

NATIONAL HIV AND AIDS STRATEGIC FRAMEWORK 2021-2025

Foreword

As Nigeria moves towards achieving epidemic control in the HIV and AIDS response, our need for a more guided evidence-based response is at a critical stage and we must pull together our efforts and resources towards implementing high impact and efficient strategies. This calls for a stronger collaboration with our stakeholders, at all levels of government and from different sectors, to leverage on our individual strengths and maximizing scarce resources for a more sustainable response. In early 2019, the Revised National Strategic Framework (2019-2021) was developed to provide interim strategies and redirection of the national HIV and AIDS response following the emergence of new evidence from the 2018 Nigeria AIDS Indicator and Impact Survey (NAIIS). Subsequent population studies and estimates have provided additional information complementing the findings of the NAIIS for a richer evidence base and narrative on the pattern and size of the epidemic. The present strategic framework is developed based on the results of those subsequent studies and estimates as well as emerging evidence based practices for epidemic control. This new framework provides the template and guidance for the national response, with a goal of fast-tracking the national response towards ending AIDS in Nigeria by 2030. NACA recognises and appreciates the technical and financial support of the Federal Government of Nigeria and our donors and partners in the development of this strategic document. The Federal Government of Nigeria led by NACA remains committed to our collective vision of an AIDS-free Nigeria, with zero new infections and zero AIDS related discrimination and stigma. It is hoped that all stakeholders will use this document and continue to provide their unflinching support to the HIV response in Nigeria. The National Strategic Framework (2021-2025) will drive the development of a HIV biannual operational Plan and State biannual operational Plans at the national and state levels, respectively, in the coming months. These will in turn guide the effective implementation of a sustainable HIV programme and interventions by all relevant stakeholders to achieve the common goal of ending AIDS in Nigeria.



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Acronyms and Abbreviations

AHF	-	AIDS Healthcare Foundation
AHD	-	Advanced HIV Disease
AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Antenatal Clinic
ART	-	Antiretroviral Therapy
ARV	-	Antiretroviral Drug
BHC PF	-	Basic Health Care Provision Fund
BMPHS	-	Basic Minimum Package of Health Services
COP	-	Country Operation Plan
CTX/INH/B6	-	Cotrimoxazole Therapy /Isoniazid Prevention Therapy/B6
DOTS	-	Directly Observed Treatment
ECOWAS	-	Economic Community of West African States
EID	-	Early Infant Diagnosis
eMTCT	-	Elimination of Mother to Child Transmission
FLHE	-	Family Life HIV & AIDS Education
FSW	-	Female Sex Workers
GFATM	-	Global Fund to Fight AIDS, Tuberculosis and Malaria
GON	-	Government of Nigeria
HBV	-	Hepatitis B Virus
HCT	-	HIV Counselling and Testing
HEI	-	HIV Exposed Infants
HTS	-	HIV Testing Services
HCV	-	Hepatitis C Virus
HIV	-	Human Immunodeficiency Virus
HMIS	-	Management Information Systems
IBBSS	-	Integrated Biological and Behavioural Surveillance Survey
ICF	-	Intensified Case Finding
IPV	-	Intimate Partner Violence

KP	-	Key Population
LTFU	-	Lost to Follow-up
MMS	-	Multi-Month Scripting
MNCH	-	Maternal New-born and Child Health
MPPI	-	Minimum Prevention Package Intervention
MSM	-	Men who have Sex with Men
MTB/RIF	-	Mycobacterium Tuberculosis /Rifampicin
NACA	-	National Agency for the Control of AIDS
NAFDAC	-	National Agency for Food and Drug Administration and Control
NAIIS	-	Nigeria HIV/AIDS Indicator and Impact Survey
NARHS	-	National HIV and AIDS and Reproductive Health Survey
NCDs	-	Non-Communicable Diseases
NEC	-	National Economic Council
NHAct	-	National Health Act
NiBUCAA	-	Nigeria Business Coalition Against AIDS
NISRN	-	National Integrated Sample Referral Network
NSF	-	National Strategic Framework
NSHDP	-	National Strategic Health Development Plan
NSP	-	Needle and Syringe Programmes
NTBLCP	-	National Tuberculosis and Leprosy Control Programme
NTPP	-	National Treatment and PMTCT Programme
OST	-	Opioid Substitution Therapy
OVC	-	Orphans and Vulnerable Children
PCR	-	Polymeric Chain Reaction
PEPFAR	-	United States President's Emergency Plan for AIDS Relief
PITC	-	Provider Initiated Testing and Counselling
PLHIV	-	People Living with HIV
PMTCT	-	Prevention from Mother to Child Transmission
PrEP	-	Pre-exposure Prophylaxis

PWID	-	People who Inject Drugs
RNSF	-	The Revised National Strategic Framework
SBCC	-	Social and Behavioural Change Communication
SRH	-	Sexual and Reproductive Health
STIs	-	Sexually Transmitted Infections
TB	-	Tuberculosis
TLD	-	Tenofovir, Lamivudine and Dolutegravir
TPT	-	TB Preventive Treatment
UHC	-	Universal Health Coverage
UN	-	United Nations
VL	-	Viral Load
WAHO	-	West African Health Organisation
WHO	-	World Health Organisation

EXECUTIVE SUMMARY

Nigeria has been engaged in the fight against AIDS for nearly three decades. The country has come a long way in scaling-up the key building blocks of a strong AIDS response, but there is still much to be done to achieve the goal of ending AIDS as a public health threat by 2030.

This Strategic Framework builds on a major effort over the past two years to better inform and guide collective efforts through hard data and evidence. The recently completed Nigeria AIDS Indicator and Impact Survey (NAIIS), the largest HIV specific population-based survey in the world, established a new baseline for understanding the epidemic in the country, with greater precision and granularity. The NAIIS surveyed nearly 90,000 randomly selected households across Nigeria, allowing for the first time a state and LGA level characterisation of HIV incidence, prevalence, viral load suppression, CD4 T-cell distribution, prevalence of detectable antiretroviral (ARV) drugs and antiretroviral drug resistance, HBV/HIV and HCV/HIV co-infections, as well as risk behaviours and the uptake of key HIV prevention, care and treatment services amongst children and adults, men and women, at each life stage.

In parallel, a series of detailed studies were undertaken to provide a new understanding of the key populations most at risk for HIV infection. Together with the NAIIS, this new understanding allows better differentiation of testing and service delivery, with an aim of reaching more people living with HIV.

In addition, there has been an in-depth assessment of how financial resources are allocated to priority programmes and objectives. This data together with programme data from across States has informed a comprehensive HIV Epidemiology and Programmatic Response Analysis underpinning this Framework.

This Strategic Framework has three complementary aims:

- 1) To communicate the current state of knowledge with respect to the epidemic and response;
- 2) To provide renewed strategic guidance to the National AIDS response for the period 2021-2025; and
- 3) To support efforts to mobilise adequate resources and undertake actions to fast-track the national response towards ending AIDS in Nigeria by 2030.

