795**
D. Commodities/Products	29,552,511,992	28,302,308,797	8,926,056,886	9,077,081,567	8,980,767,755	9,176,511,238	**94,015,238,235**
E. Drugs	29,551,475,146	39,808,356,250	51,255,108,330	64,592,271,375	79,053,014,144	86,058,195,400	**350,318,420,645**
F. Administrative Costs	3,008,042,668	1,197,077,802	770,463,452	261,690,452	730,020,252	198,935,252	**6,166,229,876**
G. Others (mostly support for OVCs, care givers and CSOs etc)	5,991,785,200	8,556,790,000	9,296,607,200	11,372,015,200	13,658,197,000	14,594,710,200	**63,470,104,800**
Sub-total	**96,489,968,122**	**103,927,379,643**	**85,124,748,400**	**100,863,167,037**	**118,263,048,381**	**125,507,683,207**	**630,175,994,790**
M&E and Research (10% of Sub-total)	9,648,996,812	10,392,737,964	8,512,474,840	10,086,316,704	11,826,304,838	12,550,768,321	**63,017,599,479**
TOTAL	**106,138,964,934**	**114,320,117,608**	**93,637,223,240**	**110,949,483,741**	**130,089,353,219**	**138,058,451,527**	**693,193,594,269**

NSP 2010-15 Budget Summary for MDAs by Thematic Area and Cost Type

MDAs:- Thematic Area	2010	2011	2012	2013	2014	2015	Total
Thematic Area 1: Prevention	322,473,333	179,042,083	302,854,333	159,098,083	214,510,333	158,954,083	**1,336,932,250**
Thematic Area 2: Treatment	4,616,206,433	2,598,111,933	393,652,950	393,652,950	437,619,500	153,079,500	**8,592,323,267**
Thematic Area 3: Care & Support	5,160,148,450	4,700,859,333	4,700,864,333	4,700,859,333	4,700,859,333	4,700,859,333	**28,664,495,117**
Thematic Area 4: Policy	409,493,667	409,493,667	346,993,667	346,183,667	407,873,667	344,563,667	**2,264,602,000**
Thematic Area 5: Institutional Arrangement	573,567,000	203,742,000	156,407,000	151,338,000	144,392,000	204,918,000	**1,434,364,000**
Sub total	**11,081,888,883**	**8,091,249,017**	**5,900,772,283**	**1,050,272,700**	**1,204,395,500**	**861,515,250**	**23,489,229,300**
Thematic Area 6: M&E and Research (10% of Subtotal)	1,108,188,888	809,124,902	590,077,228	105,027,270	120,439,550	86,151,525	**2,348,922,930**
TOTAL	**12,190,077,772**	**8,900,373,918**	**6,490,849,512**	**6,326,256,237**	**6,495,796,817**	**6,118,634,042**	**46,521,988,297**

Cost Type	2010	2011	2012	2013	2014	2015	
A. Human Resources:	35,000,000	-	-	-	-	-	**35,000,000**
B. Infrastructure/ Equipment:	2,823,727,450	1,621,802,450	399,937,950	262,437,950	21,864,500	21,864,500	**5,564,134,800**
C. Training/Planning:	4,018,569,133	2,647,663,467	1,780,686,333	589,261,000	907,503,000	641,077,000	**13,788,022,933**
D. Commodities/Products:	1,364,577,300	1,289,318,100	1251,263,000	165,338,750	242,643,000	165,338,750	**7,655,838,900**
E. Drugs:	400,000,000	100,000,000	100,000,000	-	-	-	**900,000,000**
F. Administrative Costs:	103,515,000	95,965,000	32,385,000	33,235,000	32,385,000	33,235,000	**330,720,000**
G. Others	2,336,500,000	2,336,500,000	2,336,500,000	-	-	-	**14,019,000,000**
Sub total	**11,081,888,883**	**8,091,249,017**	**5,900,772,283**	**1,050,272,700**	**1,204,395,500**	**861,515,250**	**42,292,716,633**
M&E and Research (10% of Sub-Total)	1,108,188,888	809,124,902	590,077,228	105,027,270	120,439,550	86,151,525	**4,229,271,663**
TOTAL	**12,190,077,772**	**8,900,373,918**	**6,490,849,512**	**1,155,299,970**	**1,324,835,050**	947,666,775	**46,521,988,297**

NSP 2010-15 Budget Summary for CSO Networks by Thematic Area and Cost Type

	2010	2011	2012	2013	2014	2015	
Thematic Area 1 - Prevention	1,699,702,207	1,508,427,207	1,531,009,207	1,507,557,133	1,504,357,133	1,504,357,133	**9,255,410,022**
Thematic Area 2 - Treatment	111,020,714	101,415,714	42,271,429	43,881,429	45,531,429	43,701,429	**387,822,143**
Thematic Area 3 - Care and Support	806,128,707	700,865,407	319,983,887	312,978,887	326,403,887	299,637,753	**2,765,998,527**
Thematic Area 4 - Policy	134,466,300	138,695,800	105,052,800	105,052,800	105,052,800	109,520,800	**697,841,300**
Thematic Area 5 – Institutional Arrangements	89,143,333	65,371,000	1,196,581,333	1,056,236,000	1,050,061,000	1,043,811,000	**4,501,203,667**
Sub total	**2,840,461,262**	**2,514,775,128**	**3,194,898,656**	**3,025,706,249**	**3,031,406,249**	**3,001,028,115**	**17,608,275,658**
Thematic Area 6: M&E and Research (10% of Subtotal)	284,046,126	251,477,513	319,489,866	302,570,625	303,140,625	300,102,812	**1,760,827,566**
TOTAL	**3,124,507,388**	**2,766,252,641**	**3,514,388,521**	**3,328,276,873**	**3,334,546,873**	**3,301,130,927**	**19,369,103,224**

