

NIGERIA UNGASS REPORT FOR 2005

(PRELIMINARY REPORT)

31 DECEMBER 2005

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ABBREVIATIONS/ACRONYMS

ACTION	AIDS Care and Treatment in Nigeria
AIDS	Acquired Immune Deficiency Syndrome
APIN	AIDS Prevention Initiative in Nigeria
ARV	Anti-Retroviral
NPC	National Population Commission
FOS	Federal Office of Statistics
BSS	Behavioural Surveillance Survey
CACA	Catholic Action Committee on AIDS
CBO	Community Based Organization
CiSHAN	Civil Society for HIV and AIDS in Nigeria
CSO	Civil Society Organizations
DoC	Declaration of Commitment
EA	Enumeration Area
ENHANSE	Enabling HIV/AIDS + TB and Social Sector Environment
FBO	Faith Based Organization
FCT	Federal Capital Territory
FHI	Family Health International
FLHE	Family Life HIV/AIDS Education
FMOE	Federal Ministry of Education
FMOH	Federal Ministry of Health
FSO	Federal Statistics Office
GDP	Gross Domestic Product
GHAIN	Global HIV/AIDS Initiative in Nigeria
HEAP	HIV/AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
ICASA	International Conference on AIDS and STIs in Africa
IDA	International Development Agency
IEC	Information Education and Communication
IHV/UMD	Institute of Human Virology / University of Maryland
LACA	Local Action Committee on AIDS
LGA	Local Government Area
M&E	Monitoring and Evaluation
MTCT	Mother to Child Transmission of HIV
NARHS	National AIDS and Reproductive Health Survey
NASA	National AIDS Spending Assessment
NASCP	National AIDS and STD Control Programme
NBCC	National Behavioural Change Communications
NCPI	National Composite Policy Index
NDHS	National Demographic and Health Survey
NGO	Non-Governmental Organization
NIBUCAA	Nigeria Business Coalition Against HIV/AIDS
NNRIMS	Nigeria National Response Information Management System
NPC	National Population Commission
NRR	National Response Review
NSF	National Strategic Framework
OVC	Orphan and Vulnerable Children

PCA	Presidential Committee on AIDS
PEPFAR	Presidential Emergency Plan for AIDS Relief
PLACA	Plateau State AIDS Control Agency
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
SACA	State Action Committee on AIDS
SDP	Service Delivery Point
SFH	Society for Family Health
STI	Sexually Transmitted Infections
SWAAN	Society of Women against AIDS in Nigeria
TWG	Technical Working Group
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	United Nations International Children Emergency Fund
USA	United States of America
VCT	Voluntary Counselling and Testing

INTRODUCTION

The United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001 adopted a Declaration of Commitment on HIV/AIDS. The Declaration of Commitment reflects global consensus on a comprehensive framework to achieve the millennium development goal of halting and beginning to reverse the HIV/AIDS epidemic by 2015 in all countries. It addresses global, regional and country level responses to prevent new HIV infections, expand health care access, and mitigate the epidemic's impact. Under the terms of the Declaration of Commitment (DoC) also signed by Nigeria, successes in country level response were defined by the achievement of time-bound targets on a number of indicators on which countries make biennial reports.

A sub-committee of the National Technical Working Group on Monitoring and Evaluation (NNRIMS) under the guidance and leadership of NACA was tasked to oversee the development process of this report. The process has been very consultative and widely participatory. A consensus building workshop which brought together representatives from government, civil society, private sector, bi-lateral partners and the UN System

This preliminary report presents the progress made by Nigeria towards the achievement of time-bound targets on 17 UNGASS indicators as well as an overview of the current status of the Nigerian HIV/AIDS epidemic and the National Response. This is the second in the series of Nigeria's biennial reports on UNGASS indicators. The first report was submitted in the year 2003. This report followed the agreed international format and is divided into seven sections.

It is obvious from the data on the seventeen indicators and the status of the national response that Nigeria is making tremendous and concerted effort towards achieving the millennium development goal of halting and beginning to reverse the HIV/AIDS epidemic by 2015. It is equally obvious that the national response in a big, complex, multi-sectoral and multi-level country like Nigeria has many challenges that must be addressed urgently and holistically.

COUNTRY PROFILE

Nigeria is located in the West African region within 3° and 14° longitudes, and 4° and 14° latitudes. It has a landmass of 923,968 square kilometres and a population density of 148 persons per square kilometre. The country shares international borders with the Republics of Cameroon, Chad, Niger and Benin (Chart 1). It has a long stretch of coastal area with a number of ports. These ports serve the country and some of its neighbours for international trade and haulage.



Chart 1: Map of Nigeria

Nigeria is the most populous country in Africa, and the tenth in the world. The 1991 population of Nigeria is 88.92 million (NPC, 1998) and a projected population of 132 million in 2004 at a growth rate of 2.8%. The population is predominantly rural (53.4%) NPC 2004, and this is expected to change over time with high rural to urban drift. It has over 373 ethnic groups (Ajaegbu et al, 2000) spread around the country. The major indigenous languages are Yoruba, Igbo and Hausa/Fulani. However, English is the official language in the country. In addition to the human resource, Nigeria is endowed with a lot of other natural resources, the major ones being crude oil, bitumen and agricultural products.

Administratively, the country is divided into 36 states and a Federal Capital Territory (FCT) Abuja. The states are semi-autonomous under the country's constitution with each having independent administrative, legislative and judicial system built to fit into the central system. The states and the FCT are further divided into smaller administrative units called local governments areas or councils totalling 774. For political, population and economic analysis the states are grouped into six geopolitical zones; South West (SW), South South (SS), South East (SE), North East (NE), North Central (NC) and North West (NW).

The Human Development Index (HDI) for Nigeria is 0.453 (UNESCO, 2002) in 2003, ranking it the 158th among countries. The literacy rate is 66.8% with life expectancy at birth of 43.4 years. The combined gross enrolment ratio for primary, secondary and tertiary schools is 64%, and a GDP per capita (PPP US\$) of 1,050 in 2003.

About 70% of Nigerians live below the poverty line (FOS 2002). Public health expenditure in 2002 was 1.7% of the GDP, while the private sector health expenditure was 3.5% of the GDP. Nigeria's total debt service in 2003 was 2.8% of its GDP nearly double the expenditure on public health.

STATUS AT A GLANCE

Nigeria's HIV infection has gone beyond the high- risk sub-populations to the entire general population. The HIV epidemic in the country is classified as generalized. The Declaration of Commitment report for Nigeria was first submitted in 2003 covering the period January – December 2002. This report is the second and covers the period 2003 to 2004.

Policy Development and Implementation Status	
Amount of national funds disbursed by governments in low and middle income countries	N827,094,717¹ (Government funds only) <i>Source:</i> (NACA)
National Composite Policy Index Areas covered: prevention, care and support, human rights, civil society involvement, and monitoring and evaluation	62% <i>Source:</i> National Composite Index Survey, 2005
Target groups: people living with HIV/AIDS, women, youth, orphans, and most-at-risk populations	58% <i>Source:</i> National Composite Index Survey, 2005
National Programmes: education, workplace policies, STI case management, blood safety, PMTCT coverage, ART coverage, and services for orphans and vulnerable children	
Percentage of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year	19%² <i>Source:</i> Assessment of National FLHE curriculum implementation
Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programmes	Combined: - 46.9% Public – 46.4% Private – 47.2% <i>Source:</i> HIV/AIDS Workplace Policy, Large Enterprises Survey 2005.
Percentage of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled	45%³ Female 41%, Male 46% Rural 30%, Urban 55% <i>Source:</i> NARHS, 2003
Percentage of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	0.81% <i>Sources:</i> FMOH, 2005 program report
Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy	7% <i>Source:</i> FMOH,
Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	Data Not Available
Percentage of transfused blood units screened for HIV	100%⁴ <i>Source:</i> Safe Blood Africa
Knowledge and Behaviour	
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	Female – 20.5% (Urban – 30.5% Rural – 14.8%) Male – 35.2% (Urban – 33.6% Rural – 19.8%) <i>Source:</i> FMOH, NARHS 2005 Preliminary results

Percentage of young women and men who have sex before age of 15	Male – 4.9% Female - 14.7% <i>Source:</i> FMOH, NARHS 2005 Preliminary results
Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	Female – 32.1% Urban – 42.9% Rural – 27.7% Male – 79.8% Urban – 90.5% Rural – 73.0% <i>Source:</i> FMOH, NARHS 2005 Preliminary results
Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	Female – 40.6.0% (Urban – 50.9%, Rural – 34.1%) Male – 59.7% (Urban – 66.8%, Rural – 54.1%) <i>Source:</i> FMOH, NARHS 2005 Preliminary results
Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	Data Not Available
Percentage of young women and men aged 15-24 who are HIV infected	5.2 % (13% reduction as compared to 2001 rate) <i>Source:</i> FMOH, ANC Technical Report 2004
Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	98.2% ⁵ <i>Source:</i> GHAIN Project 2005
Percentage of infants born to HIV infected mothers who are infected	25% Source: Computed from $\{T*(1-c)+(1-T)\} * v$; T = 0.0081, c = 0.5, v = 0.25
Additional Indicators for DoC Implementation	
Percentage of primary and secondary schools where life-skills-based HIV education is taught	Data Not Available
Percentage of Health facilities with capacity to deliver appropriate care to people living with HIV and AIDS	Data Not Available
Median age at first sex	Male - 20.1 years Female – 17.6 years <i>Source:</i> FMOH, NARHS 2005 Preliminary results

¹Data on government expenditure on HIV/AIDS that were managed by NACA only. Data from State Governments and Federal Line Ministries not included

² Desk review by the FMOE in collaboration with State Ministries of Education and the FCT

³ Percentage of all 15-64 years who reported symptoms of STIs (defined as genital itching, sores or discharge) in the last 12 months who sought treatment at an appropriate medical facility (defined as a pharmacy, hospital, workplace clinic or NGO clinic)

⁴ This data is for tertiary health institutions in the country. Secondary and private health facility data not captured

⁵ Data were only available from GHAIN treatment sites. However, the treatment program started in March 2005 and as such the survival is not for 12 months.

OVERVIEW OF THE AIDS EPIDEMIC

2.1 INTRODUCTION

The HIV/AIDS epidemic has become a major social, health and developmental challenge in many developing countries of the world, which account for about 95% of the burden. In some countries HIV/AIDS has already started reversing the post independence developmental gains more especially in Sub-Saharan Africa. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) AIDS Epidemic update of December 2005, an estimated 40.3 million people are living with HIV/AIDS globally. The bulk of the epidemic is in Sub-Saharan Africa where about 25.8 million adults and children are living with the infection. A clear disproportionate impact is shown as Sub-Saharan Africa region with only about 10% of the global population is nursing close to 70% of the AIDS burden. In adults, women are the most affected in the region as they contribute close to 60% of the case-load.