The aim of this framework is to achieve the shared goal of ending AIDS as a public health threat by 2030 through renewed strategic guidance built on new evidence and understanding as well as guided by seven fundamental principles and seven key strategic thrusts of the National AIDS Policy 2020. The vision remains an AIDS-free Nigeria, with zero new infections, zero discrimination and stigma and zero AIDS-related deaths. This vision can be achieved, but only if efforts are redoubled to fast-track the national response towards ending AIDS in Nigeria by 2030. This framework calls for prioritising proven measures to protect those at risk from infection, while helping to guide where to focus and whom to reach.

Additionally, it calls for implementing proven measures to suppress the HIV virus, address co-morbidities and avert new infections in order to reduce morbidity and mortality. It is a reminder that to achieve these goals, there is need to enable informed demand from “HIV competent citizens” and ensure the full participation of all stakeholders.

It highlights the need for greater investment in critical enablers as well as a strengthened health system, most especially at community level. It further showcases opportunities for greater multi-sectoral coordination and greater domestic financing. It is envisioned that this Framework will be linked to strong operating plans at state level, affording a renewed and strengthened instrument to drive collective work and reach the common goal of ending AIDS in Nigeria.

Contents

Foreword	2
Acknowledgements	4
Acronyms and Abbreviations	5
Contents	10
1.0 BACKGROUND	13
1.1. Introduction	13
1.2. Country Context	14
1.3. NSF 2021-2025 Development Process	16
1.4 Guiding Principles	16
1.5 National HIV and AIDS Policy	17
1.6 Goals & Objectives of the Strategic Framework	19
1.7 Overview of the Strategic Framework	20
2.0 HIV SITUATION AND RESPONSE IN NIGERIA	22
2.1 HIV Prevalence in Nigeria	22
2.2 People Living with HIV in Nigeria	25
2.3 HIV Incidence in Nigeria	27
2.4 AIDS Related Deaths	31
3.0 ELIMINATION OF NEW INFECTIONS AND ACHIEVING THE FIRST 90 AND 95 SUBSEQUENTLY	34
3.1 Ensuring “HIV Competent” Citizens	34
3.1.1 Family Life HIV & AIDS Education	35
3.1.2 Social Media & Traditional Media	37
3.1.3 Leveraging the Network of People Living with HIV/AIDS in Nigeria	38
3.2 Combination Prevention Services	38
3.3 Priority Prevention Strategies for General and Key Populations	38
3.3.1 General Population	38
3.3.2 Key Populations	39
3.3.3 Combination Prevention Results Framework	40
3.3.4 Elimination of Mother-to-Child Transmission of HIV	42
3.3.5 Strategic Intervention for eMTCT of HIV	45
3.3.6 EMTCT Result Framework	46
4.0 HIV TESTING SERVICES AND ACHIEVING THE FIRST 90 AND 95 SUBSEQUENTLY	47
4.1 Rationale	47

4.2 Strategic Objective.....	47
4.2.1 Strategic Interventions	50
4.2.2 HTS Result Framework	51
5.0 QUALITY HIV TREATMENT SERVICES AND ACHIEVING THE SECOND 90 AND 95 SUBSEQUENTLY	52
5.1 Rationale	52
5.2 Strategic Objective.....	54
5.2.1 Strategic Interventions	54
5.2.2 Treatment Result Framework.....	56
5.3 Reducing Morbidity and Mortality from HIV-TB	56
5.3.1 Strategic interventions.....	58
5.3.2 HIV/TB Results Framework	59
6.0 CARE AND SUPPORT AND ACHIEVING THE THIRD 90 AND 95 SUBSEQUENTLY	60
6.1 Rationale	60
6.2 Strategic Objective.....	60
6.2.1 Strategic Interventions	60
6.2.2 Care and Support Result Framework	62
6.3 Rationale for achieving the third 90.....	62
6.4 Strategic objective.....	63
6.4.1 Strategic Interventions	63
6.4.2 Viral Suppression Result Framework	64
7.0 ENABLING ENVIRONMENT & BUILDING SYNERGIES.....	65
7.1 Enabling Full Engagement.....	65
7.2 Gender and Human Rights.....	65
7.3 Community Systems Strengthening	66
7.4 Social Protection Programmes	67
7.5 Legal & Policy Advocacy	68
7.6 Enabling Environment & Building Synergies Results Framework	69
7.7 Health Systems Strengthening & Sustainability	69
7.8 The National Treatment and PMTCT Programme (NTPP)	71
7.9 Community Health Influencers, Promoters, and Services Programme (CHIPS).....	71
7.10 Ownership and Sustainability of the HIV and AIDS National Response	72
8.0 RESEARCH AND KNOWLEDGE MANAGEMENT.....	75
8.1 Rationale	75
8.1.1 Strategic Intervention.....	75
8.1.2 Research and Knowledge Management Framework.....	76

9.0 COORDINATING THE HIV AND AIDS RESPONSE	77
9.1 National HIV Response System and Structure	77
9.2 Mandates of NACA	77
9.3 Roles and Responsibilities of the States Agencies for the Control of AIDS (SACAs).....	78
9.4 Critical Multi-sectoral Coordination Issues	79
9.5 Coordination Results Framework	81
10.0 SUSTAINABLE FINANCING OF THE HIV RESPONSE	82
10.1 Sustained Support to the Response from Donors.....	82
10.2 Increasing Financing from Domestic Sources	82
10.3 The National HIV/AIDS Trust Fund	84
10.4 Domestic production of HIV Commodities	85
10.5 Strengthening interregional collaboration with border countries and related funding mechanisms i.e., Lagos-Abidjan corridor project.....	86
10.6 Sustainable Financing Result Framework.....	86
11.0 INDICATIVE COSTING FOR THE NATIONAL HIV/AIDS PROGRAMME 2021 - 2025.....	87
12.0 CONCLUSION.....	93
REFERENCES.....	94
ANNEX I: RISKS AND ASSUMPTIONS	96

1.0 BACKGROUND

1.1. Introduction

With an estimated 1.9 million people living with Human Immunodeficiency Virus (HIV) in 2018, Nigeria has the second largest HIV epidemic in the world. Over the past two decades, partners in the global AIDS response have intensively supported the Government and institutions to scale-up prevention, treatment, care and support, with a concomitant synergetic impact on a vast range of interrelated public health and development challenges. Notwithstanding the important investments and broad progress over the years, HIV/AIDS remains a leading contributor to the burden of disease and a significant public health threat for the country. In recent years, the level of reductions in new HIV infections and deaths from AIDS that are needed to achieve the shared goal of ending AIDS as a public health threat by 2030 has not been reached. The vision remains an AIDS-free Nigeria, with zero new infections, zero discrimination and stigma and zero AIDS-related deaths. This vision can be achieved if efforts are redoubled to fast-track the national response towards ending AIDS in Nigeria by 2030.

The National HIV and AIDS Strategic Framework (2021-2025) is the fifth strategic framework designed to guide the national response to HIV and AIDS, building on the achievements of the previous Frameworks. Prior to the development of this new Framework, the National HIV and AIDS Response was guided by the 2001-2004 HIV Emergency Action Plan, the 2005-2009 National HIV and AIDS Strategic Framework, the 2010-2015 National HIV and AIDS Strategic Framework and the 2010-2015 National HIV and AIDS Strategic Plan. The lifespan of the 2010-2015 National HIV and AIDS Strategic Framework (NSF) and the 2010-2015 National HIV and AIDS Strategic Plan (NSP) was extended to the end of 2016 to accommodate the technical and logistic mobilization necessary for the development of the new strategic framework. This was followed by the National HIV/AIDS Strategic framework 2017-2021.