Cost Type	**2,010**	**2,011**	**2,012**	**2,013**	**2,014**	**2,015**	
A. Human Resources:	807,662,707	702,899,407	320,483,887	313,478,887	326,903,887	300,137,753	**2,771,566,527**
B. Infrastructure/Equipment:	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	**9,000,000**
C. Training/Planning:	2,004,079,755	1,783,091,922	2,861,400,969	2,699,153,562	2,691,428,562	2,687,996,562	**14,727,151,332**
D. Commodities/Products:	14,108,800	14,108,800	4,108,800	4,108,800	4,108,800	4,108,800	**44,652,800**
E. Administrative Costs:	1,990,000	2,055,000	1,625,000	1,685,000	1,685,000	1,505,000	**10,545,000**
F. Others	11,120,000	11,120,000	5,780,000	5,780,000	5,780,000	5,780,000	**45,360,000**
Subtotal	**2,840,461,262**	**2,514,775,128**	**3,194,898,656**	**3,025,706,249**	**3,031,406,249**	**3,001,028,115**	**17,608,275,658**
M&E and Research (10% of Subtotal)	284,046,126	251,477,513	319,489,866	302,570,625	303,140,625	300,102,812	**1,760,827,566**
TOTAL	**3,124,507,388**	**2,766,252,641**	**3,514,388,521**	**3,328,276,873**	**3,334,546,873**	**3,301,130,927**	**19,369,103,224**

NSP 2010-15 Global Budget Summary by Key Implementers

Key Implementers	2010	2011	2012	2013	2014	2015	TOTAL
States	106,138,964,934	114,320,117,608	93,637,223,240	110,949,483,741	130,089,353,219	138,058,451,527	693,193,594,269
MDAs	12,190,077,772	8,900,373,918	6,490,849,512	6,326,256,237	6,495,796,817	6,118,634,042	46,521,988,297
CSO Networks	3,124,507,388	2,766,252,641	3,514,388,521	3,328,276,873	3,334,546,873	3,301,130,927	19,369,103,224
TOTAL	121,453,550,094	125,986,744,167	103,642,461,273	120,604,016,851	139,919,696,909	147,478,216,496	759,084,685,790

Appendix 1: Major Strategic interventions by Thematic Area of the NSP

Sub-Thematic areas	Objectives	Major Strategic Interventions
1. Promotion of Behavior Change and Prevention of New HIV infections		
HIV Counseling and Testing (HCT)	1. At least 80% of adults (including discordant couples and people in concurrent multiple partnerships) accessing HCT services in an equitable and sustainable way by 2015	Implement HCT protocol
		Institutional and technical capacity building for gender/youth sensitive HCT services at all levels
		Advocacy
		Accelerate the scale up of HCT services
		Demand creation for HCT services including promotion of couple counseling
	2. At least 80% of most at-risk-populations (MARPs) accessing HIV counseling and testing by 2015	Implement the BCC strategy for MARPs
		Building the capacity of service providers for gender responsive services
		Advocacy
		Scale up of HCT services targeting MARPs
Sexually Transmitted Infections (STIs)	3. At least 80% of sexually active Nigerians with access to quality and gender responsive STI services by 2015	Capacity building
		Demand creation for service utilization
		Advocacy/resource mobilization
		Integration of services into HIV prevention programs
		Prioritize service provision by target populations and drivers of the epidemic
		Strengthen partnerships
	4. STI treatment & prevention services integrated into HIV prevention services by 2015	Capacity building
		Demand creation for service utilization
		Advocacy/resource mobilization
		Integration of services into HIV prevention programs
		Prioritize service provision by target populations and drivers of the epidemic
		Strengthen partnerships
Prevention of Mother-to-Child Transmission (PMTCT) of HIV	5. At least 80% of all pregnant women have access to quality HIV testing and counseling by 2015	Scale up of quality PMTCT services
		Advocacy/resource mobilization Communication and social mobilization
		Ensure regular supply of PMTCT commodities
		Capacity building (Infrastructure & Personnel)
		Public Private Partnership
		Evidence based approach to programming
		Referral and Linkages
	6. At least 80% of all HIV positive pregnant women access ARV prophylaxis by 2015	Scale up of quality PMTCT and EID services
		Advocacy/resource mobilization Communication and social mobilization
		Ensure regular supply of PMTCT and EID commodities
		Capacity building(Infrastructure & Personnel)
		Public Private Partnership
		Evidence based approach to programming
		Referral and linkages (adult/pediatric treatment, OVC and RH/FP)
	7. At least 80% of all HIV exposed infants have access to ARV prophylaxis by 2015	Scale up of quality PMTCT and EID services
		Advocacy/resource mobilization Communication and social mobilization
		Ensure regular supply of PMTCT and EID commodities

		Capacity building (Infrastructure& Personnel)
		Public Private Partnership
		Evidence based approach to programming
		Referral and linkages (adult and pediatric treatment, OVC, RH/FP)
	8. At least 80% of HIV positive pregnant women have access to quality infant feeding counseling	Scale up of quality PMTCT and EID services
		Advocacy/resource mobilization Communication and social mobilization
		Ensure regular supply of PMTCT and EID commodities
		Capacity building (Infrastructure & Personnel)
		Public Private Partnership
		Evidence based approach to programming
		Referral and linkages (adult/pediatric treatment, OVC, RH/FP)
	9. At least 80% of all HIV exposed infants have access to early infant diagnosis services	Scale up of quality PMTCT and EID services
		Advocacy/resource mobilization, Communication and social mobilization
		Ensure regular supply of PMTCT and EID commodities
		Capacity building (Infrastructure & Personnel)
		Public Private Partnership
		Referral and linkages (adult/pediatric treatment, OVC, RH/FP.)
		Evidence based approach to programming
Communication Interventions	10. At least 80 % of all Nigerians have comprehensive knowledge on HIV and AIDS by the year 2015	Capacity building
		Advocacy
	11. At least 80% of young people 15-24 years adopting appropriate HIV and AIDS related behavior	Develop, and implement relevant culturally appropriate and group specific SBCC oriented programs
		Capacity-building of service providers, including teachers, health & social workers
		Capacity building for young people, including FLEH issues and life skills
		Operationalise/strengthen FLHE curriculum implementation
	12. At least 80% of Most-At-Risk Populations (MARP) reached with group-specific interventions and adopting appropriate HIV and AIDS related behavior.	Capacity-building
		Develop, and implement relevant culturally appropriate and group specific SBCC oriented programs
	13. At least 80% of registered organizations engaging in HIV communication interventions address gender inequalities and comply with national standard/guidelines by 2015	Capacity building on SBCC
		Operations research
		Document and disseminate best practices on SBCC interventions
	14. At least 80% of men and women of reproductive age (MWRA) have knowledge about dual protection benefit of condoms	Accelerate the scale up of social marketing of condoms (especially female condoms) and lubricants
		Advocacy, communication and social mobilization