In Nigeria, the first case of HIV was reported in 1986, and the epidemic has since expanded rapidly from an adult prevalence rate of 1.8% in 1991 to 4.5% in 1996, 5.8% in 2001 and 5.0% in 2003 (Chart 2). Although the prevalence rate appears low, Nigeria ranks third in terms of actual impact of HIV/AIDS after South Africa and India.

The table 1 shows how Nigeria's HIV prevalence rates compare to some selected countries in the Sub Saharan Africa region.

The epidemic in the country has extended beyond the commonly classified high-risk groups and now common in the general population. As at the time of preparing this report, the 2005 sero-prevalence survey was ongoing and results from this survey will confirm the true direction of prevalence.

The true caseload of AIDS in Nigeria, just like other countries in the region is unknown.

However, through projections the impacts of the epidemic in the country have been estimated.

Table 2 below shows selected statistics on AIDS in Nigeria.

Table 1: Adult (15-49) HIV Prevalence rates in selected Sub-Saharan Countries, 2003

Benin	1.9
Cameroon	6.9
Chad	4.8
Cote d' Ivoire	7.0
DR Congo	4.2
Ethiopia	4.4
Ghana	3.1
Niger	1.2
South Africa	21.5
Nigeria	5.4

Source: UNAIDS, 2004

Table 2: Selected statistics on HIV/AIDS in Nigeria

- An estimated 3.2-3.8 million people are living with HIV/AIDS
- An estimated 520,000 are in need of ARVs
- About 1.2 million children have been orphaned by AIDS
- About 300,000 people have succumbed to AIDS

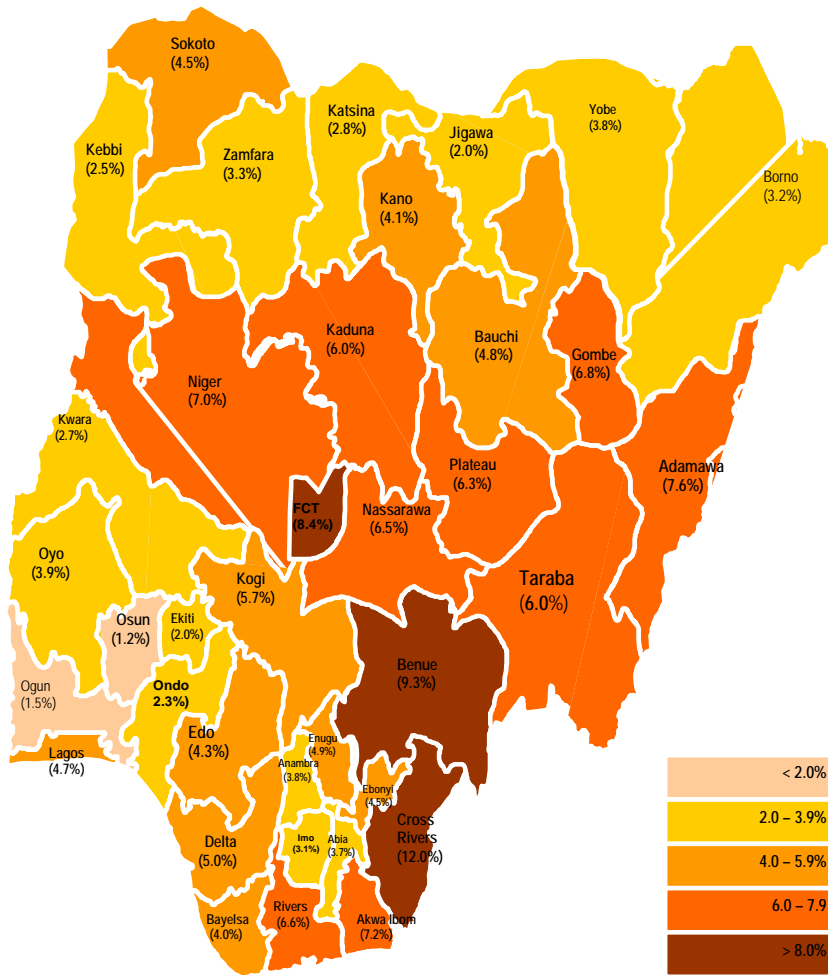
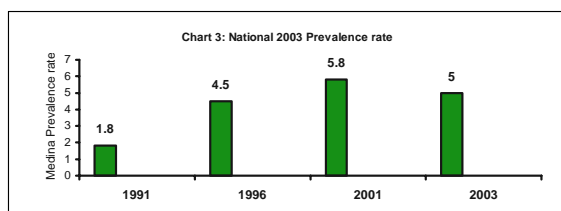


Chart 2: State prevalence rates in Nigeria from 2003 Sentinel Survey Source: *FMOH, 2004a*

2.2 THE HIV/AIDS EPIDEMIC

HIV/AIDS and high level of poverty are posing problems and challenges to developmental efforts of government in Nigeria. The median prevalence rate in adult population increased from 1.8% in 1991 to 5.8% in 2001 and to 5.0% in 2003 (Chart 3). It has extended beyond the commonly classified high-risk groups and is now common in the general population across all the states of the federation.



Source: FMOH, National HIV Sero-prevalence Surveys

2.2.1 HIV Prevalence by Location

The median HIV prevalence rate in 2003 varied significantly across states, geopolitical zones, and by urban and rural locations in the country. Osun State recorded the lowest prevalence rate of 1.2% while the highest rate of 12.0% was observed in Cross River State (Chart 2). HIV prevalence in urban areas is generally higher compared to the rural areas. Stratifying the rural /urban HIV prevalence by geopolitical zones yields a similar picture. Refer to chart 4 below. Additional data are, therefore, required to help understand the cultural, behavioural and social practices that can explain the observed differences.

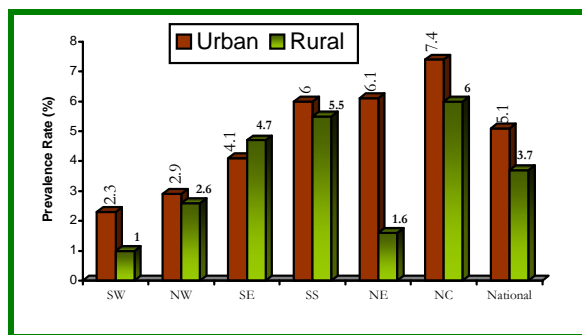


Chart 4: HIV Prevalence by Rural/Urban Locations in Zones: Source 2003 National HIV Sero-prevalence Sentinel Survey, FMOH 2004a.

2.2.2 HIV Prevalence by Age

Chart 5 below shows the age pattern of HIV infection. The chart shows the variation in HIV prevalence across age-groups, with the 20 –29years age bracket having higher prevalence rates.

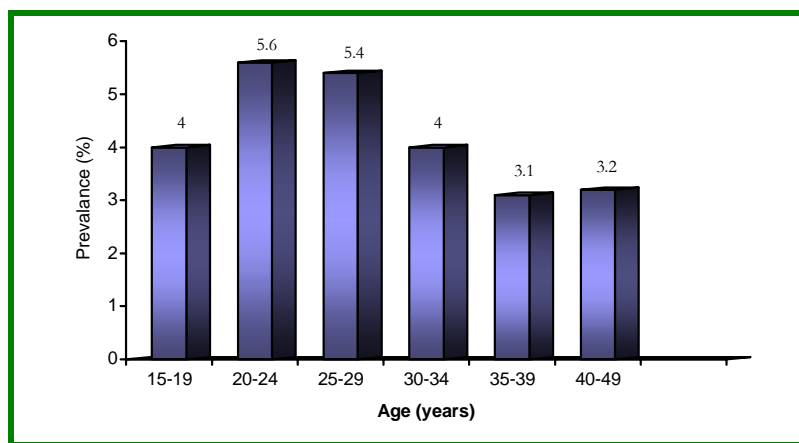
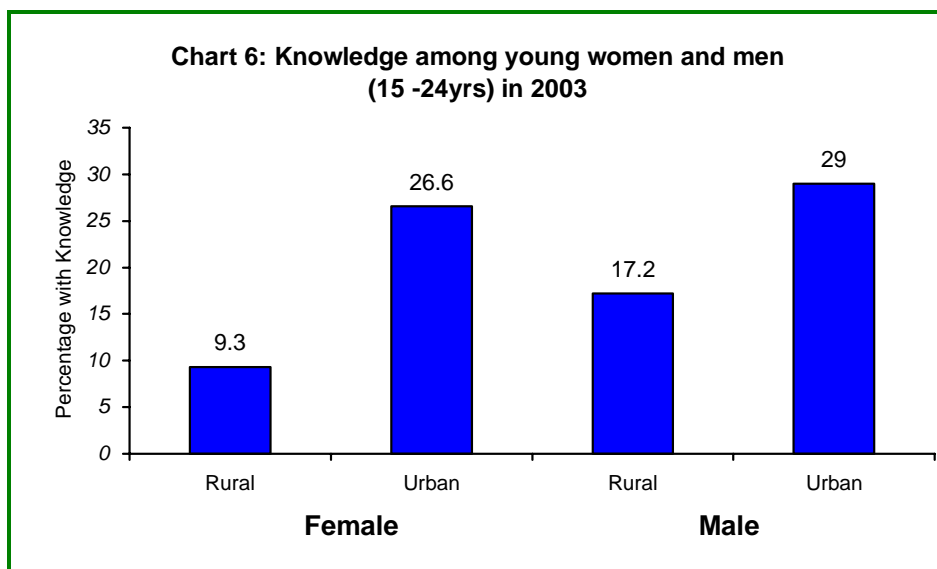


Chart 5: National HIV Prevalence by Age from 2003 Sentinel Survey: FMOH 2004a.

2.2.3 HIV Knowledge and Behaviour

Knowledge of HIV/AIDS in Nigeria is very high. According to the Nigeria Demographic and Health Survey of 2003, HIV/AIDS knowledge is higher among men (97%) than women (86%) (NPC, 2004). Among men differences in HIV/AIDS knowledge across demographic characteristics like age, geographic location, residence (rural/urban), educational achievement and wealth quintile were low compared to women. Knowledge among women in the southern part of the country was generally higher than their counterparts in the north (NPC, 2004). Although, there is a high level of HIV/AIDS knowledge in the country particularly among the age group 15 –24years, this has not yet translated to a corresponding levels of positive behaviour change.



Source: National Population Commission (NPC) 2004

In 2003, 23% of young women and men aged 15-24 correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission (Chart 6 above). The distribution of correct knowledge by location and sex is presented in chart 5 above.

The median age at first sex is 16.9 years (female) and 19.8 years (men). Reported high-risk sexual behaviour young women and aged 15-24 is still unacceptably high. About 25.5% (female) and 78.6% (male) respondents admitted having sex with non-marital and non-cohabiting partner. Of these 32.0% (female) and 53.2% (male) indicated the use of condoms (FMOH, 2004b).