In 2018, findings from the NAIIS; an unprecedented population-based survey, brought a new, data-driven understanding of the epidemic with greater precision and granularity. Added to this were a recently completed revised size estimates of key populations in 16 States plus the Federal Capital Territory (FCT) as well as an important study in Nigerian prisons. These studies necessitated the development of the Revised National Strategic Framework 2019-2021 and its successor, the current National HIV and AIDS Strategic Framework 2021-2025. The recently completed National AIDS Spending Assessment (NASA) 2015-2018 provides insight on spending patterns for the national response.

In Nigeria, as elsewhere, despite collective efforts, the resources available to drive the HIV/AIDS response forward are limited. Working together with global partners in a framework of shared responsibility and solidarity to secure and sustain the needed resources and using the available resources strategically and efficiently is essential to saving more lives and averting new infections. Continuously improving and recalibrating such evidence-informed strategy,

driven by a more insightful understanding of the epidemic in the nation and recent global experience in the AIDS response, is the purpose of this National HIV and AIDS Strategic Framework 2021-2025.

The new data and wealth of analytic insights makes it possible to optimise and differentiate programmatic actions at all levels with a view to maximizing the impact of available resources and hastening the end of AIDS in Nigeria. It makes possible better focused prevention efforts for key populations and vulnerable groups, expanded testing to ensure people living with HIV know their status, better focussed support for the necessary treatment and service delivery systems to ensure people living with HIV are provided the care and treatment they need. Support systems to ensure improved adherence to appropriate treatment can be better strengthened; and the scale-up of viral load monitoring to ensure people on treatment achieve viral suppression can be effected in a more targeted way.

Building on the new data and analytic insights, this Strategic Framework has three complementary aims:

- 1) To communicate the current state of knowledge of the epidemic and response;
- 2) To provide strategic guidance to the National AIDS response for the period 2021-2025;
and
- 3) To support efforts to mobilise adequate resources and undertake actions to fast-track the national response towards ending AIDS in Nigeria by 2030.

1.2. Country Context

Nigeria lies between latitudes 4°16' and 13°53' to the north of the equator and longitudes 7°40' and 14°41' to the east of the Greenwich Meridian. The country is located in the West African sub-region and is bordered by Niger to the north, Chad to the northeast, Cameroon to the east, and the Republic of Benin to the west. To the south, Nigeria is bordered by approximately 800 kilometers of the Atlantic Ocean. Nigeria is a federation comprising 36 states and a federal capital territory (FCT), which enjoys the status of a state but is recognised as the administrative capital of the federation. The 36 states and the FCT are delineated into 774 local government areas (LGAs). For operational convenience, the country is divided into six geo-political zones: North-East, North-West, North Central, South-East, South-West and South-South. The zoning is used for planning and implementation of national programmes and initiatives.

Nigeria is an ethnically and culturally diverse country, with about 374 identifiable ethnic groups. The three largest ethnic groups in Nigeria are Hausa/Fulani (Northern Nigeria), the Igbo (South-East Nigeria) and the Yoruba (South-West Nigeria). Together, these three ethnic groups make up more than half of the country's population. The National Population and Housing Census reported Nigeria's population as 140.4 million in 2006 with a growth rate of 3.2%. Projecting the population to slightly above 206 million in 2020, the United Nations ranks Nigeria as the seventh most populous country and one of the fastest growing populations in the world. About a quarter (24.9%) of the Nigerian population are women of reproductive age (15-

49 years) and 31.7% are young people aged 10-24 years. Nigeria has a young population structure, as 62% of the population is within the age range of 0 to 24 years, and the median age is 17.9 years. According to the World Bank estimates, life expectancy in Nigeria is 54.81 years in 2020. This figure is lower than the average of 59 years for the sub-Saharan Africa and 67 years for lower middle-income countries. The 2015 World Health Statistics, on the other hand, indicates Nigeria's life expectancy as 55 years for 2013 (55 years for females and 54 years for males). The country's current life expectancy figure is a substantial improvement over the 1990 figure of 46 years (47 years for females and 45 years for males).

Nigeria ranks 152 out of the 188 countries and territories covered by the United Nations Development Programme's Human Development Report. With a Human Development Index (HDI) value of 0.532 for 2017, Nigeria is categorised as a low human development country. Nigeria's HDI is lower than the average of 0.537 for sub-Saharan Africa. Nigeria's HDI value however increased from 0.467 in 2005 to 0.514 in 2014, representing an average annual rate of about 1.07% over the 10-year period. The HDI value for females (0.468) compares poorly with that of males (0.556), resulting in a gender development index (GDI) of 0.841. The inequality adjusted HDI (IHDI) for Nigeria was 0.320 in 2014, reflecting a loss of 37.8% due to inequality in the distribution of the HDI dimension indices, which is greater than the average loss due to inequality of 32.0% for low HDI countries, and 33% for sub-Saharan Africa: these figures signify a relatively high level of inequality.

Traditional socio-cultural norms and practices are still very strong in many Nigerian communities despite the growing influence of globalisation. The tension between traditional values and modernization is apparent in many areas, particularly with regards to gender and human rights issues, the development and behaviour of young people, health beliefs and health-seeking behaviour at community and household levels. On the one hand, a number of cultural norms and practices in Nigeria have positive values and implications for HIV prevention, treatment and care, such as the strong kinship and family network system, the emphasis on chastity and avoidance of pre-marital sex, as well as male circumcision. On the other hand, practices such as widowhood rites, female genital mutilation (FGM), denial of women's access to inheritance, encouragement of multiple sexual partners for males, and children of early and forced marriage (CEFM) to much older men in some communities may increase vulnerability to HIV.

Nigeria is the eighth largest oil exporter in the world and her economy is the largest in Africa after the Gross Domestic Product (GDP) rebasing of 2014. Oil accounts for almost 90% of the country's exports and about 75% of her consolidated budgetary revenue. Despite significant national economic growth that spanned decades, poverty level has remained high: the absolute poverty incidence is 62.6%. Over 80% of young people live in poverty, with young women and youth living in rural areas being the worst groups affected. The unemployment rate is high with 26.06 million persons of the 79.9 million (32.6%) labour force being either unemployed or underemployed; the worst affected groups are young people aged 15-24 years and females. This is a developmental paradox that paints the picture of a small proportion of the population in great wealth co-existing with the vast majority of the population in great poverty. The

economic situation has significant implications for the HIV and AIDS response as poverty increases vulnerability to HIV and impacts negatively on the ability of people living with HIV (PLHIV) to appropriately seek for, or adhere optimally to treatment. The growing episodes of violence in the country including armed clashes between nomadic Fulani herdsmen and indigenous farming communities, and insurgency by the Jama'atu Ahlis Sunna Lidda'awati Wal-Jihad (otherwise known as *Boko Haram*) also have implications for an increase in the incidence of HIV infection. Violent situations are associated with increased risk for sexual and reproductive rights violation such as rape, and risky sexual behaviour such as selling of sex by young girls. The Boko Haram challenge resulted in the worst humanitarian crisis in Nigeria's history with about 15 million people affected since 2009, and over two million people internally displaced. Consequently, an estimated seven million people required urgent, life saving humanitarian assistance in 2019 according to the United Nations Office for the Coordination of Humanitarian Affairs. Natural disasters that result in displacement of populations also have implications for HIV incidence.