Condom Promotion	15. At least 80% of sexually active males and females use condoms consistently and correctly with non-regular partner by 2015.	Promote condom use
		Capacity building
		Promote appropriate operational research
		Promote referral and linkages with other SRH services
	16. At least 80% of MARPS use condoms consistently and correctly by 2015 with non-marital partners	Promote consistent and correct condom use
		Capacity building of service providers
		Promote appropriate operational research
		Promote referral and linkages with other SRH services
Integration of Sexual and Reproductive Health (SRH) and Other Relevant Health Issues into HIV Prevention Program	17. SRH services integrated into HIV prevention programs at all levels by 2015	Capacity building
		Scale up of integration
		Demand creation for service utilization
		Advocacy
		Supply of commodities
	18. Integrate drug demand reduction and other substance use control services into 80% of HIV prevention programs by 2015	Capacity building
		Scale up of integration
		Demand creation for service utilization
		Advocacy
Prevention with Positives	19. At least 80% of people living with HIV/AIDS (PLWHA) have access to Positive Health, Dignity and Prevention (PHDP) interventions 2015.	Capacity building
		Scale up of PHDP services
		Demand creation for PHDP services
		Advocacy
Prevention of Biomedical Transmission of HIV	20. At least 80% of all private and public health institutions practicing universal safety precautions and procedures by 2015	Adaptation of policies
		Capacity building
		Strengthening SBCC
		National protocol on PEP and health workers injection safety guidelines
		Use of safe injection commodities
		Operationalize the National Health Care Waste Management plan, policy and guidelines
	21. All (100%) donors of blood, blood products and organs for transplant including sperm for assisted reproductive technology shall be screened for HIV and other transfusion transmissible infections (TTIs) according to relevant national protocol, standards and guidelines by the year 2015.	Adapt and operationalize the national blood transfusion policy and guidelines at all health levels
		Capacity building
		Strengthen SBCC to promote VNRBD
		Disseminate and implement national protocol on VNRBD
		Advocacy
		Initiate upstream policy dialogue for enactment of relevant legislations and regular accreditation of blood banking institutions
		Operations research with special focus on incidence studies

	22. At least 80% of drug dependant persons (IDUs and non-IDUs) have access to quality prevention programs/services in accordance with national guidelines by 2015.	Develop and adapt policies and guidelines
		Capacity building
		Advocacy
		Strengthen SBCC
		Operations research with special focus on incidence studies
		Implement National drug control master plan
	23. At least 80% of traditional medical practitioners adopt universal safety precaution by 2015	Develop and adapt policies and guidelines
		Capacity building
		Strengthen SBCC
		Promote the use of blood safety commodities
		Operationalize the national Health Care Waste Management plan, policy and guidelines
	24. At least 80% of health facilities provide post-exposure prophylaxis (PEP) to relevant health workers and rape survivors in line with national protocols by 2015	Review and adapt policies and guidelines
		Capacity building
		Strengthen SBCC
		Disseminate and implement National protocol on PEP and relevant safety guidelines
		Promote the use of aseptic procedures
2. Treatment of HIV/AIDS and Related Health Conditions		
ART	1. At least 80% of eligible adults (women and men) and 100% of children (boys and girls) are receiving ART by 2015	Advocacy
		Training
		Decentralization and integration
		Medical commodities and equipments
		Provision and upgrade of physical infrastructure
		Public Private Partnership
		Laboratory quality system management network
		Q|A/QI
		Clinical Pharmacovigilance for ARVs
		Local manufacture of ARVs and other commodities
Opportunistic Infections (OIs)	2. At least 80% of PLHIV are receiving quality management for OIs (diagnosis, prophylaxis, and treatment) by 2015	Training
		Upgrade laboratory infrastructure for OI management
		Provision of medical commodities, equipments and drugs for OI management
		Implementation of QA/QI for OI management
HIV/TB Collaboration	3. All states and local government areas (LGAs) are implementing strong TB/HIV collaborative interventions by 2015	Coordinating bodies
		Training and Capacity Building
		Communities, PLHIV and PATB involvement

	4. All TB patients have access to quality and comprehensive HIV and AIDS services by 2015	HCT of TB patients
		Cotrimoxazole Preventive therapy for PLWHIV with TB
		Medical commodities and supplies
		ARVs for PLWHIV with active TB
	5. To ensure all PLHIV have access to quality and comprehensive TB services by 2015	Intensified case finding of TB
		Laboratory support for TB and MDR-TB diagnosis in HIV infection
		Isoniazid Preventive therapy for PLHIV
		Medical commodities and equipments
		Pharmacovigilance for anti-TB drugs
		TB infection control in HIV health care delivery sites
3. Care and Support for People Infected with and Affected by HIV/AIDS		
PLHIV and PABA	1. At least 50% PLWHIV receive quality care and support services by 2015	Advocacy to relevant stakeholders
		Review/develop and disseminate national policies, standards and protocols for care and support services
		Institutional and human capacity building for MDAs and CSOs providing care and support services
		Provision of integrated care and support services to PLWHIV
	2. 50% of PLWHIV and PABA especially women, marginalized and people with special need are linked to IGAs and poverty alleviation programs.	Advocacy to relevant stakeholders
		Capacity building on IGA programs targeted at PLWHIV and PABA especially women, young girls and persons with special needs infected with HIV
		Resource mobilization and fund allocation
	3. To improve access to and support to 60% of PLWA, especially women marginalized persons including persons with special needs Infected with HIV within a right based approach	Behavior change communication
		Capacity building of care providers and PLWHA
		Policy enforcement
	4. To improve by 80% effective referral and linkages within and between relevant health care facilities and communities based care service points.	Advocacy
		Networking and collaboration
		Institutional and human capacity building
OVC	5. To create an enabling environment for the legal protection of OVC by 2015	Advocacy
		Community mobilization and participation
		Development, revision and implementation of existing legislation and policy for OVC
	6. To provide gender sensitive integrated care and support for 30% of OVC by 2015	Capacity building of service providers and OVC
		Resource mobilization
		Provision of quality essential services to OVC.
		Provision of Pediatrics Care and Support
		BCC