2.3 IMPACT OF HIV AND AIDS

The impact of HIV/AIDS in Nigeria is not yet quite noticeable. However, studies have been carried out to assess impact in the some significant sectors. Furthermore, from projected figures, the impact of HIV/AIDS pandemic on the socio-economic development could be understood from an increasing number of orphans vulnerable children, incidence of tuberculosis and other opportunistic infections and reduction in life expectancy. Others include, an increase in school dropouts especially among young girls.

The assessment of socio-economic and demographic impacts of HIV/AIDS has not

HIV/AIDS Burden: Socio-economic implications in Nigeria

	2005	2010
Number of children orphaned due to AIDS	1,640,000	2,680,000
Number of Orphans	7,820,000	9,130,000
Number of HIV positive pregnant women	227,900	223,300
Life Expectancy	47years	43.4 years

Sources: A report on the HIV/AIDS estimates for the Nigeria in 2005: FMOH 2005,

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been carried out in Nigeria. The current demographic structure of the country’s population is documented from the 1991 census. However, to assess the real impact of HIV and AIDS on the demography of the country, results of the 2006 census are required. On the other hand, the national response review (NRR) carried out in 2004 revealed some socio-economic impacts of the epidemic on the traditional social safety nets (results not expatiated). The NRR also documented progress made in mitigation of impacts as limited to those being undertaken by FBOs, CBOs and NGOs. Table 3 above shows the projected impact of HIV/AIDS on some selected socio-economic indicators.

A case in point is a study carried out in Benue State, one of the states with high HIV prevalence rates, that showed that in some communities orphans increased from one in every 100 households in 1997 to one in every 8 in 2002 (BSRDA, 2004). The study also revealed that 66% of households affected by HIV/AIDS lost their incomes as persons who were ill or died were more often traders or working in public service. Medical costs of up to \$292.31 and funeral cost of up to \$146.15 have been recorded in AIDS-affected rural households (Royal, 2004). About 25% of the households have ended up using up their reserves or liquidating assets, 75% borrowing, while 87% received external contributions. A number of affected households used erosive strategies like reduction in farming investment (19%), stopping payment of school fees (12%) abandon their farms for casual employment (8%). These results reflect the heavy burden of HIV and AIDS on households in Nigeria.

THE NATIONAL RESPONSE TO HIV/AIDS EPIDEMIC

3.1 INTRODUCTION

Nigeria recorded her first case of AIDS in 1986. In response, the Government constituted an ad-hoc committee coined the National Experts Advisory Committee on AIDS (NEACA) in 1987. This was followed by the establishment of the National AIDS and STDs Control Programme (NASCP) in 1988 to coordinate all HIV/AIDS activities. Since the first case was reported, the epidemic has steadily increased as shown by the sentinel surveillance survey results of 1.8% in 1991 to 5% in 2003. The low literacy levels and poor healthcare seeking behaviour of most Nigerians, as well as the limited access to health services, have strengthened sceptics' opinion that the magnitude of the epidemic might be under-reported in the country to date. Furthermore, due to the military rule as at the time of the unveiling of the epidemic in the country, the initial attitude of the government and general population to the epidemic was denial.

The advent of democratic rule in 1999 brought about a significant change in the attitude of government to the epidemic as well as the response to it. In 2000 a Presidential Committee on AIDS (PCA) was established and directed the development of the HIV/AIDS Emergency Action Plan (HEAP) in 2001. The HEAP served as a medium term strategic plan to tackle the epidemic through a multi-sectoral approach covering the period 2001 to 2004. The HEAP focused on three major areas: creation of an enabling environment through the removal of socio-cultural, informational and systematic barriers to community-based responses; prevention; care and support. The National Action Committee on AIDS (NACA) with a broad-based multi-sectoral membership from private, civil society and public sector organizations was given the mandate of coordinating the timely execution of the HEAP. The revised HIV/AIDS policy was adopted and launched in 2003 entrenched the multi-sectoral approach and highlighted the need for the formation of a statutory agency to replace NACA.

Towards the expiry of the HEAP, a review of the national HIV/AIDS response was carried out and pointed to the need for a new plan. The 2005 – 2009 National Strategic Framework (NSF) was developed through a widely consultative and participatory process. The consultation involved over 200 members from different partners and stakeholder organizations under the facilitation of both national and international consultants. The NSF has set targets in line with national, UNGASS and other international declarations that Nigeria is a signatory to. The document was officially launched on 11 October 2005 by Secretary to the Federal Government.

3.1 Institutional and Coordination Structures

Coordination and institutional management is the core of an effective national response to the epidemic. The national response in Nigeria, in line with the country's federal constitution is coordinated through a three-tier system of administration led by the National Action Committee on AIDS (NACA), State Action Committee on AIDS (SACA), and the Local Government Action Committee on AIDS (LACA). NACA led the successful raising of HIV/AIDS awareness among the leaders in various sectors and the general population that has stimulated responses to the epidemic. Despite some impressive responses in some states, not all states have effective SACAs and LACAs. NACA as a federal coordinating body is not able to exercise full control in coordinating SACA and LACA HIV and AIDS activities,

due to the semi-autonomous status of states in Nigeria and the lack of legal status. Thus, SACAs and their respective LACAs have some degree of autonomy, which does not bind them to follow through on all NACA coordination requirements. While NACA has a strong multi-sectoral representation and participation in HIV and AIDS planning and activities, this approach is not reflected effectively at the SACA and LACA levels. The capacity of most of the coordinating entities still needs strengthening to ensure an effective management and coordination of all activities to stem the epidemic in Nigeria.

3.2 Resource Mobilization and Management

Resource mobilization is pivotal to an effective national response to HIV and AIDS. The HEAP provided the context for partnership in resource mobilization. At the national level, over US\$300 million was attracted into the national response in the last four years from a wide range of stakeholders which included the government, development partners, private sector, the Global Fund, World Bank, United Nations System, United States and United Kingdom governments and others. The expiry of the HEAP coincided with the launch of the United States Presidential Emergency Plan for AIDS Relief (PEPFAR), from which the country expects about US\$500 million between 2004 and 2009 into the national response. Over-dependency on donor funding has restrained the responsiveness of indigenous resource mobilization. The Private sector is currently not adequately involved. Religious bodies and communities are yet to be sufficiently motivated and mobilised to contribute to the national response. Despite the country's ability to attract significant resources, there is still a huge resource gap in view of the scale and enormity of the epidemic.

In addition to coordination and resource mobilisation, NACA is also managing substantial amounts of money for the national response. Financial resources from the government, World Bank and Global Fund among others are channelled through NACA. However, some of the donors like USG manage the resources by themselves. In an effort to ensure coordinated and harmonised donor support, a platform coined Donor Coordination Group has been formed and meets on a monthly basis. Furthermore, there is a Programme Support Group (PSG) that also meets regularly under the leadership of the government. The PSG comprises government, UN system, bilateral donors, civil society and organised private sector. Among so many things the PSG looks at issues of coordination, harmonisation, resource mobilisation, allocation and management to ensure equity.

3.3 Prevention

With the rising prevalence, prevention activities have become a priority within the national response. Most of the resources available are being expended on Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT) and Behaviour Change Communication (BCC) programmes.

Voluntary Counselling and Testing (VCT)

Voluntary Counselling and Testing is an effective means of addressing the psychological and socio-sexual aspects of HIV/AIDS. It is an entry point for both HIV/AIDS prevention and care intervention programmes. Access and uptake of VCT has remained a major challenge. For instance, the result of 2003 NARHS indicated that 7% of Nigerian reported ever been tested for HIV. The Guidelines for VCT have been developed and on 1 December 2005 the President of the Federal Republic of Nigeria launched the "Heart to Heart" VCT strategy. To date, there are 228 operational VCT centres in the country.

Prevention to Mother to Child Transmission (PMTCT)

The National PMTCT programme was launched in 2002. Operational guidelines and a scale-up plan have been developed and widely disseminated. The programme is delivering services at 33 national sites while NGOs and State Governments are supporting a number of sites across the country. Despite the institution of the guidelines and programmes, access, male support and involvement remains a challenge.

Behavioural Change Communication (BCC)

A framework to guide implementation of behaviour change communication intervention programmes was developed and launched in 2004 targeting the general populace and vulnerable groups. The framework provides a direction for all HIV/AIDS intervention activities in information, education and communication (IEC). Key messages centre on abstinence, mutual fidelity and condom use. A typical example is the “*Zip-up*” campaign, focusing on delay of sexual debut (abstinence) targeting youth in and out-of-school. Civil society organizations, Faith-Based Organizations (FBOs), Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) and community leaders, by virtue of their comparative advantage of reaching out to remote corners of the country with IEC materials.

The country has also witnessed an increase in the number of pieces of male condoms distributed. In 2004 alone over 200 million pieces were distributed. The numbers are projected to increase as more players are getting into condom programming.

3.4 Treatment, Care and Support

Following the African Summit of Heads of State in 2001, renewed government commitment at the highest level and active involvement of PLWAs in advocacy, the federal government initiated an anti-retroviral (ARV) programme in 25 centres targeting 10,000 adults and 5,000 children. Albeit there had been delivery of ART services in few private, NGOs and missionary hospitals across the country though at very high costs.

To achieve rapid ART scale-up the GON and stakeholders have put in place frameworks and guidelines. These include: National Strategic Framework (2005-2009); Health Sector Strategic Plan (2005 – 2009); ART Scale-up plan (2005- 2009), Presidential Mandate to scale ART to 250,000 PLWAs by June 2006 and National ART Treatment Guidelines. In support of the strong commitment demonstrated by the GON in providing quality and comprehensive treatment, other partners notably GFATM, MAP and PEPFAR have committed resources into ART programme. To date the number of PLWAs on treatment in the country stands at about 40,000.

With close to 300 PLWAs support groups nationwide, the capacity of PLWAs has been strengthened to provide care and psychosocial support to their members and affected families. Community-based care and psychosocial support activities targeting PLWAs and OVCs are being provided primarily by faith-based CSOs. Women constitute the bulk of support providers in this area. In February 2004, a national conference on OVC was conducted to facilitate the further development of a national OVC response.

3.5 Socio-economic Impact and Impact Mitigation

Gender inequalities and poverty worsen the course and socio-economic impact of the HIV/AIDS on societies in the world. The NRR revealed some socio-economic impacts of the epidemic that have affected the traditional social safety nets in Nigeria. The review also highlighted progress in mitigation of socio-economic and psychosocial impact, though limited both in terms of scale and scope, largely being undertaken by FBOs, CBOs and NGOs without a clear and coordinated strategy amidst severely limited resources. Some modest progress has been made with implementation of workplace policies in the organized private sector; however, not much has been achieved within the small and medium enterprises, where most of the labour force is employed. Likewise, the strategies and activities directed at vulnerable groups, especially orphans and other vulnerable children, widows and widowers, called for in the HEAP, have not been adequately implemented.