1.3. NSF 2021-2025 Development Process

The NSF was developed through a highly participatory and consultative process involving a wide cross-section of stakeholders at various stages of its development. These stakeholders included policy makers and government officials from federal and state levels, technical experts, representatives of the national HIV and AIDS Technical Working Groups (TWGs), representatives of the civil society, as well as bilateral and multilateral development partners. The civil society participants cut across various segments of stakeholders in the national response, including representatives of the Network of People living with HIV and AIDS in Nigeria (NEPWHAN), the Association of Young People living with HIV in Nigeria, interest groups with focus on women and children living with HIV, and the key population secretariat. The development of the strategic framework identified critical priorities for achieving the 90-90-90 targets by 2023 while also addressing the country's aspirations of ending the AIDS epidemic by 2030.

Feedback from stakeholders was used to revise the zero draft of the NSF. The revised draft NSF document was circulated to national stakeholders as well as donors/partners and further inputs were received during a one-day validation meeting of stakeholders. The feedback was used to finalise the draft NSF document, in readiness for presentation to the National Council on AIDS. This framework will be utilised in the development of a National HIV and AIDS Strategic Plan (NSP) 2021-2025.

The NSP will be developed using a bottom-up approach: the NSF was developed by NACA while the states and the various sectors involved in the national HIV response have the responsibility for developing their HIV response plan. Guidance notes will be utilised to facilitate the development of the State and sectoral HIV plans. This will include a costing template shared with stakeholders for their review and input.

1.4 Guiding Principles

The provisions of the NSF are guided by the following principles:

- ***Political leadership and ownership:*** Strong political leadership of the national and state HIV and AIDS responses, driven by a sense of ownership, and with commitment to transparent and prudent management of financial resources at all levels of the response.
- ***Partnerships and multi-sectoral collaborations:*** Synergy between all multi-sectoral partners for the purpose of stronger collaboration and partnerships between all stakeholders, including government, civil society organisations, networks of people living with HIV, and international development partners.
- ***Rights and gender-responsiveness:*** Respect for gender equality and fundamental human rights through adoption of rights-based and gender-responsive approaches in HIV programming by all stakeholders and at all levels.
- ***Meaningful involvement of people living with HIV and AIDS:*** Commitment to the meaningful involvement of people living with HIV and AIDS (MIPA) through institutionalization of the engagement of people living with HIV in the implementation of the HIV response; and respect for the rights and dignity of all persons living with HIV.
- ***Strategic Investment programming:*** Targeted strategic investment driven by the latest evidence in the field of HIV and AIDS, with the aim of optimizing the utilization of resources and maximizing the returns on investment in the HIV response.
- ***Optimization of the health system:*** Strengthening of the health system as a basis for effective delivery of quality HIV prevention, treatment, care, support and adherence programmes.
- ***Community involvement, engagement and participation:*** Strengthening the community systems and related elements as a fundamental to achieving the goal and objectives of the NSF.

1.5 National HIV and AIDS Policy

The revised National AIDS Policy identifies 7 key strategic thrusts which guide this framework:

- I. To eliminate new infections:***
 - To reduce the incidence of new HIV infections by 90% by 2030
 - Facilitate all modes of HIV testing including self-testing
 - Promote safer sexual behaviour through behaviour change communication-related interventions
 - Promote appropriate biomedical prevention interventions
- II. To ensure treatment for all people living with HIV:***
 - All persons testing positive for HIV, immediately placed on Antiretroviral Therapy (ART), having continuous access to treatment for Sexually Transmitted

Infections (STIs), Tuberculosis (TB) and opportunistic infections, as well as Sexual and Reproductive Health Rights (SRHR), mental health services, and Non-Communicable Diseases (NCDs) services;

- Promote the availability, acceptability and accessibility of ART, STIs, TB, and opportunistic infections, SRH, mental health and NCDs services;
- Promote the linkage of treatment to HIV testing services both at the facility and the community levels including in closed settings and for incarcerated populations;
- Promote the integration of STIs, TB, and opportunistic infections (including Hepatitis B & C), SRH, Mental health and NCDs services into HIV treatment intervention programming, and vice versa.

III. *To ensure care and support for all people living with and affected by HIV:*

- To ensure improvement in quality of care and quality of life of PLHIV, their family members, and vulnerable communities
- Promote activities that improve the quality of lives of vulnerable communities, PLHIV and people affected by AIDS
- All PLHIV should have access to affordable quality ART services
- All children, adolescents and young people, and key populations infected and affected by HIV as well as other vulnerable populations should have access to comprehensive HIV counselling, treatment and care and social services including through youth-friendly service points
- All infected and affected persons, adolescents and young people, key populations and other vulnerable populations should have comprehensive knowledge of HIV, sexual reproductive health and rights
- All persons infected and affected should have access to basic education and vocational skills and/or income generating activities
- Society should be sensitised and knowledgeable about HIV and other viral diseases

IV. *To ensure the resourcing of the national response:*

- To achieve national ownership and sustainability of the national response through appropriation and deployment of financial and other resources to meet programme needs
- To ensure an enabling environment in which prevention and treatment services are available to all
- Support infrastructure needs for programme implementers at all levels
- Develop and utilise cost effective locally produced solutions
- Implement best practices for the effective management of human resource for health at all levels

V. *To create an enabling environment & build synergies across the development spectrum:*

- Create an enabling gender and human rights responsive environment by stimulating domestic ownership, engaging relevant stakeholders and supporting continuous review and response to progress of all critical enablers for the national response.
- Promote the engagement of key stakeholders in addressing barriers to HIV elimination
- Taking HIV out of isolation
- Support strengthening of community engagement, community linkages and coordination, including local needs assessments, services mapping and planning of health system linkages at ward, LGA and State levels.