	7. To strengthen capacity of 30% of older OVC, households, caregivers and community based initiatives respectively to mitigate the impact of OVC especially young girls by 2015	Capacity building
		Support Income generating activities
	8. To establish functional gender-responsive coordinating mechanism by 2015	Capacity building of policy makers, decision makers and program planners on gender - mainstreaming
		Establish and/or strengthen existing gender- responsive coordination structures
		Establish functional gender - responsive management information system
4. Institutional Architecture, Systems, and Resourcing		
Institutional Arrangement and Coordination Mechanism	1: NACA, SACA and LACAs capacity to effectively coordinate sustainable and gender-sensitive multi-sectoral HIV/AIDS at national, state and LGA respectively strengthened	Institutional Capacity assessment
		Development of Capacity building plan
		Establish and strengthen all LACAs
		Advocacy to all governors to upgrade SACAs to agencies
		Capacity building in program management and coordination of NACA SACA LACA
		Convene regular coordination meeting of NACA SACA LACA
	2: Strengthened coordination mechanisms of development partners at all levels, national state and local government to harmonize support to the national response.	Create Partnership forum
		Conduct meetings with development partners
		Conduct quarterly ETG meetings
	3: Strengthened coordination mechanisms of CSO at all levels – national, state, and local government.	Capacity Building - Technical, financial, and material support to CSO networks at national, State, and LGA levels
Human Resources	4: Ensure that at least 80% of HIV/AIDS programs have adequate number of appropriately skilled and gender-responsive personnel.	Standardized and harmonize training curricula
		Develop sustainable system for training and re-training staff
		Conduct training
		Develop retention strategy for health care workers
		Develop innovative strategies for task sharing among health workers
		Integrate HIV/AIDS curricula into Pre-service training of health workers at all levels
		Develop innovative and sustainable capacity building mechanisms to link with other related health programs
		Develop sustainable systems for Human resource capacity building in management and leadership
		Develop Human Resource Management Information Systems
		Develop and implement human resource plan for the sector.

Procurement & logistics supply	5: Efficient and sustainable logistics systems for uninterrupted supply of ARVs, drugs for the management of opportunistic infection and other HIV/AIDS-related commodities operational by 2015	Establish HIV/AIDS PSM Steering committee and TWG
		Conduct National forecasting & quantification exercise.
		Rehabilitate existing Federal medical warehouses.
		Conduct training in logistics management at all levels
		Develop Unified HIV commodities distribution system.
Financial Resources	6: Increase in the financial contribution of governments at all levels to at least 30% of financial resources required for HIV/AIDS by 2015	Advocacy to key stakeholders
		Establishment of budget lines for HIV/AIDS
		Integration of HIV issues into budgetary process
	7: To mobilize adequate financial resources in support of the implementation of the national HIV/AIDS response	Partnership building
		Strengthening of public-private partnerships
		Operationalisation of Joint Funding Agreements
	8: To progressively improve the effectiveness of HIV/AIDS resource tracking and enhance the efficiency of fund management for HIV/AIDS programs	Capacity building on financial management
		Establishment of pro-active budget tracking methods
		Documentation and dissemination of resource trackingresults
		Advocacy on using result of budget tracking for improved program management
5. Policy, Advocacy, Human Rights, and Legal Issues		
	1: Protect the rights of and empower PLHIV	Capacity Building
		Capacity building on linkages between HIV and human rights for people living with HIV and AIDS
		Capacity building for NHRC, Legal Aid Council and Human Right CSOs on human rights and HIV and AIDS
		Public education on human rights, rights based programming and channels to access justice, seek redress in instances of violation
		Strengthen linkages between NACA, SACA, LACA,NEPWHAN and NHRC, Human rights CSOs etc to provide free legal services to PLWHIV Establish and strengthen linkages/referrals between PLWHIV, support groups, NEPWHAN etc and NDE, NAPEP for economic empowerment for PLWHIV.
		Advocacy
		Public education on human rights for specific settings i.e. health, education, religious places , workplace ,etc.
		Advocacy for the passage of Anti-discrimination Bill at all levels
		Sensitization of members of the judiciary and law enforcement agencies on the rights of PLWHA
		Advocacy to relevant government agencies for gender-responsive economic empowerment for PLWHIV.
		Advocate for the inclusion of HIV/AIDS in health insurance schemes.

	2: An equitable increase in participation of PLWHIV in decision making processes at all levels.	Advocacy
		Advocacy for greater and meaningful gender-responsive inclusion of PLWHIV in HIV response in Nigeria
		Promote affirmative action for economic empowerment and other opportunities for PLWHIV.
		Capacity Building
		Strengthen capacity of PLWHIV networks and support groups to enhance their participation in decision making processes.
	3: Protect women, children and other socially vulnerable and marginalized groups from HIV Infections	Advocacy
		Promote the removal of cultural and traditional barriers/practices that impede access to reproductive health information and services.
		Advocacy for the domestication of the Protocol of African Charter on the rights of women in Africa and CEDAW Bill to protect the rights of women/ Pass The Child's Right Act at all levels.
		Improved services for the protection of people who are vulnerable and marginalized (Persons living with disability, out-of-school youth, OVC and MARPS) from HIV.
		Support Family Life and HIV education among youths in-and out- of school in urban, rural and hard-to reach places.
	4. Progressive funding for HIV/AIDS response through political commitment at all levels	Advocacy
		Advocacy for the institutionalization of SACAs and LACAs for improved budgetary allocation and release.
		Advocacy for sustained political leadership and support at all levels.
		Capacity Building
		Strengthen capacity for transparency and accountability in HIV response in partnership with the private sector, media, PLHIV and CSOs. Promote Public Private Partnerships.
		Policy
		Develop a policy framework on donor funding co-ordination on HIV and AIDS.
	5: Compliance with existing guidelines on ethical standards on HIV/AIDS	Capacity Building
		Strengthening of national and state research ethical Boards/Committees.
		Strengthening compliance with human rights guidelines with regard to mandatory testing and discrimination against PLWHIV at all institutions
		Capacity building and dissemination of ethical and research standards and policies at all levels.
		Capacity building and advocacy to health professional bodies, labor unions, employers, legislators, educational institutions, media and Faith-based bodies on ethics, human rights and HIV and AIDS.
6. M&E, Research, Knowledge Management		
	1. To enhance the leadership and managerial role of Federal/State/LGA authorities for the delivery of an effective One national M&E system by 2015	Review and clarify the competencies, and professional and managerial accountability structures for M & E, and strengthen their alignment to organizational strategies at State/LGA/SDP/Project levels