3.6 Uniformed Services, Regional Programmes and New Technologies

Uniformed Services

There is significant progress in HIV and AIDS programmes targeting the Armed Forces, Police, Immigration, Custom, and Prison Personnel. With support from local NGOs; the Armed Forces Programmes on HIV/AIDS (AFPAC) has recorded a lot of success in their programmes. The lessons learnt from AFPAC programme are being replicated in other uniformed services. Nigerian uniformed services are actively involved in the peacekeeping operations within the West-Africa region and beyond. Hence, the need for countries to develop a comprehensive HIV/AIDS programme targeting peace-keepers to mitigate the spread and impacts.

Regional Programmes

Nigeria has major highways running south to north and across to West and Central African countries. With rail-routes out of use for more than a decade, road has become the only means of haulage and mass transit. Transport workers, their clients and populations in towns and along major transit routes are now classified as high-risk groups. The World Bank has provided grant to provide preventive intervention programmes for migrants, transport workers and their clients on major routes in particular the Lagos-Abidjan transport corridor.

New Technology Initiatives

There exists a strong political will and commitment by the Nigerian government for the development of new technologies for HIV prevention. Nigeria has an HIV/AIDS vaccine framework making her more prepared for the international HIV vaccine research efforts. Several NGOs are also conducting advocacy interventions on vaccines and microbicides.

3.8 Policy, Advocacy, Legal and Human Rights

At both the state and federal levels, HIV/AIDS related policies have been developed. At the Federal level, the National Assembly has designed a constituency outreach programme to enable Senators and Members of the House of Representatives mobilize their constituencies against HIV/AIDS. Furthermore, the President has also sent a bill to transform NACA into an agency, and this is receiving attention on the floor of parliament. Public hearing of the bill has already been held. On the other hand some states have already transformed their State

Action Committees on AIDS (SACAs) into legal Agencies with budgetary allocation. Examples are Lagos and Plateau States. Anecdotal evidence has it that other states are in the process of following suit.

Nigeria, through the Federal Ministry of Health, adopted the National Policy on HIV/AIDS and STIs in 1997. In recognition of the importance of multi-sectoral efforts to control the epidemic, the National policy on HIV/AIDS was revised in 2003 with a wide acceptance by all and sundry. However, the major challenges around policies implementation are; the lack of widespread knowledge by the general public, and the inability of most policies to address the gender dimensions of the HIV and AIDS epidemic. There is also the need for review of some policies to ensure that they are more supportive to the fight against HIV/AIDS. Equally important is the need for development of relevant legal instruments to give strategic policies (workplace, insurance coverage and more) legal backing to ensure that the response to HIV/AIDS observes human rights.

Critical to the above is the reduction of stigma and discrimination against persons living and affected by HIV/AIDS. All the above documents deliberately include issues on providing support aimed at discouraging the discriminating against persons living with AIDS.

3.2.3 Civil Society Organizations

There are more than 1,300 Civil Society member organisations working on HIV/AIDS in Nigeria. The response within the Civil Society is organised principally under the umbrella of six networks namely Civil Society for HIV and AIDS in Nigeria (CiSHAN), Nigerian AIDS Research Network (NARN), Interfaith Coalition, Society for Women and AIDS in Africa, Nigerian chapter, (SWAAN), National Youth Network on HIV and AIDS (NYNETHA), Media Arts and Entertainment (MAE) and Network of People Living With HIV and AIDS in Nigeria (NEPWHAN). In the spirit of the three ones, these six are currently working independently having individual management structures and work plans but also in partnership with CiSHAN. These groups are housed in the 'Civil Society House' with support from NACA and UNAIDS.

CiSHAN

This is the body that coordinates and advocates for an enabling environment for its member organisations. It has a well-developed and efficient organisational and management structure that replicates the country's three tiers of government namely National, State and LGA chapters. In addition, CiSHAN also has the mandate of leveraging and allocating resources for the use of its members.

The network is currently engaged in capacity building, Gender and Human rights mainstreaming and budget tracking activities. Furthermore, it organises a biannual meeting for all its members across the country.

The organization has representation on the boards of NACA, Country Coordinating Mechanism of the Global Fund to Fight AIDS Tuberculosis and Malaria, PEPFAR/GHAIN project and the Expanded UN Theme Group. It has been actively involved in the development of the HEAP as well as the NSF and worked closely with UNAIDS, USAID, DFID, Action Aid International, SFH, FHI Pathfinder, ENHANSE (Policy project), and the Federal Ministries of Health, Women Affairs and Education in the process.

CiSHAN has used capacity building strategy in improving the knowledge base and programme management capacity of its members for an effective national response. Some of capacity building initiatives have been on HIV/AIDS preventive interventions, increasing participation of civil society in the assessment, monitoring and evaluation of resource mobilization and utilization. In 2004, 135 members were trained on prevention interventions, 96 members on resource mobilization in three States and 180 members in programme development.

Interfaith Coalition (Faith based organisation) on HIV/AIDS

This was formed in 2002 and operates through a network of 51 member organisations, representing both Christians and Muslims. These groups integrate HIV/AIDS messages into their sermons and encourage HIV testing among potential marital partners. They have endorsed statements on commitment to reducing stigma and discrimination. NACA and partners have facilitated and supported the formation of an interfaith forum to discuss HIV/AIDS issues in Nigeria. One major outcome of the 2005 Interfaith forum was the setting up of a 12-member national faith based Advisory Council on HIV which will act as an advisory body to NACA on faith based responses.

Media Arts and Entertainment Network:

Central to this constituency is the issue of media response and accurate reporting. In recent years, there has been a marked increase in both quality and quantity of media coverage of the epidemic and the response to it. Although, sensational reporting still occasionally occurs, reports are less stigmatising and utilise appropriate language. Media owners are being engaged as partners in the campaign and journalist networks have been formed to promote specific issues such as PMTCT. Media NGOs such as Journalists Against AIDS (JAAIDS), Development Communications Network (DEVCOMS) and Internews Nigeria are coordinating these efforts.

NARN

NARN is the research arm of the civil society response and the overall goal of NARN is to ensure that programs on HIV/AIDS undertaken by its members are evidenced based. It supports strong research and advocate for the critical role of research in policy and programming. NARN has strengthened human resources vital to the scale up of HIV/AIDS interventions in Nigeria particularly in the area of research by promoting, implementing and disseminating research findings on various aspects of HIV/AIDS in Nigeria.

NEPWHAN

This organization was established in 1998, exists to ensure greater and meaningful involvement of people living with HIV and AIDS in the response at all levels. It is an umbrella body of over 360 support groups spread across the country. It has three principal organs namely, Women, Youth and Association of Religious persons living with or affected by HIV and AIDS. NEPWHAN intends to increase access to comprehensive gender-sensitive care, treatment and support services for PLWHA by 50% in 2009.

NYNETHA

NYNETHA came into existence in 2004 focusing on the prevention care and support and impact mitigation of the HIV and AIDS among the youth. This is the most recent of all the

CiSHAN constituencies. It was formed through combined efforts of UNAIDS, NACA and UNICEF. It spearheads the establishment of youth friendly facilities that allow youths to access and utilise services in a conducive environment.

3.10 Organised Private Sector Response

The organized private sector responded to the HIV/AIDS epidemic by establishing the Nigerian Business Coalition Against AIDS (NIBUCAA) in 2003 with a mission to mitigate the impacts of the HIV/AIDS pandemic in the Nigerian private sector. NIBUCAA's vision is to help develop a private sector where businesses are well informed and committed to addressing the growing challenges of HIV/AIDS in the workplace and broader community. NIBUCAA facilitates private sector response that focus on strengthening of workplace policy implementation, mobilizing and empowering youth groups against the epidemic. In responding to the HIV/AIDS pandemic, some private establishments have developed their workplace policies and programmes (VCT, ART, STI case management and condom distribution).

There exists increasing collaboration between the public and private sectors in addressing HIV/AIDS in Nigeria. About 120 private sector organizations are engaged in mobilizing over N700 million (about \$6 million) worth of resources to battle the epidemic in Nigeria. The public private partnership comprising NIBUCAA, Nigerian Employees Consultative Assembly and Nigerian Labour Congress has contributed immensely to the national response.

MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE GOALS/TARGETS

From the discussions under the national response to HIV/AIDS epidemic it is clear and evident that there are challenges and gaps that need to be addressed by Nigeria in order to achieve the goals/targets. The gaps are in the areas of: Institutional and coordination mechanisms across the three tiers of response, resources mobilization and management, prevention, treatment, care and support, socio-economic impacts and impact mitigations, civil society, policy and legal environment and monitoring and evaluation.

Based on the above challenges and gaps, the following critical recommendations are being proposed:

Institutional and Coordination Mechanism

- There is urgent need to conclude work on the legal status of NACA and to review the current Bill on NACA, in order to allow for an effective coordination relationship between NACA, SACAs and LACAs.
- There is need to provide technical support to SACAs and LACAs in order to strengthen their ability to coordinate stakeholders within the State/Local government response.
- States and Local Governments require sustained high-level advocacy to secure commitment of political office holders and administrative institutions
- Establish and operationalize the national HIV/AIDS partnerships forum.

Resource Mobilization and Management

- Development of a resource framework to ensure equitable distribution and targeting of resources.
- Provision of capacity building at all levels for HIV/AIDS resource mobilization and management.
- Conduct of a comprehensive study on donor support to map activities, strengths, and impact of investment in HIV/AIDS programmes.
- Develop institutional mechanism for transparency and accountability in public and private sectors for HIV/AIDS resource mobilization, allocation, and utilization.

Prevention

- Promote and strengthen youth-friendly and gender sensitive programmes.
- Promote and expand access and usage of male and female condom.
- Encourage mutual fidelity and consistent condom use among sexually active people.
- Mainstream Gender into all prevention, care, and treatment programmes.
- Scale-up PMTCT services and implementation of STI syndromic management into all levels of care particularly secondary and primary facilities in public and private sectors.

Behavioral Change Communication

- Promote the operationalization of the Nigerian National five-year BCC Strategic Framework on HIV/AIDS for sustainable behaviour change.
- Increase the capacity of the media, arts and entertainment industries to respond adequately to HIV/AIDS prevention and control.
- Engage long distance drivers in interpersonal communication skills and target IEC materials and BCC campaigns on HIV/AIDS at motor parks and junction towns.