VI. *To ensure coordination and harmonization of the response:*

- To ensure all stakeholders are provided clear guidance and strategic direction to work with a shared vision, mutual responsibility & accountability
- Ensure effective coordination of the multi-sectoral response at all levels
- Enhance synergy and collaboration with national and international partners
- Develop and adopt a sustainable unified data management system to inform programme planning and decision making at all levels
- Promote decentralization of service delivery to enhance access and equity
- Ensure shared accountability
- Increasing political will and leadership

VII. *To promote research and knowledge management:*

- To establish a national research agenda
- Build robust systems for supporting research in the country
- Promote open and early sharing of research findings
- Subject research findings to broad peer review before adoption of policy implications

1.6 Goals & Objectives of the Strategic Framework

This National Strategic Framework is a pillar of the collective work towards achieving the Sustainable Development Goals and Universal Health Coverage (UHC) for all Nigerians. It provides strategic direction for the HIV response towards meeting key national targets, pending the development of a comprehensive and new strategic plan. It will serve as the strategic template and guidance for the national response, with a goal of fast-tracking the national response towards ending AIDS in Nigeria by 2030. The objectives are:

- To ensure 90% of the population, including key and vulnerable populations, have access to HIV combination prevention interventions by 2023, and 95% by 2025;
- To ensure that 90% of people living with HIV know their status by 2023, and 95% by 2025;
- To reduce new HIV infections by 90% by 2025;
- To reduce mother-to-child transmission of HIV by 90% by 2025;

- To ensure that 90% of HIV positive persons are on sustainable antiretroviral therapy by 2023, and 95% by 2025;
- To ensure that 90% of HIV positive persons on antiretroviral therapy are virally suppressed by 2023, and 95% by 2025;
- To make policy directives and funding recommendations for the HIV and AIDS response Post NAHIS; and
- To foster increased financing from domestic resources and strengthened national and state-level ownership and accountability of a sustainable HIV/AIDS response.

1.7 Overview of the Strategic Framework

Ending HIV/AIDS as a public health threat in Nigeria is a challenge that can only be met through a broad multi-sectoral approach, with coordinated strategies across sectors. Preventing new infections will be key. At the most basic level, sustained measures must be put in place to protect from infection all those at risk, including the unborn, new-born, youth, adolescents, and sexually active adults. Simultaneously, measures to suppress the virus in those who are already infected in order to avert new infections, and reduce AIDS-related morbidity and mortality, must be introduced and sustained. Care and support must also be provided to improve the quality of lives of PLHIVs. This requires reaching beyond health facilities to communities, institutions, and businesses.

At the core of the strategy to protect from infection all those at risk, are the delivery of combination prevention services and the elimination of mother-to-child transmission, through provision of preventive services. The necessary knowledge and bio-medical tools for prevention are available. Ensuring youth, adolescents, and sexually active men and women are functionally knowledgeable, “HIV-competent” citizens, is critical to ensuring this knowledge and these tools are in the right hands and used skilfully. Over the coming decade, an additional 15 million young Nigerians will join the ranks of sexually active adults and must be equipped with knowledge and tools *before* they transition. Only informed, functionally knowledgeable citizens will demand condoms; pre-exposure prophylaxis (PrEP); harm reduction services; HIV testing and counselling services; antiretroviral prophylaxis or therapy; safe delivery; safer infant feeding and postpartum interventions such as cotrimoxazole prophylaxis; early diagnosis for HIV-exposed infants; and links to treatment and care, as well as standard postpartum child survival interventions. Without informed demand from functionally knowledgeable, “HIV-competent” citizens, proposed strategies will surely fail to end AIDS as a public health threat. Here too, the response must reach beyond health facilities and ensure the vigorous engagement of teachers, social and other media, communities, and partners.

It’s been demonstrated that achieving undetectable viral loads through treatment makes HIV un-transmittable. Central to the strategy of suppressing the virus to achieve undetectable viral loads in PLHIV, is achieving the 90-90-90 and subsequently higher targets of 95-95-95 - ensuring 90% of all people living with HIV know their HIV status; 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy; and 90% of all people receiving antiretroviral therapy have sustained viral suppression. When this three-part target is achieved, at least 73% of all people living with HIV will be virally suppressed. Modelling

suggests that achieving these targets world-wide, and subsequently higher targets of 95-95-95, will enable the world as a whole to end the AIDS epidemic by 2030, which in turn will generate profound health and economic benefits¹.

The 90-90-90 strategy is also the key to reducing mortality. In 2019, Nigeria lost nearly 43,000 lives to AIDS and its complications.² Achieving viral suppression is critical to sustaining life for infected individuals. Also, protecting HIV infected individuals from tuberculosis (TB), hepatitis, and other causes of premature mortality and morbidity is essential.

How people are reached with information to create “HIV-competent” citizens, how combination prevention services and prevention of mother-to-child transmission services are delivered, how to test, treat, and ensure adherence to treatment and viral suppression, and how infected individuals are reached to provide tuberculosis preventive treatment and other services are the critical choices that must be tailored at a location-population level to be effective. This is where the NAIIS and other surveys are of such vital importance. The success of the strategies for preventing new infections and reducing premature morbidity and mortality will be conditioned by the ability of the response to enable the full engagement of all who are concerned, whether infected or vulnerable. Every barrier to full engagement, including stigma, discrimination, disempowerment and social exclusion must be overcome.

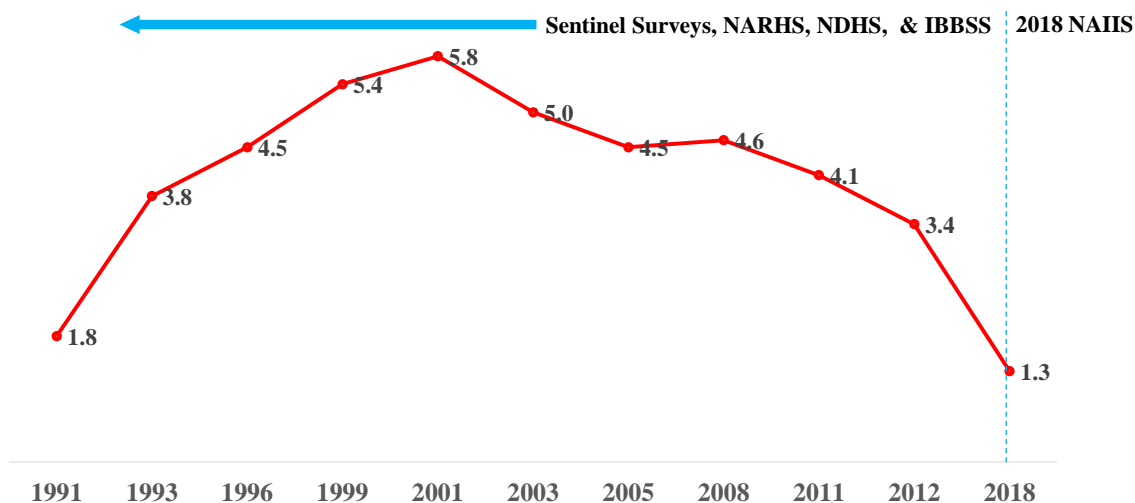
Collectively, these strategies will enable healthier lives and faster development of Nigeria in ways far beyond ending AIDS alone. The AIDS response is truly the tip of the spear, in helping the country to strengthen its health systems to reach all Nigerians with quality services, to strengthen the ability to educate and inform, and strengthen the ability of all people living in Nigeria to engage and contribute to this common purpose.