		Develop/strengthen appropriate, fully funded mechanisms for coordination of M&E activities at all levels, (e.g. managed networks, monthly meetings etc.)
		Review and enhance the organizational culture for sustainable human capacity development and timely adequate budgetary provision and release of funds for the M&E system
	2. To improve coordination, partnership and cost-effectiveness of data collection, analysis and information (routine, surveys and surveillance) to inform program planning and decision-making by all HIV/AIDS implementing agencies and stakeholders at all levels of HIV/AIDS response by 2015	Establish/strengthen cost-effective M&E TWGs at LGA/State/Federal levels
		Facilitate the emergence of an enabling environment to promote identification, sharing and learning from best practices' projects across State/LGAs/implementing partners of the national response by 2015
		Advocate for an enhanced knowledge of and commitment to the HIV M&E system among policy makers, program managers, PLHIV and other stakeholders at National, State , LGAs levels and all sectors (private & public) by 2015
		Review and implement enhanced minimum standards for routine program monitoring activities, including use of nationally harmonized data flow and collection tools, routine data analysis and use, feedback mechanism and electronic data quality control "early alert" measures
		In proactive collaboration with the wider national health care systems, establish an integrated client/patient Unique Identifier system
	M&E	Review and strengthen the effectiveness and efficiency of coordinating mechanisms for national/project/program specific surveys/surveillance by 2015
		Review and strengthen capacity building for states on surveys/ surveillance report analysis and use
		To establish a cost-effective, evidence-based national documentation system for Evaluation & Research and put in place mechanisms for promoting the timely presentation of Nigeria HIV/AIDS experience in International Conferences and fora by 2015
	4. To continuously improve data quality and supportive supervision at all levels by 2015	Review and strengthen the implementation of national guidelines and Standard Operating Procedures on data quality auditing at all the service delivery points, intermediate aggregation levels and national M&E unit
		Timely dissemination of supervisory and auditing reports to Stakeholders suing the most appropriate evidence based means
	5. To improve the efficiency and effectiveness of the delivery of the costed national multi-sectoral HIV M&E plan through a systems management approach	Facilitate and embed a systems approach, results-based performance management culture in the delivery of all program components of by the implementing agencies and stakeholders of the national response
		Ensure that national indicators and frameworks are evidence-based, appropriate to level of decision-making, and integrated to the relevant wider public/private sector systems
		Enforce One harmonized national data collection and information flow structure
	6. To strengthen and regularly update an integrated, optimally aligned, cost-effective, appropriate to local context, National HIV/AIDS database(s) to capture, verify, analyze and present program monitoring data from all levels and sectors by 2015.	Establish a national Technical Review Group on national HIV/AIDS databases
		Periodically review and strengthen national capacity to design and maintain databases used in the Nigeria national response by 2015
		Develop and cost-effectively implement the evidence-based national guidelines on data storage, data protection and access, emergency and business continuity plans at service delivery points, intermediate aggregation levels and national M&E unit by 2015

APPENDIX 2: LIST OF CONSULTANTS:

NATIONAL HIV/AIDS RESPONSE ANALYSIS AND DEVELOPMENT OF NSF/NSP 2010-15

S/N	Name of Consultant	Role/Thematic Area	Email	Originating Location
1.	Dr Pat Youri	Lead Consultant, International	patyouri@hotmail.com patyouri@4u.com.gh	Ghana
2	Dr. Adesegun Fatusi	Co-Lead Consultant	adesegunfatusi@yahoo.co.uk	Ife/Osun
3.	Dr Bunmi Asa	Promotion of Behavior Change and Prevention of New Infections	bunmi_asa@yahoo.com	Lagos
4.	Dr. Hadiza Khamofu	Treatment of HIV/AIDS and Related Health Conditions	hgkhamofu@yahoo.com	Abuja
5.	Dr Comfort Agada-Kiboigo	Care and Support for People Infected and Affected by HIV/AIDS including OVC	eyojo@yahoo.com	Abuja
6.	Dr Ifenne Eyantu	Institutional Architecture, Systems, Coordination & Resourcing	mail4enaibi@yahoo.com	Benue
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1.	**STATE STRATEGIC PLANS**	Akwa- Ibom State Strategic Plan (2006-2010)	Akwa-Ibom State	2006
2.		Bauchi State Strategic Plan (2006-2009)	Bauchi State	2006
3.		Benue State Strategic Plan for HIV/AIDS (2006-2010)	Benue State	2006
4.		Borno State Strategic Framework and Plan of action of identified groups (2005-2007)	Borno State	2005
5.		Cross River State HIV/AIDS Strategic Plan Of Action (2006-2010)	Cross river state	2006
6.		Edo State Strategic Plan for HIV/AIDS (November 2007-2010)	Edo State	2007
7.		Enugu State HIV/AIDS Strategic Plan of action (2006-2010)	Enugu State	2006
8.		Ekiti State HIV/AIDS State Strategic Plan (2010-2014)	Ekiti State	2009
9.		Gombe State HIV/AIDS Strategic Plan (2006-2009)	Gombe State	2006
10.		Imo State HIV/AIDS Strategic Framework of Action	Imo State	
11.		Kaduna State HIV and AIDS Strategic Plan for (2006-2010)	Kaduna State	2006
12.		Kogi State HIV/AIDS Strategic Plan (2006-2009)	Kogi State	2007
13.		Kwara State HIV/AIDS Response Review and Strategic Plan (2006-2009)	Kwara State	2006
14.		Lagos State HIV/AIDS Strategic Plan (2006-2010)	Lagos State	2006
15.		Nasarawa State HIV/AIDS Strategic Plan (2005-2009)	Nasarawa State	2006
16.		Niger State Strategic Plan (2009-2012)	Niger State	2009
17.		Ondo State HIV/AIDS Strategic Plan (2007-2010)	Ondo State	2007
18.		Oyo State HIV/AIDS Strategic Plan (2008-2012)	Oyo State	2009
19.		Plateau State HIV/AIDS Strategic Plan (2006-2010)	Plateau State	2006
20.		Sokoto State Strategic Plan (2009-2011)	Sokoto State	2009