Treatment, Care and Support

- Produce and widely disseminate guidelines and protocols in ART, PMTCT, VCT and OVC services to all stakeholders including FBOs, CSOs and the private sector.
- Expand access to integrated and comprehensive services including home-based/community services
- Strengthen partnerships amongst public sector, private sector, FBOs and CSOs in the delivery of ART, OI, HBC, and OVC services.
- Strengthen capacity of family members, PLWAs and communities to provide home-based care and support, including care for OVC.
- Document and widely disseminate Best Practices on ART, VCT, OIs, OVC, etc.
- Create and strengthen linkages with available services for OVC such as Universal Basic Education (UBE), NAPEP, NDE etc.

Socio-economic Impact and Impact Mitigation

- Develop and implement appropriate plans to provide children made vulnerable by or to HIV/AIDS, with needed social support, such as assistance with: continued schooling, shelter, nutrition, health and other social services. For example, the UBE programme should be used to catalyse undeterred access by orphans and vulnerable children to education.
- Involvement of poor and vulnerable groups particularly widows, women, and young people, as resources and not beneficiaries only, towards impact mitigation of HIV/AIDS. Specifically, the women and youth are to be targeted for skill acquisition and micro credit facilities.
- There is the imminent need to scale up private sector response and build their capacity to address the increasing burden of AIDS epidemic on the society. Specific areas of input include resource mobilization, care and support and workplace policy development and implementation.
- Develop and implement advocacy strategies aimed at specific cultural challenges that address stigma and discrimination, including upholding the rights of PLWAs in the communities.

Monitoring and Evaluation, Surveillance and Research

- There is a need to review the NNRIMS to include indicators that will address all objectives in the NSF.
- There should be general population-based seroprevalence survey to validate the magnitude of the epidemic.

- There is need to establish M&E units across at all levels of coordination - NACA, SACAs, LACAs, as well as focal persons responsible for collecting and collating relevant information at the facility and CSO levels. Such data should be analysed and widely disseminated to ensure evidence based decision making.
- There is need to ensure adequate funding for M & E activities by advocating for a minimum of 10% allocation of the HIV/AIDS budget to M&E for all the coordinating bodies.
- There should be increased research that will inform HIV/AIDS programming.
- There is a need to ensure community preparedness and participation in research and to ensure community preparedness preceding community trials.

Policy, Advocacy, Legal and Human Rights

- There is need for capacity development among key HIV/AIDS implementers on gender and human rights dimensions of HIV/AIDS to operationalize gender and human rights-friendly policies.
- There is the need to enforce and enact laws amenable to the protection of the PLWAs and other vulnerable groups.
- There is need for concerted and coordinated mass literacy programmes and civic education programmes around legal issues surrounding HIV/AIDS.
- There is need for increased awareness among HIV/AIDS stakeholders on the linkages between Human rights and HIV/AIDS.
- There is need for the development of a rich legal environment that would ensure protection of PLWAs when their rights are violated.

Civil Society Organizations

- Develop and implement a comprehensive National Counselling and Testing Scale-up plan at all levels with active involvement of CSOs, FBOs, PLWA support groups, public and private sector.
- Strengthen partnerships amongst public sector, private sector, FBOs and CSOs in the delivery of ART, OI, HBC, and OVC services.
- NACA should actively facilitate civil society capacity building to enhance programme design, implementation monitoring and management
- More states and FBOs should be encouraged to develop policies on HIV/AIDS that are sensitive to gender and vulnerable groups and ensure widespread dissemination of policies among critical stakeholders.

SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS

Nigeria appreciates the support of development partners in the fight against the epidemic without which the resource gap (financial, material and technical) would have been much wider. To successfully implement the NSF and arrest further spread of HIV, the country would like development partners to provide support in the following areas:

1. Continue and improve the scope of current intervention activities in prevention, treatment care and support for the infected, affected and the OVCs.
 2. Increase funding levels in their current areas of focus and supplement national effort.
 3. Provide TA in the areas of planning, monitoring and evaluation, capacity building and facility infrastructure development.
 4. Provide TA in particular areas of OVC and life skills education for in school youth to ensure equitable geographic coverage within a reasonable timeframe.
 5. Commit to working with NACA and other Coordinating structures to align their support to national strategies, policies and annual priority action plans.
-

MONITORING AND EVALUATION ENVIRONMENT

INTRODUCTION

The monitoring of the HIV/AIDS epidemic in Nigeria began in 1991 with efforts to determine the magnitude and determine trends of the HIV epidemic in the country by the Federal Ministry of Health. When the country adopted a multi-sectoral and multi-disciplinary approach in responding to the epidemic, HIV prevalence became grossly inadequate as a tool for monitoring the national response. Other systems that were collecting data were uncoordinated and unsystematic. In addition, the systems did not have standardised indicators and data collection methods

Recognising the need for a robust country monitoring and evaluation system, NACA with support from partners initiated the development process of a National HIV and AIDS monitoring and evaluation framework to guide the national response and provide key indicators for the evaluation of the impact of the various interventions in 2002. The system, coined Nigeria National Response Information Management System (NNRIMS) was officially launched in April 2004. NNRIMS has since then endeavoured to develop a multi-level monitoring and evaluation infrastructure, using a multi-sectoral approach that will provide the most efficient, high quality, standardised, relevant and timely information on the national response through implementation of the NSF. In addition, the system aims at ensuring accountability, accurate and timely data for appropriate policy formulation, review and program development and redirection of resources.

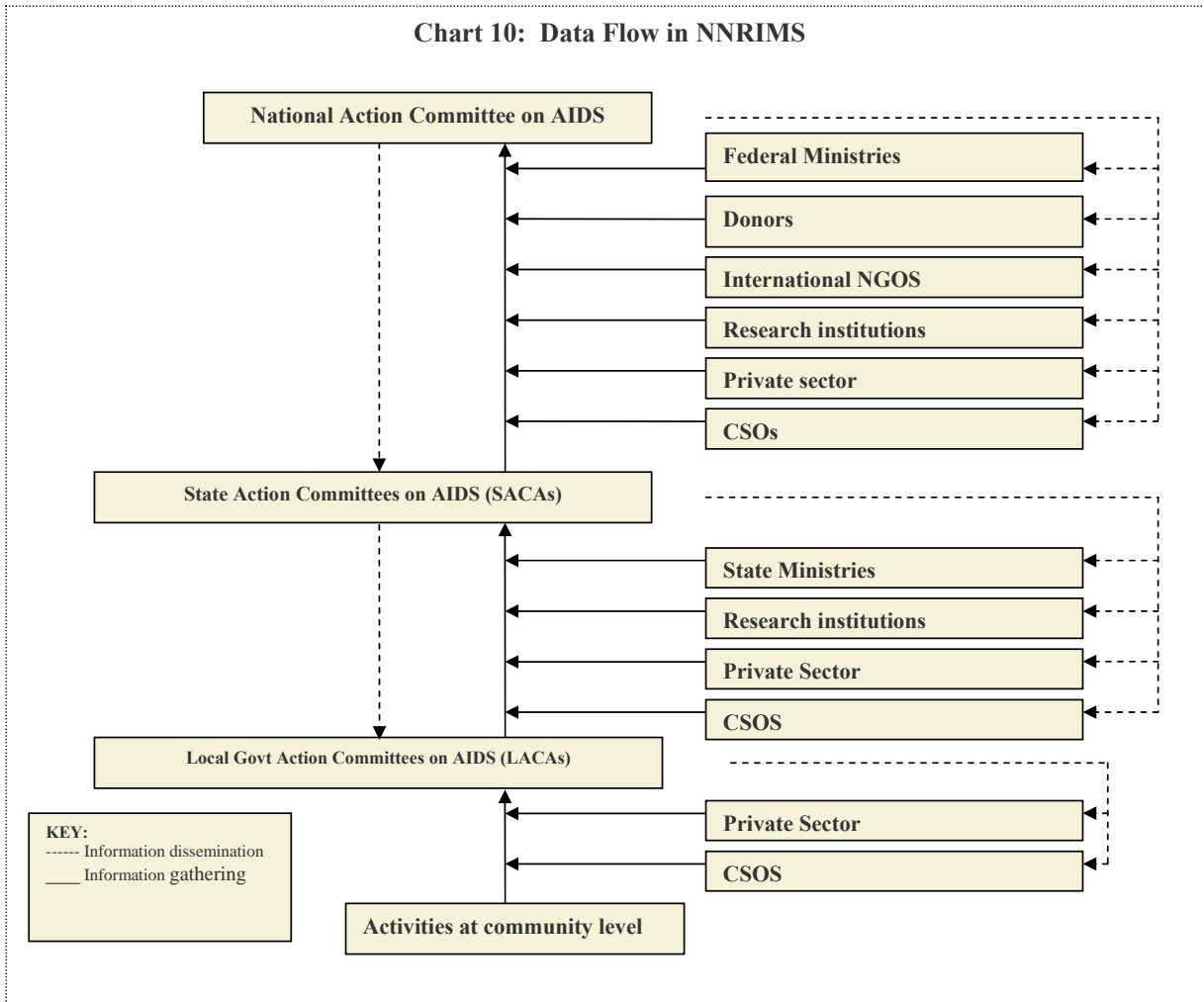
NNRIMS has identified data sources as: HIV and Behavioural Sentinel surveys, population based surveys (examples are Demographic and Health Surveys, National AIDS and Reproductive Health Surveys), research work, special surveys, program and project reports, assessments and service statistics captured through routine management information system (MIS). A system has been put in place to generate data through NARHS, BSS and HIV sentinel surveillance surveys every two years beginning 2003. All NNRIMS related activities will as much as possible incorporate a gender perspective by ensuring gender-disaggregated data where possible in issues addressed.

6.2 DEVELOPMENT OF NNRIMS

In 2002, NACA commenced the development of a National HIV and AIDS monitoring and evaluation framework to guide the national response. The review of Nigeria's HIV/AIDS emergency action plan (HEAP) in 2004 revealed that monitoring and evaluation (M&E) was essentially lacking to assess responses activities. This observation stressed the importance of national strategic and M&E frameworks. NNRIMS was therefore developed along side and to meet one of the objectives of the country's 2005-2009 National Strategic Framework (NSF). The NNRIMS was developed with the full participation of stakeholders, partners and donor agencies. The NNRIMS consist of an MIS and an M&E system. The MIS provides for a system for data flow, sharing and feedback, especially for information gathering, research, program and project reports and service coverage data collection. This component of the NNRIMS was piloted in five of the 36 states in the country between September 2004 and April 2005 to enable learning and identification of better operational tools and methods. The pilot has been evaluated and lessons learnt are being used to facilitate scale up of NNRIMS to all states and line ministries.

6.3 THE NNRIMS INFORMATION FLOW

NNRIMS has taken cognizance of the country’s extensive landmass, administrative set-up and the principles of the “Three Ones.” NACA has a replica at the state (SACA) and LGA (LACA) levels. The flow of data in NNRIMS rolls up from service providers to NACA through LACAs and SACAs (Chart 10) and disseminated in the reverse order.