2.0 HIV SITUATION AND RESPONSE IN NIGERIA

2.1 HIV Prevalence in Nigeria

In common with practices worldwide, over the years Nigeria has relied upon a combination of periodic epidemiological sample surveys - Antenatal Clinic (ANC) sentinel surveys, National HIV and AIDS and Reproductive Health Surveys (NARHS), Nigeria Demographic Health Surveys (NDHS), and Integrated Biological and Behavioural Surveillance Surveys (IBBSS) – together with routinely collected programme data to monitor and estimate the population level HIV epidemic trends in the country. These estimates indicated that HIV prevalence nationally among people aged 15- peaked in 2001 at an estimated 5.8%, and has since declined significantly. Based on the NAIIS, the national prevalence of HIV (15-49 years) in 2018 is estimated at 1.3% (1.2% - 1.4%). [figure 1]

Estimates* of HIV Prevalence Over Time, Ages 15-49



*From diverse sources over time including Antenatal Clinic (ANC) sentinel surveys, National HIV and AIDS and Reproductive Health Surveys (NARHS), Nigeria Demographic Health Surveys (NDHS), and Integrated Biological and Behavioral Surveillance Surveys (IBBSS) and Nigeria AIDS Indicator and Impact Survey (NAIIS)

Figure 1: National trend in HIV prevalence, ages 15-49, (spectrum estimates from NAIIS data)

Prevalence among females (15-49 years) nationally is significantly higher, at an estimated 1.7%, (1.6% – 1.9%), than male prevalence (15-49 years) estimated at 0.8% (0.7% – 0.9%). Prevalence among females nationally is significantly higher than for males in all age bands between the ages of 15 and 49. The peak in female prevalence occurs at ages 45 to 49 whereas for men peak prevalence occurs in older men, aged 50 to 54. [Figure 2]

HIV prevalence by sex and age, NAIIS 2018

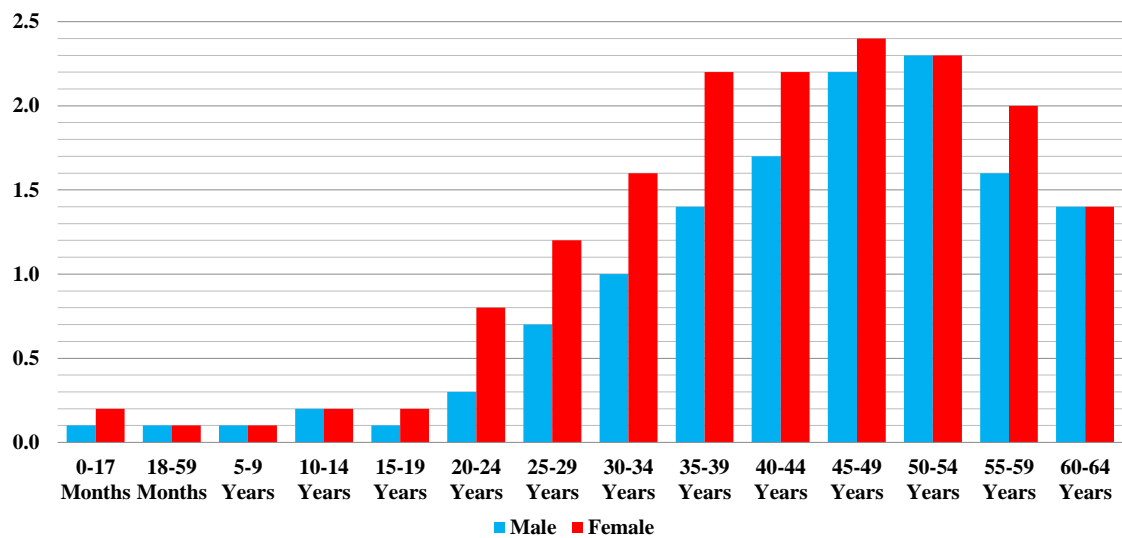


Figure 2: National HIV prevalence by sex and age band, NAIIS 2018

HIV prevalence by state among adults aged 15-49 years NAIIS 2018

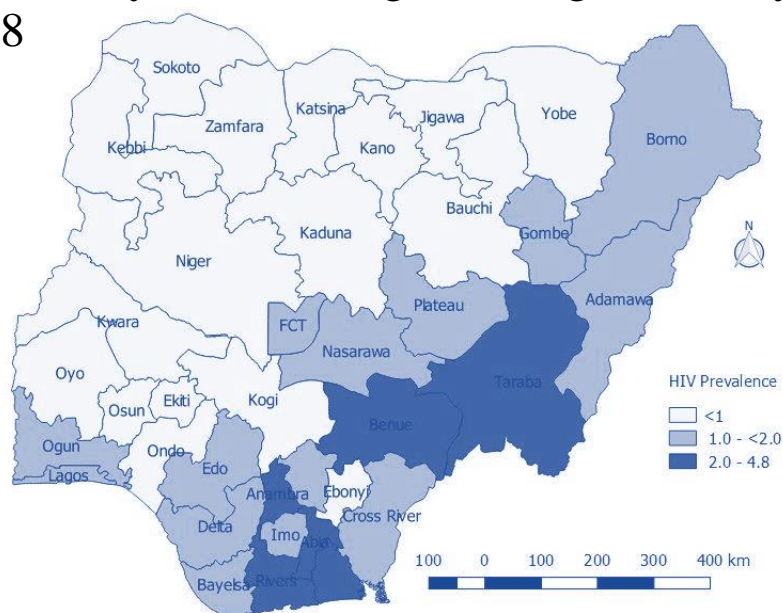


Figure 3: Map of HIV prevalence by state

All states in the North-West and South-West, with the exception of Lagos and Ogun, have relatively low HIV prevalence, below 1.0. In the North East zone, Borno, Gombe and Adamawa are medium prevalence, with Taraba a high prevalence state. The North-Central zone includes a mix of low and medium prevalence states, with one high prevalence state above 2.0 (Benue) in the extreme east. Four states in the South-South and South-East (Abia, Anambra, Akwa Ibom and Rivers) have relatively high prevalence of 2.0% and above. [Figure 3]

Six states in the South-South and South-East have relatively high prevalence of 2.0% and above. These states include Abia, Taraba, Benue, Anambra, Akwa Ibom and Rivers. Within the group of six high prevalence states, Akwa Ibom, Benue and Rivers have average prevalence among people aged 15-49 more than twice the national average. A further thirteen states including Enugu, Delta, Nasarawa, Bayelsa, Edo, Cross River, Imo, Plateau, Lagos, Borno, Gombe, Adamawa and Ogun plus the Federal Capital Territory have medium prevalence of between 1.0% and 1.9%; the remaining seventeen states have relatively low prevalence, below 1.0%. [Figure 4]