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21.		Taraba State Strategic Plan (2007-2011)	Taraba State	2007
22.	**SURVEYS**	National Survey on HIV/AIDS knowledge,attitudes, practices, skills and school Health in Nigeria	Federal Ministry of Education	2006
23.		Nigeria demographic and Health Survey (North central) zone	National Population Commission	2004
24.		National HIV/Syphilis Sero-prevalence Sentinel Survey among Pregnant Women..	Federal Ministry of Health	2005
25.		National HIV Sero-prevalence Sentinel Survey	Federal Ministry of Health	2004
26.		National demographic and Health Survey	National Population Commission	2003
27.		National HIV/AIDS Response and Review (2001-2005)	NACA	2005
28.		Nigeria DHS EdData Survey: Education data for decision making	National Population Commission	2004
30.		Sentinel Survey of the National Population Programme: baseline report 2000	National Population Commission	2002
31.		Behavioural surveillance Survey	Federal Ministry of Health	2005
32.		National HIV/AIDS & Reproductive Health Survey 2003	Federal Ministry of Health	2003
33.		National HIV/AIDS & Reproductive Health Survey 2005	Federal Ministry of Health	2005
34.	**GAZETTES/ CHARTERS**	Borno State Law for the establishment of BOSACAM	Borno State	2009
35.		Anambra State Law for the establishment of ANSACA	Anambra State	2007
36.		Benue State Law for the estabishment of BENSACA	Benue State	2007
37.		Nassarawa State Law for the establishment of NASACA	Nasarawa State	2008
38.		Kogi State Law for the establishment of KOSACA	Kogi State	2008
39.		Kaduna State Law for the establishment of KASACA	Kaduna State	2007
40.		Niger State Law for the establishment of NGSACA	Niger State	2008
41.		Child's Rights Act 2003	FGoN	2003
42.		Reform of Nigerian Family Law	NLRC	2006

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43.		African Youth Charter	Federal Ministry of Youth Development	2006
44.	**PLANS(INCLUDING WORK PLANS) AND TRAINING MANUALS**	Scale- up Plan on prevention of PMTCT of HIV in NGR	Federal Ministry of Health	2005
45.		National HIV/AIDS Prevention Plan 2007-2009	NACA	2007
46.		National Health sector Strategic Plan for HIV/AIDS	Federal Ministry of Health	Jul-05
47.		Implementation of the National AIDS & STI control Programme 2005-2009	Federal Ministry of Health	2005
48.		HIV/AIDS NNRIMS Operational Plan 2007-2010	NACA	2007
49.		OVC, National Plan of action 2006-2010	Federal Min. of Women Affairs and Social Dev.	2006
50.		Borno State Reviewed Operational Plan of Action for Nigeria	BOSACAM	2009
51.		National Education sector HIV/AIDS Strategic Plan 2006-2010	Federal Ministry of Education	2006
52.		National Drug control Master Plan		May-99
53.		Mapping the involvement of civil society in HIV/AIDS in Seven States in NGR. (ActionAid)	ActionAid	Mar-02
54.		Cross river State SPT workplan 2005	CRSACA	2005
55.		Benue State Work Plan for 2005-2009	BENSACA	2009
56.		Kogi State activity and implementation Plan	KOSACA	2007
57.		Kogi State Annual AIDS Priority Plan	KOSACA	2008
58.		Taraba HPDP Work Plan	Taraba State	2005
59.		Akwa-Ibom State Work Plan (2005-2009)	Akwa-Ibom State	
60.		Training manuals for community support and home based care for people and communities infected & affected by HIV/AIDS in Nigeria	CISHAN	Mar-07

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61.		Monitoring and evaluation training manual on Nigerian National Response Information Management System	NACA	Jun-06
62.		Background document for the training modules on laboratory tests and monitoring of HIV infection	NIMR	2003
63.		PMTCT: Nigeria curriculum participants manual	Federal Ministry of Health	Jul-07
64.		Gombe State monitoring and evaluation plan for HIV/AIDS	GOMSACA	Sep-08
65.		Ondo State HIV/AIDS Priority Plan	ODSACA	2009
66.		HIV Counseling and Testing trainees manual	Federal Ministry of Health	Oct-08
67.		HIV/AIDS Manual For State Focal Officers Of The Nigeria Prisons Service	Nigeria Prison Service	Jan-09
68.		Mainstreaming Gender Into The Kenya National HIV/AIDS Strategic Plan 2000-2005	NACC	Nov-02
69.		CRSACA state AIDS priority plan (2009-2010)	CRSACA	Nov-08
70.	**RESPONSE REVIEWS, ANALYSIS AND REPORTS**	National situation analysis of the Health sector Response to HIV/AIDS in Nigeria	Federal Ministry of Health	2005
71.		Summary of the declaration of commitment on HIV/AIDS	UNAIDS	2001
72.		The level of effort in the National Response to HIV/AIDS (USAID et al)	USAID et al	2003
73.		Nigeria National Response to HIV/AIDS Update	NACA	2009
74.		Human development Report: HIV/AIDS- A challenge to sustainable human development in NGR	UNDP	2004
75.		Benue State HIV/AIDS Response Analysis and Strategic Plan (2005-2009)	Benue State	2005