6.4 IMPLEMENTATION OF THE NNRIMS

Results from the MIS evaluation of NNRIMS pilot in the five states revealed wide gaps in resource capacity to effectively implement the components of the system at all levels. To fill in these gaps, a progressive human capacity building with financial complements is being pursued. Implementation of NNRIMS has commenced with the roll out of NNRIMS first to 17 states, and this will closely be followed by the remaining 19 states.

6.5 PERIODIC/SPECIAL SURVEYS AND RESEARCH

Four special surveys are conducted in Nigeria for assessing the impacts of the national response and to monitor the prevalence of HIV in the country. These are the National AIDS and Reproductive Health Survey (NARHS), the Behavioural Surveillance Survey (BSS), the National Demographic and Health Survey (NDHS) and the HIV Sero-prevalence Survey.

6.5.1 National HIV/AIDS and Reproductive Health Survey

The Federal Ministry of Health in collaboration with donor agencies and key partners have committed to conducting three biennial nationwide behavioural surveys in Nigeria, the National HIV/AIDS and Reproductive Health Survey (NARHS). The first in the series was conducted in 2003 and this was followed by the 2005 survey with last coming in 2007. The overall objective of NARHS in Nigeria is to provide information on the situation and the variety of factors that influence reproductive and sexual health, and provide data regarding the impact of ongoing HIV and family planning behaviour change interventions, and to yield into existing gaps that require attention. A technical committee supervises the survey with the aspect of fieldwork contracted out to an independent research agency, which works closely with the local National Population Commission (NPC) staff. Interviewers are usually recruited within localities and trained by the agency.

For NARHS a nationally representative sample of about 10,000 respondents consisting of women aged 15-49 years and men aged 15-64 years is used. A multi-stage probability sampling is used for selecting respondents; stage one involves the selection of rural and urban localities in states, the second stage involves the selection of enumeration areas (EAs) within selected localities, and the third stage is the selection of individual respondents within selected enumeration areas. The EAs in all localities in the country are maintained by the NPC for population activity surveys and the national census. Respondents allocated to states are proportional to the population of the states.

6.5.2 Behavioural Surveillance Survey (BSS)

The behavioural surveillance survey (BSS) a biennial survey focuses on most vulnerable and high-risk segments of the population to provide information about behaviours that drive the HIV epidemic to guide intervention programmes. It provides information on social, demographic and contextual factors of the respondents as well as the level of current risk behaviours in various segments of the population. The key characteristics used in the selection of the high risk groups include: HIV/AIDS epidemiology (prevalence rate), high-risk activities and presence of ongoing HIV/AIDS/STIs intervention.

The BSS in Nigeria focuses on unmarried youths aged 15-24 years, sex workers, transport workers and uniformed services and is being implemented by the Federal Ministry of Health (FMOH) in collaboration with Family Health International, AIDS Prevention Initiative in Nigeria and Society for Family Health. A sample of about 30,000 respondents is selected from rural and urban settings and different locations of high-risk activities in the country.

6.5.3 National HIV Sero-prevalence Sentinel Survey

HIV Sero-prevalence surveys have been repeatedly carried out since 1991, but it became a biennial activity since 1999. It is carried out with the objective to determine the prevalence of HIV infection among the adult population 15-49 years, monitor the trend of HIV infection, and make information available to inform policy and planning of intervention programmes.

The survey uses pregnant women attending antenatal clinic in public health institutions in all states of the country as proxy.

The survey is implemented by the Federal Ministry of Health (FMOH) in collaboration with NACA, UN and bilateral agencies. About 30,000 samples are used from rural and urban sites in all the states including the FCT.

6.5.4 National Demographic and Health Survey (NDHS)

The NDHS is conducted by the National Population Commission (NPC) with the objective to provide current and reliable data on fertility and family planning behaviour, child mortality, children's nutritional status, the utilization of maternal and child health services, and knowledge and attitudes towards HIV/AIDS. NDHS is repeated every four years (NPC, 2004).

Respondents in the NDHS are women aged 15-49 and men aged 15-59 years in selected households. The NPC EAs for 1991 census are the basis of selecting households in the 1999 and 2003 NDHS.

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- UNAIDS (2004) 2004 Report On the global AIDS epidemic.
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APPENDICES

APPENDIX 1: PROCESS NOTES ON SELECTED INDICATORS

National Spending

The amount of funds disbursed was collected from records of the FMOF, NACA, NASCP. The funds reflected are funds reported as utilized by agents and service providers in the year 2004. The NASA form 1 and 2 and their annexes were used in soliciting for information. The budgetary functions adopted by fund sources and agents are not particularly as defined by NASA.

Life Skills HIV/AIDS Education

In 2002, only one (Oyo State) of the 36 states and the FCT was implementing HIV/AIDS life skills education curriculum in schools. In 2005, all the states including the FCT have committed to commencement of the family life HIV/AIDS education (FLHE) in public and private schools. The programme started with the development of the curriculum by the FMOE/UNICEF. State ministries of education have appointed HIV/AIDS desk officers to provide leadership for the implementation of FLHE in their states. The FMOE has distributed the FLHE curriculum and is training teachers for federal and state owned schools. So far 14 of the 36 states and the FCT have commenced implementation in junior secondary schools. From records of the FMOE and a study carried out by FMOE in all the six geopolitical zones reveal that about 19% of all public secondary schools in the country are now implementing FLHE while all the states have concluded preparations to commence implementation in September 2005.

Workplace Policy

In April 2005, the Federal Ministry Labour and Productivity adopted the National Workplace Policy on HIV/AIDS. This policy which is rights based provides guidelines for government, employers, workers and other stakeholders in the workplace and identifies strategies and programmes for: a) protection of human rights and dignity of workers infected/affected by HIV and AIDS, b) provision of HIV/AIDS information and services to workers, c) HIV/AIDS prevention, impact mitigation, care and support within the workplace, and d) reduction of stigma and discrimination based on real or perceived HIV status. This policy covers all Federal Line Ministries and Extra Ministerial Organizations.

To energize the private sector, President Olusegun Obasanjo addressed a cross section of the business community in 2003 urging them to utilize their core competencies and resources to fight HIV and AIDS. The private sector responded by establishing the Nigerian Business Coalition Against AIDS (NIBUCAA) with the mission to mitigate the impact of the HIV and AIDS pandemic in the Nigerian private sector, and the vision to help develop a private sector where business is informed and committed to addressing the growing challenges of HIV/AIDS in the workplace and broader community. NIBUCAA facilitates private sector response including the development of workplace policies and intervention activities, and building the human capacity for private sector response.

A survey was carried out to determine the extent of public and private sector response in the area of mitigation and specific intervention actions against the HIV and AIDS epidemic in terms of existence of employee workplace policies and provision of preventive and care

services. The survey has a national coverage for both public and private sectors and is targeted at firms/institutions or organisations.

The survey was facilitated by the National M & E Technical Working group committee on UNGASS 2006 with financial support from EHANSE Policy Project, Nigeria. The committee developed the survey instrument, selected a nationally representative sample of major public and private sector employers. Other factors like ownership, type of services provided, location and size (number of employees) were considered during the selection. The instrument was administered to the employers by trained field consultants.

Of all the selected organisations, 81% respondent and the distribution of responding organisations by different characteristics are given in tables 1 to 3. Simple statistical procedure was carried out to investigate for any systematic relationship between existence of HIV/AIDS workplace policy and any of these characteristics. No systematic relationships were observed.

Table 1: Distribution of Organisation by Type of Services

Type of Organisation	Percentage
Manufacturing	26.6
Oil & Gas	3.1
Communication	1.6
Services	45.3
Finance	14.1
Construction	1.6
Other	7.8
Total	100.0

Table 2: Distribution of Organisations by Size

Number of employees	Percentage
< 500	45.3
500 < 1000	28.1
> 1000	26.6
Total	100.0

Table 3: Distribution of Organisations by Location

Location	Percentage of Organisations
ABIA	6.3
BAUCHI	4.7
FCT	4.7
GOMBE	1.6
KADUNA	3.1
KANO	9.4
LAGOS	51.6
OGUN	1.6
OYO	7.8
PLATEAU	1.6
RIVERS	7.8
Total	100.0

Of all the organisations that responded, 46.9% (Table 4) had HIV/AIDS workplace policy and programmes for staff and sometimes with members of their families.

Table 4: Presence of HIV/AIDS Workplace policy in Organisations

Organisations with Workplace policy	46.9%
Organisation without workplace policy	53.1%
Total	100.0

National AIDS Spending Assessment 2005 for UNGAS Reporting

REPORTING TO UNGASS

MANDATORY (as agreed in the UNGASS

DECEMBER, 31, 2005

RECOMMENDED (Components of the total figure to be reported)

Expenditure on HIV and AIDS 2004

ORIGIN OF THE SOURCES / FINANCING AGENT

Functions	PUBLIC			INTERNATIONAL			PRIVATE	
	Total NAIRA	Central (National)	Sub-national	Bilateral	Multilaterals	Global Fund	Corporations	Out-of-pocket
1. Prevention								
1.2. Community mobilization	425,481,534.00	425,481,534						
1.9. Workplace Activities	32,916,000.00					32,916,000		
2. Care and Treatment								
3. Orphans and Vulnerable children								
4. Program Management costs								
4.1. Programme Management.	204,609,715.20	204,609,715.2						
4.3. Monitoring and Evaluation	1,608,628.00	1,608,628						
4.4. Operations Research	4,836,000.00					4,836,000		
4.5. Surveillance (sero-sentinel, behaviour surveillance)	22,280,495.00	22,280,495						
4.6. Training.	189,784,594.00	184,282,594				5,502,000		
4.7. Logistic and supply, including transportation:	48,090,746.00	29,378,746				18,712,000		
4.9. HIV drug resistance surveillance.	22,176,000.00					22,176,000		
4.10. Upgrading laboratory infrastructure.	36,098,000.00					36,098,000		
4.12. Non-governmental institutional capacity building:	1,663,000.00					1,663,000		

5. Human Resources Incentives								
6. Social Mitigation								
7. Community development and enhanced environment								
8. Other Items								
TOTAL	989,544,712.20	867,641,712.20				121,903,000		

APPENDIX 2

CONSULTATION AND PREPARATION PROCESS

The UNGASS 2006 report was prepared in consultation and involvement of Nigeria's partners in HIV and AIDS National Process. Nigeria has a national M&E technical working group (TWG) which meets every two months to review reports from its subgroups and committees assigned tasks of monitoring and evaluation. The M&E TWG is headed by the Director Response Monitoring in NACA with all M&E officers of implementing partners, donor agencies, multi-lateral and Bi-lateral organizations, and Line ministries as members.

In August 2005, the M&E TWG appointment a committee of twelve to identify sources of data, put in process the procurement of funds to drive the report process, facilitate the collection of required data, and prepare a draft report for presentation to the M&E TWG. UNAIDS Nigeria sponsored a consultant to facilitate and drive the process, and to be supervised by NACA and UNAIDS.