HIV prevalence levels across states, NAIIS 2018

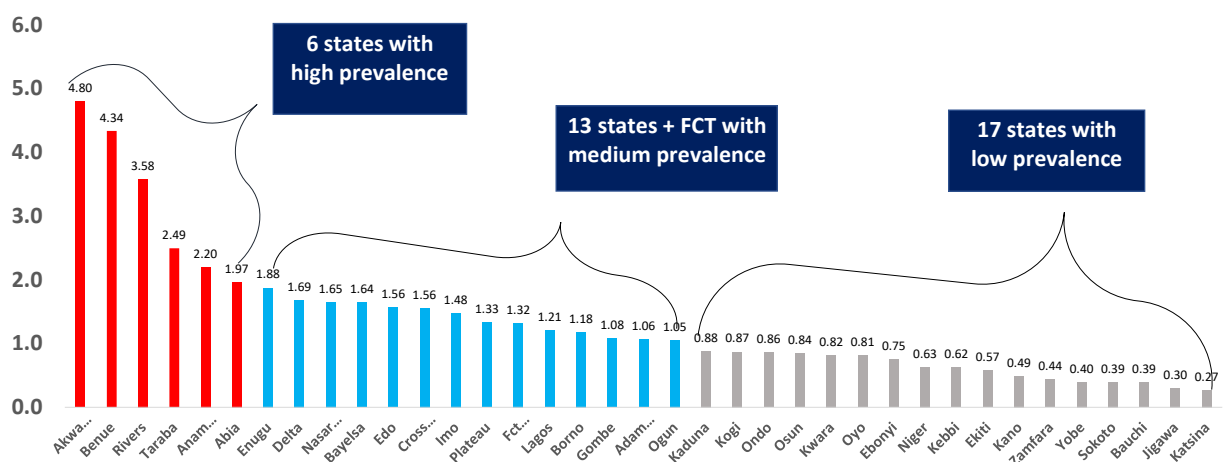


Figure 4: HIV prevalence by state (NAIIS 2018)

The HIV epidemic in Nigeria remains a mixed epidemic partly driven by significant key populations, particularly female sex workers (FSW), including both brothel-based (BBFSW) and non-brothel based (NBFSW), men who have sex with men (MSM) and people who inject drugs (PWID), with substantial overlap with urban casual sexual networks. Prevalence among key populations is significantly higher than in the general population. The best available data indicates prevalence has declined significantly in FSW and PWID, while rising worryingly among MSM. [Figure 5]

Prevalence trend among key populations (IBBSS 2007 & IBBSS 2015)

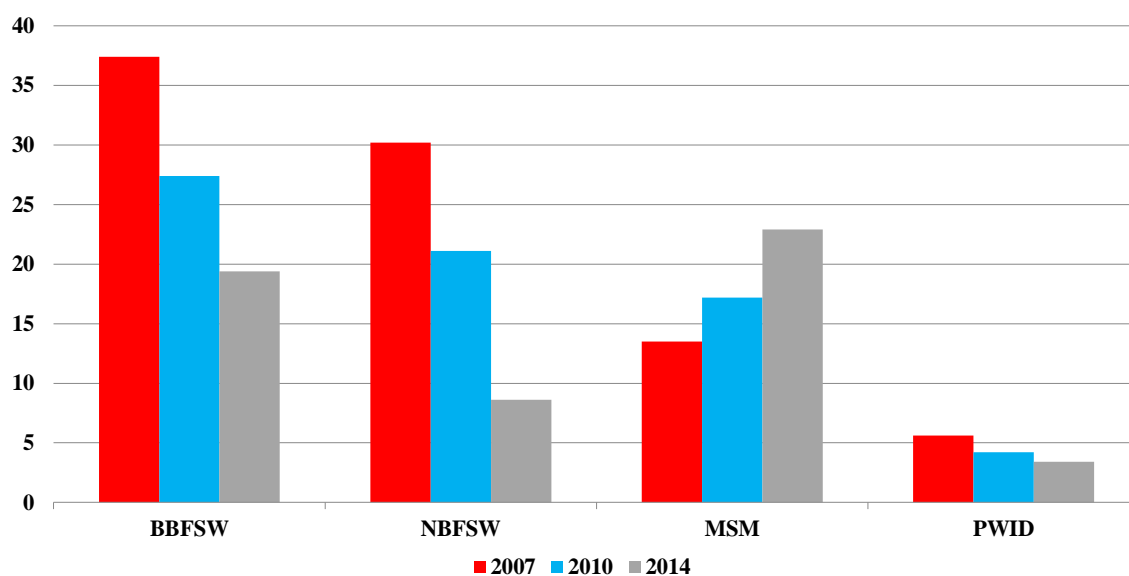


Figure 5: Prevalence trend among key populations (IBBSS 2007, 2010 & 2015)^{3,4}

Prevalence is higher in rural areas than in urban areas for both men (0.9% vs. 0.7%) and women (1.9% vs 1.6%). Prevalence is also significantly higher for divorced/separated men (3.2%) and women (5.8%) as well as widowed men (6.8%) and women (9.1%), both of whom face difficulties in adapting to life outside a stable relationship coupled with stigma and insecurity.

2.2 People Living with HIV in Nigeria

In 2019, a total of 1.9 million persons were estimated to be living with HIV in Nigeria, among the largest populations living with HIV of any country. Approximately 58% were estimated to be female, and 42% male. Females make up the majority of persons living with HIV overall and in all geopolitical zones with the exception of the North-West, where more men than women are seropositive.

The estimated number of persons living with HIV is highest in the South-South geopolitical zone of the country followed by the North-Central zone and lowest in the North-East zone. [Figure 6]

Burden of PLHIV By State, NAIIS 2018

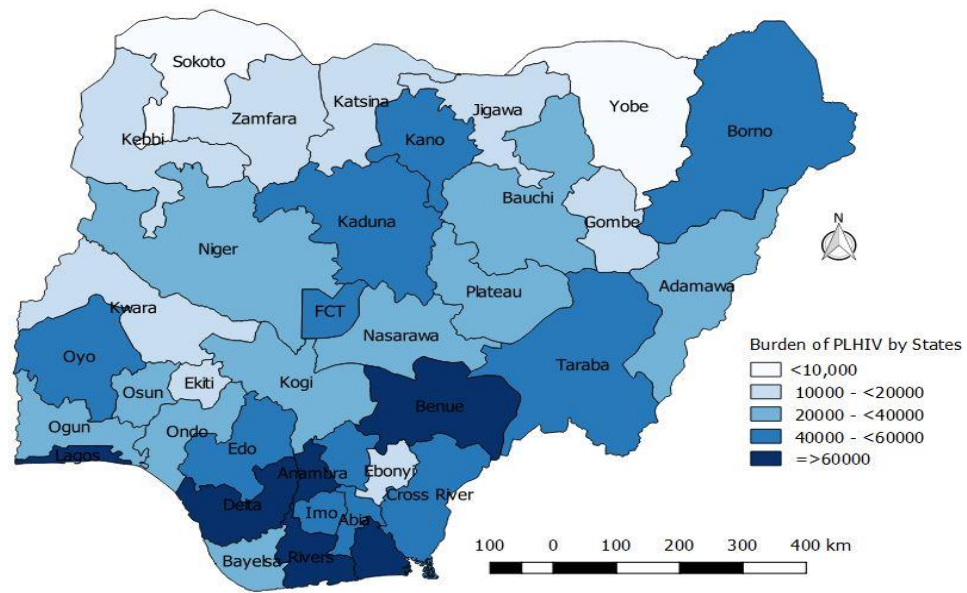


Figure 6: Burden of PLHIV by state (NAIIS 2018)