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76.		Kogi State HIV/AIDS Response Review (2001-2005)	Kogi State	2007
77.		Ekiti State HIV/AIDS Response Review (2004-2008)	Ekiti State	2004
78.		Ekiti State HIV/AIDS Response Profile	Ekiti State	2008
79.		Enugu State HIV/AIDS Response Review 2000 - 2005	Enugu State	2000
80.		Niger State Annual Report of the NGSACA	Niger State	2008
81.		Nigeria 6th Country Periodic Report	FMWASD	2006
82.		Assessment Report of the National Response to young People..	Federal Ministry of Health	2009
82.		MDG report 2005	National Population Commission	2005
83.		Gender analysis of the mid term NSF implementation	UNIFEM	
84.		Analysis of the human rights of people living with HIV/AIDS and people affected by HIV/AIDS including widows in Nigeria: a) report one- desk review, b) report two- fieldwork	UNIFEM	Jul-05
85.		Edo State HIV/AIDS situational assessment, survey report 2007	Edo State	Jun-05
86.		Nigeria National HIV/AIDS Response Review (2001-2004)	NACA	2005
87.		Lagos State HIV/AIDS Response Review (2000-2005)	LSACA	2000
88.		Laboratory Based HIV Rapid Test Validation in Nigeria phase 1	Federal Ministry of Health	Apr-07
89.		Report of Desk Review On Mainstreaming HIV/AIDS Into Line Ministries and Parastatals	NACA	Jul-07
90.	**GUIDELINES**	National ethics and operational Guidelines for research on human subjects (NACA)	NACA	
91.		National Guideline on contraceptive logistics management system	Federal Ministry of Education	2003
92.		Guidelines for the Implementation of the FMWASD HIV/AIDS Workplace Policy	FMWASD	2007
93.		Guidelines for the use of anti-retroviral drugs in NGR.	Federal Ministry of Health	2005

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94.		National Guideline on pediatric HIV/AIDS treatment and care	Federal Ministry of Health	2007
95.		National Guideline for HIV/AIDS treatment and care in adolescents and adults	federal Ministry of Health	May-07
96.		National Guideline and standards of practice on OVCs	Federal Min of women & Social Dev.	Jan-07
97.		Guideline for the implementation of the National workplace Policy on HIV/AIDS	Federal Ministry of Labor and Productivity	2006
98.		National Guideline on PMTCT	Federal Ministry of Health	2007
99.		Operational Guidelines for blood transfusion practice in NGR.	National blood transfusion service	2007
100.		National Guidelines on the syndromic management of STIs & RTIs (FMOH) 2002	Federal Ministry of Health	2002
101.		National Guideline for HIV/AIDS palliative care (FMOH)	Federal Ministry of Health	
102.		Armed Forces HIV/AIDS Control Policy Guidelines	Federal Ministry of Defense	2007
103.		HIV/AIDS Extension Guide	Federal Ministry of Agriculture	2008
104.		National Guideline for HIV/AIDS VCT	Federal Ministry of Health	2003
105.	**POLICIES**	Benue State HIV/AIDS workplace Policy	Benue State	2009
106.		Kwara State Policy on HIV/AIDS (KWASACA)	Kwara State	2008
107.		Draft workplace policy for Ondo State	Ondo State	
108.		Work Place Policy on HIV/AIDS (Civilian Cell)	Federal Ministry of Defense	
109.		HIV/AIDS Workplace Policy	FMWASD	2007
110.		HIV/AIDS Workplace Policy	Federal Ministry of Information & Communication	

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111.		National workplace Policy on HIV/AIDS	Federal Ministry of Labor and Productivity	2005
112.		National workplace Policy on HIV/AIDS for the Energy Sector	Federal Ministry of Energy	2008
113.		Policy for the control and Management of HIV/AIDS among staff	Federal Ministry of Science and Technology	2004
114.		FMOH HIV/AIDS Personnel Policy	FMOH	2008
115.		National Policy on Protection and Assistance to Trafficked Persons in Nigeria	NAPTIP	
116.		National Policy on Injection Safety and Healthcare Waste Management	Federal Ministry of Health	2007
117.		National Gender Policy Strategic Implementation Framework and Plan	Federal Ministry of Women Affairs	2008
118.		HIV/AIDS Policy for the Federal Ministry of Internal Affairs/ Paramilitary Sector	federal ministry of Internal Affairs	2005
119.		National Youth Policy	Federal Ministry of Youth Development	2001
120.		National Gender Policy: Situation Analysis and Framework	FMWASD	
121.		National Gender Policy	Federal Min. of Women & Social Dev.	2006
122.		Promoting gender equality and human rights sensitive policy environment in the Nigerian HIV/AIDS national response…a)EDUCATION SECTOR b)HEALTH SECTOR	UNIFEM	Oct-08
123.		Promoting gender equality…agriculture, education and health sectors	UNIFEM	
124.		Civil society for HIV/AIDS in Nigeria: Information sharing policy	CISHAN	

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125.		Civil society for HIV/AIDS in Nigeria: Monitoring and evaluation procedures and policies	CISHAN	Feb-08
126.		CISHAN HIV/AIDS workplace policy	CISHAN	
127.		Promoting gender equality and human rights sensitive policy environment in the Nigerian HIV/AIDS national response…AGRICULTURAL SECTOR	UNIFEM	Oct-08
128.		UNAIDS/WHO Policy statements on HIV testing	UNAIDS	Jun-04
129.		ECWA Policy on HIV/AIDS	The ECWA AIDS Ministry	2004
130.		National policy on the health & development of adolescents and young people in Nigeria	Federal Ministry of Health	2007
131.	**STRATEGIES AND ASSESSMENTS**	Kaduna State prevention and strategy: Behavior Change Communication Strategy 2007-2010	KADSACA	2008
132.		The National HIV/AIDS BCC 5yr Strategy 2004-2008	NACA	Apr-04
133.		Benue State Prevention & Strategic Behavioural Communication (2008-2010)	BENSACA	Jun-05
134.		In depth HIV/AIDS Response assessment (KADSACA)	KADSACA	2005
134.		Implementation Strategy for the National youth Policy	Federal Ministry of Youth Development	2001
135.		The 2008 Situation Assessment and analysis on OVC in Nigeria	FMWASD	2008
136.		APIN Phase 11 project: a training needs Assessment for ind. & organizational capacity building of SACAs	APIN	
137.		Injection safety assessment in NGR.	Federal Ministry of Health	2004