The reporting period coincided with periods for project reviews, evaluation of PMTCT and NNRIMS pilot schemes, special surveys like; NARHS, BSS and ANC surveillance had also reached advanced stages of field work.

For national AIDS spending assessment, the committee approached the HIV/AIDS resources envelop with forms 1 and 2 of the NASA tools. The process relied on projects annual reports for 2004 spending. The major problem encountered here is that of assigning funds to appropriate functions since providers were not interviewed and records not kept in accordance with NASA functions.

Two teams of consultants administered the NCPI questionnaires to appropriate respondents identified by the committee. The responses were analyzed by the committee from harmonized responses from the two groups. NEPWHAN, CiSNHAN and other NGOs were involved in all the processes. Respondents to section A of the NCPI questionnaire did not disagree so much with respondents to section B.

ENHANSE Policy Project provided funds for the workplace policy indicator. For this purpose, the committee developed an instrument for the workplace survey, selected a representative sample of public and private sector employers, recruited and trained field staff and supervised the administration of the questionnaires. The questionnaires were returned and analyzed by the committee.

A stakeholders' consultative meeting was called for 16th December 2005 to discuss and validate the report.

APPENDIX 3

Consultation/preparation process for the National Report on monitoring the follow-up to the DoC on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

- | | | |
|----------------------|-----|--|
| a) NAC or equivalent | Yes | |
| b) NAP | Yes | |
| c) Others | Yes | (please specify: <u>Bilateral agencies, and NGOs</u>) |

- UNAIDS
- USAID
- NEPWHAN
- CiSNHAN
- ENHANSE Policy Project
- CRH
- Prof. Atsenuwa, University of Lagos, Law professor and human rights activists
- Dr. Ima Arit Kashim, Independent Policy Group (IPG) and Gender Specialist.
- Odumuye MSM

2) With inputs from

Ministries:

- | | | |
|-----------------|-----|----|
| Education | Yes | |
| Health | Yes | |
| Labour | Yes | |
| Foreign Affairs | | No |
| Others | Yes | |

(please specify: Women Affairs and Youths)

- | | |
|--|-----|
| 3) Was the report discussed in a large forum? | Yes |
| 4) Are the survey results stored centrally? | No |
| 5) Are data available for public consultation? | Yes |

Name / title: Professor Babatunde Osotimehin/ Chairman NACA

Date: _____

Signature: _____

APPENDIX 4

NATIONAL COMPOSITE POLICY INDEX - 2006

Country: NIGERIA

Name of the National AIDS Council officer in charge:

Prof. Babatunde Osotimehin

Signed by: Prof. Babatunde Osotimehin, Chairman NACA

Address:

TEL:

FAX:

E-MAIL:

DATE:

Once the questionnaire is completed, please return it by e-mail, mail or fax to:

Evaluation Unit
UNAIDS Geneva
Tel:
Fax:
E-mail:

SECTION A

I. Strategic plan

1	Has your country developed a national multi-sectoral strategy/action framework to combat HIV/AIDS	YES
	Period covered	2005-2009
1.1	<i>IF YES</i> , which sectors are included?	
	Sectors included	Strategy/Action framework
	Focal point /Responsible	
	Health	Yes
	Education	Yes
	Labour	Yes
	Transportation	Yes
	Military (Defence)	Yes
	Women	Yes
	Youth	Yes
1.2	<i>IF YES</i> , does the national strategy/action framework address the following me areas, target populations and cross-cutting issues? (<i>Yes/No</i>)	
	Programme	
	a. Voluntary counselling and testing?	Yes
	b. Condom promotion and distribution?	Yes
	c. STI prevention and treatment?	Yes
	d. Blood safety?	Yes
	e. Prevention of mother-to-child transmission?	Yes
	f. Breastfeeding?	Yes
	g. Care and treatment?	Yes
	h. Migration?	No
	Target populations	
	i. Women and girls?	Yes
	j. Youth?	Yes
	k. Most-at-risk populations ¹ ?	Yes
	l. Orphans and other vulnerable children?	Yes
	Cross-cutting issues	
	m. HIV/AIDS and poverty?	Yes
	n. Human rights?	Yes
	o. PLHA involvement?	Yes
1.3	<i>IF YES</i> , does it include an operational plan?	Yes
1.4	<i>IF YES</i> , does the strategy/operational plan include:	
	a. Formal programme goals?	Yes
	b. Detailed budget of costs?	Yes
	c. Indications of funding sources?	Yes
	d. Monitoring and evaluation plan?	Yes
1.5	Has your country ensured “full involvement and participation” of civil society in the planning phase?	Yes

¹ Most-at-risk populations are groups that have been *locally* identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, commercial sex workers, motor-taxi drivers etc)

1.6 Has the national strategy/action framework been endorsed by key stakeholders? **Yes**

Comments Consultative and consensus meetings were held and the framework was signed off by stakeholders

2 Has your country integrated HIV/AIDS into its general development plans (such as: a) National Development Plans, b) United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, and d) Common Country Assessments)? **Yes**

2.1 IF YES, in which development plan? **In a, b, c and NEEDS**
 Covering which of the following aspects? (Yes/ No)

	a)	b)	c)
HIV Prevention	Yes	Yes	Yes
Care and support, & Treatment	Yes	Yes	Yes
HIV/AIDS Impact alleviation	Yes	Yes	Yes
Reduction of gender inequalities as relates to HIV/AIDS prevention/care	Yes	Yes	Yes
Reduction of income inequalities as relates to HIV prevention/care	Yes	Yes	Yes
Others: <u>Private sector Initiative</u>	Yes	Yes	Yes

3 Has your country evaluated the impact of HIV/AIDS on its economic development for planning purposes? **No**
 IF YES, how much has it informed resource allocation decisions? **N/A**
 (Low to High)

4 Does your country have a strategy/action framework for addressing HIV/AIDS issues among its national uniformed services, military, peacekeepers and police? **Yes**

4.1 YES, which of the following have been implemented?

HIV Prevention	Yes
Care and support	Yes
Voluntary HIV testing and counselling	Yes
Mandatory HIV testing and counselling	
Overall, how would you rate strategy planning efforts in the HIV/AIDS programmes?	
	2005 9
	2003 4

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference Response in 2003 was mainly health based and under HEAP, multi-sectoral response started picking up 2003 and based on informed response

II. POLITICAL SUPPORT

1 Does the head of the government and/or other high officials speak publicly and favourably about AIDS efforts at least twice a year?

Head of government	Yes
Other high officials	Yes

2	Does your country have a national multi-sectoral HIV/AIDS management/coordination body recognized in law? (National AIDS Council or Commission)		No
2.1	<i>IF YES</i> , when was it created? Year:		N/A
2.2	Does it include?		
	Terms of reference		N/A
	Defined membership		N/A
	Including civil society		N/A
	PLHIV		N/A
	Private sector		N/A
	Action plan		N/A
	Functional Secretariat		N/A
	Date of last meeting of the Secretariat		N/A
3	Does your country have a national HIV/AIDS body that promotes interaction between government, PLHIV, the private sector and civil society for implementing HIV/AIDS strategies/programmes?		
3.1	If yes, does it include?		
	Terms of reference		Yes
	Defined membership		Yes
	Action plan		Yes
	Functional Secretariat		Yes
	Date of last meeting	Date: 28/9/2005	
Comments	<u>The body meets quarterly and the bill is going second reading to make NACA an agency. Public hearing already held by the House of representatives</u>		
4	Does your country have a national HIV/AIDS body that is supporting coordination of HIV-related service delivery by civil society organizations?		Yes
4.1	If yes, does it include?		
	Terms of reference		No
	Defined membership		Yes
	Action plan		Yes
	Functional Secretariat		Yes
	Date of last meeting	Date:	
Comments	<u>This body is the Civil Societies Consultative Group against HIV/AIDS in Nigeria</u>		
	Overall, how would you rate the political support for the HIV/AIDS programme?	2005	8
		2003	7
	<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>	<u>Political leaders are getting more involved in the fight against AIDS</u>	

III. Prevention²

1	Does your country have a policy or strategy that promotes information, education and communication (IEC) on HIV/AIDS to	Yes
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² Strategies/policies discussed under *Prevention* may be included in the national strategy/action framework discussed in I.1 or separate

	the general population?	
	In the last year, did you implement an active programme to	
1.1	promote accurate HIV/AIDS reporting by the media?	Yes
2	Does your country have a policy or strategy promoting HIV/AIDS related reproductive and sexual health education for young people?	Yes
2.1	Is HIV education part of the curriculum in:	
	primary schools	Yes
	secondary schools	Yes
2.2	Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?	Yes
Comments	<u>All states have committed to implementation of the family life and HIV/AIDS education curriculum. Level of implementation varies with states</u>	
3	Does your country have a policy or strategy to promote IEC and other preventive health interventions for most-at-risk populations?	Yes
3.1	Does your country have a policy or strategy for these most-at-risk populations?	
	Injecting drug users, including:	No
	- Risk reduction information, education and counselling?	No
	- Needle and syringe programmes?	No
	- Treatment services?	No
	- If yes, drug substitution treatment?	N/A
	Men who have sex with men?	No
	Sex workers?	No
	Prison inmates?	No
	Cross border migrants, mobile populations	No
	Refugees and/or displaced populations?	No
Comments	<u>Work is in progress for other policies</u>	
4	Does your country have a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities? (These commodities include, but are not limited to, access to VCT, condoms, sterile needles and STD drugs)	Yes
	Do you have programmes in support of the policy or strategy?	
	A social marketing programme for condoms?	Yes
	A blood safety programme?	Yes
	A programme to ensure safe injections in health care settings?	Yes
	A programme on ante-natal syphilis screening	Yes
	Overall, how would you rate policy efforts in support of prevention?	
	2005	7
	2003	8
	<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference</i>	<u>Focus is now shifting to treatment</u>

IV. Care and support³

1	Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with sufficient attention to barriers for women, children and most-at-risk populations? (Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)	Yes	
2	Which of the following activities have been implemented under the care and treatment of HIV/AIDS programmes?	2003	2005
	a. HIV screening of blood transfusion	Yes	Yes
	b. Universal precautions	Yes	Yes
	c. Treatment of opportunistic infections (OI)	No	Yes
	d. Antiretroviral therapy (ART)	Yes	Yes
	e. Nutritional care	Yes	Yes
	f. STI care	Yes	Yes
	g. Family planning services	No	No
	h. Psychosocial support for PLHIV and their families	No	No
	i. Home-based care	No	No
	j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	Yes	Yes
	k. Cotrimoxazole prophylaxis among HIV-infected people	Yes	Yes
	l. Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Yes	Yes
	m. Other: (please specify) Care and Support	Yes	Yes
	Overall, how would you rate the efforts in care and treatment of the HIV/AIDS programme?	2005	6
		2003	4
	<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference</i>	<u>Funds from the Global Fund, more structure plan, more donor participation, states are going into treatment, institutional strengthening</u>	
3	Does your country have a policy or strategy to address the additional HIV/AIDS related needs of orphans and other vulnerable children (OVC)?	No	
3.1	IF YES, Is there an operational definition for OVC in the country? Yes, No	N/A	
	IF YES, please provide definition: _____		
3.2	Which of the following activities have been implemented under OVC programmes?	2003	2005
	School fees for OVC	NA	NA
	Community programmes	NA	NA
	Other: (please specify)	NA	NA
	Overall, how would you rate the efforts to meet the needs of OVC?	2005	NA
		2003	NA