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138.		National HIV/AIDS Strategic Framework for Action	NACA	2005
139.		Achieving universal access- The UK's strategy for halting and reversing the spread of HIV/AIDS in the developing world	DFID	
140.		Achieving universal access- evidence for action	DFID	
141.		The National HIV/AIDS BCC Strategy 2009-2014	NACA	Aug-08
142.		Strategies For an Extended and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic	FHI	
143.	**MAGAZINES, DIRECTORIES AND PROJECTS**	Gender watch Magazine	CEDPA	2007
144.		HIV/AIDS & the Nigerian Prison Service	Nigeria Prison Service	
145.		The Watchdog Magazine	CEDPA	2007
146.		Directory of institutional capacity details of stakeholders on HIV/AIDS in Ekiti State	Ekiti SACA	2008
147.		Directory of institutions for capacity building on HIV/AIDS project management in NGR.	NACA	2005
148.		The Femi and Fati HIV billboard campaign evaluation report	Society for Family Health	2003
149.		Meeting everyone's needs	National Population Commission	2004
150.		Governance of HIV/AIDS Responses, issues and outlook	UNDP	
151.		Population and the quality of life in NGR(NPC)	National Population Commission	Sep-04
152.		Establishing and sustaining HIV comprehensive care services in cottage hospitals in the Niger-Delta 2007-2008	FHI	2009

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153.		Kogi State HIV/AIDS Program Development Project	KOSACA	2008
154.		HIV/AIDS Project: Be informed about HIV/AIDS	Federal Ministry of Information and Communication	
155.		National Protocol for HIV counseling and testing at PHC level	NACA	2007
156.	**PROJECTIONS AND STATISTICS**	Projections for contraceptives including condom for HIV/AIDS in Nigeria (2003-2015)	Federal Ministry of Health	2003
157.		National and State Population projections	National Population Commission	2002
158.		Basic and Senior Secondary Education Statistics Ngr. 2004 & 2005	Federal Ministry of Education	2006
159.		Planning , costing and budgeting Framework	UNAIDS	2003
160.		Statistics of education in Nigeria 1999-2005	Federal Ministry of Education	2007
161.	**WORLD BANK**	Addressing youth within the World Bank's Multi Country HIV/AIDS program (MAP)	World Bank	
162.		World Bank's commitment to HIV/AIDS in Africa 2007-2011	World Bank	2007
163.	**TB**	Civil society perspectives on TB Policy in Bangladesh, Brazil etc	Open Society Institute	2006
164.		TB Policy in Nigeria: A Civil Society Perspective	Open Society Institute	2006
165.	**STATEMENTS, ALGORITHMS AND FORMS**	UNAIDS/IOM Statements on HIV/AIDS-related travel restrictions	IOM	Jun-04
166.		Algorithm for estimating adherence	IHVN	

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167.		New GON recommended serial algorithm	IHVN	
168.		ART monthly summary form	NACA	
169.		HCT monthly summary form	NACA	
170.		PMTCT monthly summary form	NACA	
171.	**MISCELLANEOUS**	National HCT High Level Stakeholders' forum	NACA	Oct-08
172.		MDGs Information kit 2007	Federal Government of Nigeria	2007
173.		Action Plus Bulletin		2007-2009
174.		Federal Ministry of Labor Circular	Federal Ministry of Labor and Productivity	2002
175.		National Policy on HIV/AIDS for the Education Sector in NGR	Federal Ministry of Education	2005
176.		Basic facts about HIV.	Federal Ministry of Labor and Productivity	
178.		National Policy on HIV/AIDS.	Federal Government of Nigeria	2003
179.		Lagos State AIDS Control Agency.	LSACA	
180.		HIV/AIDS and Sports Q & As.	Federal Ministry of Sport & Social Dev.	
181.		The Prohibition of Infringement of A widow's & widowers fundamental rights law of Enugu State.	Ministry of Gender affairs & Social Development. Enugu State.	
182.		Assessing Behavior Change Maintenance among HIV Risk	Society for Family Health	2006

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183.		MAP Study on the availability of social marketing products in Nigeria.	Society for Family Health	2007
184.		Assessing Behavior change among HIV Risk Group in Nigeria: Indirect Interventions through Civil Society Organizations.		2008
185.		An Impact Evaluation of a Transport Corridor Project.		
186.		National Guidelines on the Syndromic Management of Sexually Transmitted Infections and other reproductive tract Infections.	Federal Ministry of Health	2007
187.		HIV/STI Integrated biological and behavioral Surveillance Survey(IBBSS) 2007.	Federal Ministry of Health	2007
188.		Evaluation of the Prevention of mother to child Transmission (PMTC T) of the pilot program in Nigeria.		Oct 2005
189.		Update of HIV/AIDS Program in the Nigeria Prisons Service.	Nigeria Prison Service	June 2000-Mar. 08
190.		HIV/AIDS Program Report in Nigeria Prisons.	Nigeria Prison Service	2006-2008
191.		Assuring Quality: Report of the National Workshop for Effective Family Life HIV/AIDS (FLHE) Curriculum Implementation in Nigeria.	Federal Ministry of Education	Jan 06.
192.		Female condom study among Female Sex Workers.	Society for Family Health	2008
193.		Accelerating the Education Sector Response to HIV/AIDS in Nigeria: Report and Strategic framework for action.	Federal Ministry of Education	Feb 03.

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194.		Accelerating the Education Sector Response to HIV/AIDS in Nigeria:	Federal Ministry of Education	June 05.
195.		National Guidelines and standards of practice on orphans and vulnerable children.	FMWASD	Jan 07.
196.		Nigeria Demographic and health Survey 2008.	National Population Commission	2008
197.		National HIV/SYPHILIS Sero - prevalence Survey Among pregnant women Attending Antenatal clinics in Nigeria	Federal Ministry of Health	2005
198.		National Guidelines on Prevention of mother-to child Transmission of HIV(PMTCT).	Federal Ministry of Health	Jul-07
199.		Joint Midterm Review of the HIV/AIDS National Strategic Framework for Action (NSF) 2005-09	NACA	Dec -07

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