V. Monitoring and Evaluation^{4*}

³ Strategies/policies discussed under *Care and Support* may be included in the national strategy/action framework discussed in I.1 or separate

1	Does your country have one national Monitoring and Evaluation (M&E) plan?	Yes
	<i>Years covered</i>	<u>2005/06</u>
1.1	<i>IF YES</i> , was it endorsed by key partners in evaluation?	Yes
Comments	<u>It was participatory in development, and developed through consensus</u>	
1.2	Was the M&E plan developed in consultation with civil society, PLHIV?	Yes
2	Does the M&E plan include?	
	data collection, analysis, reporting and information feed back	Yes
	well defined standardized set of indicators	Yes
	guidelines on tools for data collection	Yes
	a data management plan	Yes
3	Is there a budget for the M&E plan?	No
3.1	If yes, has funding been secured?	N/A
4	Is there a Monitoring and Evaluation functional Unit or Department?	Yes
	<i>IF YES</i> ,	
	Based in NAC or equivalent?	Yes
	Based in Ministry of Health?	No
	Elsewhere?	No
4.1	If yes, are there mechanisms in place to ensure that all major implementing partners submit their reports to this Unit or Department?	
4.2	Is there a full time officer responsible for monitoring and evaluation activities of the national programme?	Yes full time
4.3	<i>IF YES</i> , since when? : Year	2003
5	Is there a committee or working group that meets regularly coordinating M&E activities, including surveillance?	Yes regular
5.1	Does it include representation from civil society, PLHIV?	Yes
6	To what degree (<i>Low to High</i>) are UN, bi-laterals, other institutions sharing M&E results?	3
Comments	<u>Working to improve this</u>	
7	Have individual agency programmes been reviewed to harmonize M&E indicators with those of your country?	Yes
8	Does the M&E Unit manage a central national database?	No
8.1	<i>IF YES</i> , what type is it? _____	N/A
9	Is there a functional* Health Information System?	No
	National level	N/A
	Sub-national*	N/A
10	Is there a functional Education Information System?	No
	National level	N/A
	Sub-national*	N/A
11	Does your country publish at least once a year an evaluation report on HIV/AIDS, including HIV surveillance reports?	No

⁴ The whole M&E section is relevant for the "Third One"

12 To what extent strategic information is used in planning and implementation? 7

Comments In 2006 all stakeholders will be planning based on the NSF and Global Task Team recommendations

13 In the last year, was training in M&E conducted
 At national level? Yes
 At sub-national level? Yes
 Including civil society? Yes

Overall, how would you rate the monitoring and evaluation efforts of the HIV/AIDS programme? 2005 5
 2003 1

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: Nothing before 2003, stablishment of M&E unit in NACA, partners' support, capacity building

SECTION B

CIVIL SOCIETIES AND NGO RESPONSES

I. Human rights		
1	Does your country have laws and regulations that protect people living with HIV/AIDS against discrimination (such as general non-discrimination provisions or those that specifically mention HIV, that focus on schooling, housing, employment, etc.)?	Yes
<i>Comments</i> <u>There is a general non-discrimination clause in the constitution. However, there is no specific legislation directly related to HIV/AIDS. It is unclear whether the general provision will be interpreted as specifically including HIV/AIDS.</u>		
2	Does your country have non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV/AIDS discrimination (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?	No
3	Does your country have laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations? <i>IF YES, please list groups:</i>	N/A Yes
<i>IF YES, please list</i> <u>Criminal provisions criminalizing homosexual relations and sex work as well as IDUs. See specifically the criminal code, the penal code and NDLEA act.</u>		
4	Is the promotion and protection of human rights explicitly mentioned in any HIV/AIDS policy/strategy?	
<i>Comments</i> <u>HIV/AIDS is specifically mentioned in the HIV/AIDS policy of 2003</u>		
5	Has the Government, through political and financial support, involved vulnerable populations in governmental HIV policy design and programme implementation? <i>IF YES, give examples:</i>	Yes
<i>IF YES, give examples:</i> <u>MSMs, PLWAs, and representatives of mobile populations (e.g transport workers' unions) are engaged in policy dialogue and program implementation.</u>		
6	Does your country have a policy to ensure equal access, between men and women, to prevention and care?	Yes
<i>Comments</i> <u>Component of 2003 National HIV/AIDS policy and the 2005 NSF</u>		
7	Does your country have a policy to ensure equal access to prevention and care for most-at-risk populations?	Yes
<i>Comments</i> <u>while not specifically mentioning the most-at-risk populations, the neutral language of the existing policy ensures their coverage</u>		
8	Does your country have a policy prohibiting HIV screening for general employment purposes (appointment, promotion, training, benefits)?	Yes
9	Does your country have a policy to ensure that HIV/AIDS research	

protocols involving human subjects are reviewed and approved by a national/local ethical review committee? **Yes**

9.1 IF YES, does the ethical review committee include civil society and PLHIV? **Yes**

Comments The committee is non-functional at national level

10 Does your country have the following monitoring and enforcement mechanisms?
 Collection of information on human rights and HIV/AIDS issues and use of this information in policy and programme development reform **No**
 Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons which consider HIV/AIDS related issues within their work **Yes**
 Establishment of focal points within governmental health and other departments to monitor HIV-related human rights abuses **Yes**
 Development of performance indicators or benchmarks for compliance with human rights standards in the context of HIV/AIDS efforts **No**

11 Have members of the judiciary been trained/sensitized to HIV/AIDS and human rights issues that may come up in the context of their work? **Yes**

Comments Trained by NGOs but not by government or through a formal programme

12 Are the following legal support services available in your country?
 Legal aid systems for HIV/AIDS casework **Yes**
 State support to private sector laws firms or university based centers to provide free pro bono legal services to people living with HIV/AIDS in areas such as discrimination **No**
 Programmes to educate, raise awareness among people living with HIV/AIDS concerning their rights **Yes**

13 Are there programmes designed to change **societal attitudes** of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance? **Yes**

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV/AIDS?	2005	5
	2003	2

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: Since 2003, there has been public exposure of landmark cases of right violation, workplace policies at national and organisational levels with more explicit mention of human rights, increased sensitisation. The 2005 NSF is more direct and detailed than earlier documents.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations?	2005	5
	2003	2

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference: While the framework document and policies provide a setting for effective interventions, the absence of an adequate legal framework, inadequate funding, absence of an independent institution negatively impact implementation. There is also evidence of non-inclusion of critical stakeholders, especially members of the legal community even now.

II. Civil society participation

1 To what extent civil society has made a significant contribution to strengthening the political commitment of top leaders and national policy formulation? **6**

2	To what extent civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on HIV/AIDS or for the current activity plan (attending planning meetings and reviewing drafts)?		7
3	To what extent the complimentary services provided by civil society to areas of prevention and care are included in both the National Strategic plans and reports?		7
4	Has your country conducted a National Periodic review of the Strategic Plan with the participation of civil society in:	Month/Year	Yes 04/2005
5	To what extent your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an independent national/local ethical review committee <i>in which PLHIV and caregivers participate?</i>		3
	Overall, how would you rate the efforts to increase civil society participation?	2005	8
		2003	7
	<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>	<u>Increased recognition of CSO work as well as increased government and NGOs relations in an emerging democracy. Mutual suspicion has been minimized between CSOs and government officials</u>	

III. Prevention

1	Which of the following prevention activities have been implemented in 2003 and 2005 in support of the HIV prevention policy/strategy? (Check all programmes that are implemented beyond the pilot stage to a significant portion of both the urban and rural populations).		2003	2005
	a. A programme to promote accurate HIV/AIDS reporting by the media.			
	b. A social marketing programme for condoms			
	c. School-based AIDS education for youth	√		√
	d. Behaviour change communications	√		√
	e. Voluntary counselling and testing			
	f. Programmes for sex workers			
	g. Programmes for men who have sex with men			
	h. Programmes for injecting drug users, if applicable			
	i. Programmes for other most-at-risk populations (<u>transport workers and military</u>)		√	√
	j. Blood safety			√
	k. Programmes to prevent mother-to-child transmission of HIV			
	l. Programmes to ensure safe injections in health care settings			
	Overall, how would you rate the efforts in the implementation of HIV prevention programmes?	2005		7
		2003		4
	<i>In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:</i>	<u>Increased involvement of CSOs and resources availability</u>		

IV. Care and support

1 Which of the following activities have been implemented under the care and treatment of HIV/AIDS programmes?

	2003	2005
a. HIV screening of blood transfusion	√	√
b. Universal precautions	√	√
c. Treatment of opportunistic infections (OI)	√	√
d. Antiretroviral therapy (ART)	√	√
e. Nutritional care	√	√
f. STI care	√	√
g. Family planning services	√	√
h. Psychosocial support for PLHA and their families	√	√
i. Home-based care	√	√
j. Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)	√	√
k. Cotrimoxazole prophylaxis among HIV-infected people		
l. Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)	√	√
Overall, how would you rate the care and treatment efforts of the HIV/AIDS programme?	2005	2003
		5
		2

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

Improved resources, greater sensitization, improved skills and more actors.

2 Does your country have a policy or strategy to address the additional HIV/AIDS related needs of orphans and other vulnerable children (OVC)?

No

2.1 Which of the following activities have been implemented under the OVC programmes?

	2003	2005
School fees for OVC	3	5
Community programmes		
Other: (please specify)		

Comments **Some NGOs are making efforts which are minimal as compared with what is required. The federal Ministry of Women Affairs is the focal point and plans are being finalized for OVC response**

Overall, how would you rate the efforts to meet the needs of OVC?	2005	2003
		3
		1

In case of discrepancies between 2003 and 2005 rating, please provide main reasons supporting such difference:

Stigma was still high in 2003, OVC was only a family issue, now there is greater sensitization and improved resources availability

APPENDIX 5: LIST OF UNGASS TECHNICAL SUB-COMMITTEE MEMBERS

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**APPENDIX 6: LIST OF PARTICIPANTS AT THE UNGASS
REPORT CONSENSUS MEETING**

FRIDAY, 16TH DECEMBER 2005

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