HIV Burden By State

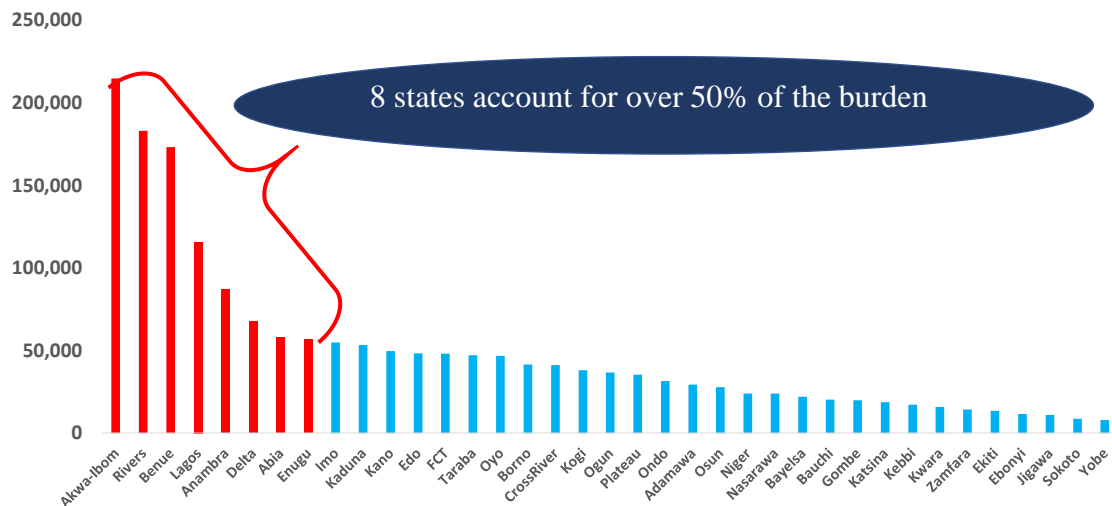


Figure 7: PLHIV burden by state (Spectrum estimates using NAIIS (2018) data).

Eight states – Akwa Ibom, Rivers, Benue, Lagos, Anambra, Delta, Abia, and Enugu - account for over half of all persons estimated to be living with HIV in Nigeria. [Figure 7]

Distribution of PLHIV burden by age and sex, NAIIS 2018

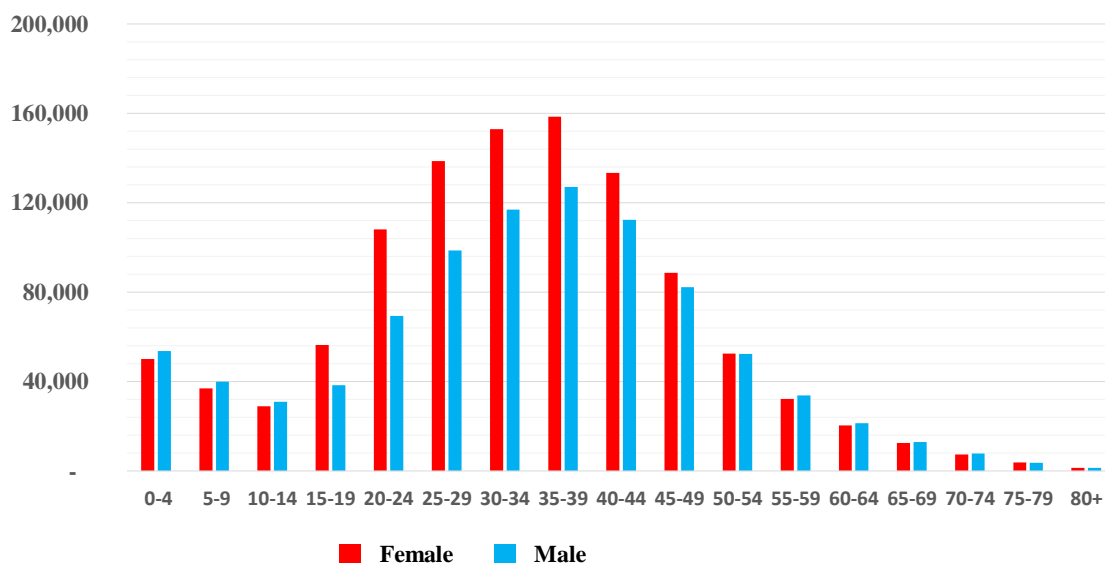


Figure 8: Distribution of PLHIV burden by age and sex (Spectrum estimates with data from NAIIS).

Approximately 75% of all persons living with HIV in Nigeria are between the ages of 15 and 49. Neonates, infants, children and early adolescents up to the age of 14 collectively account for 12% of persons living with HIV. Early and late adolescents together (10-19 years) account for 8% of persons living with HIV. Older adults, 50 years of age and above, account for 13% of all persons living with HIV. Between the ages of 15 and 44, the proportion of females living with HIV is significantly higher than men in every age band. [Figure 8]

2.3 HIV Incidence in Nigeria

The number of new infections in Nigeria is among the highest of any country in the world. In 2019, Nigeria had an estimated 107,112 total new infections. New infections declined approximately 10% between 2010 and 2019, but progress has stagnated in recent years. [Figure 9]

Trend in New Infections 2010 - 2019

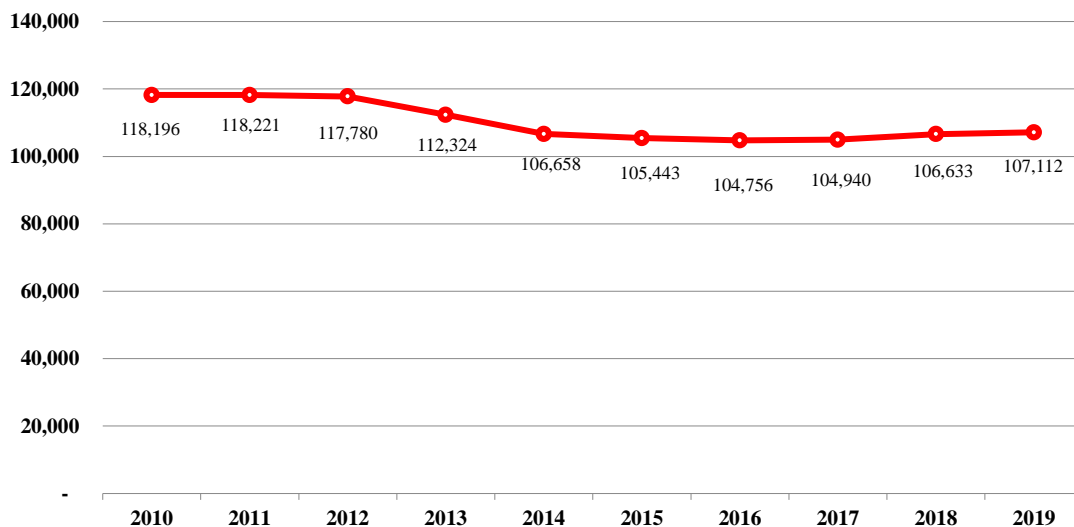


Figure 9: Estimated number of new infections by year 2010-2019 (Spectrum estimates with data from NAHS)

Eight states – Rivers, Akwa Ibom, Benue, Anambra, Lagos, Delta, Imo and Enugu – are estimated to account for over half of all new infections. [Figure 10]

Estimated New Infections by State, 2019

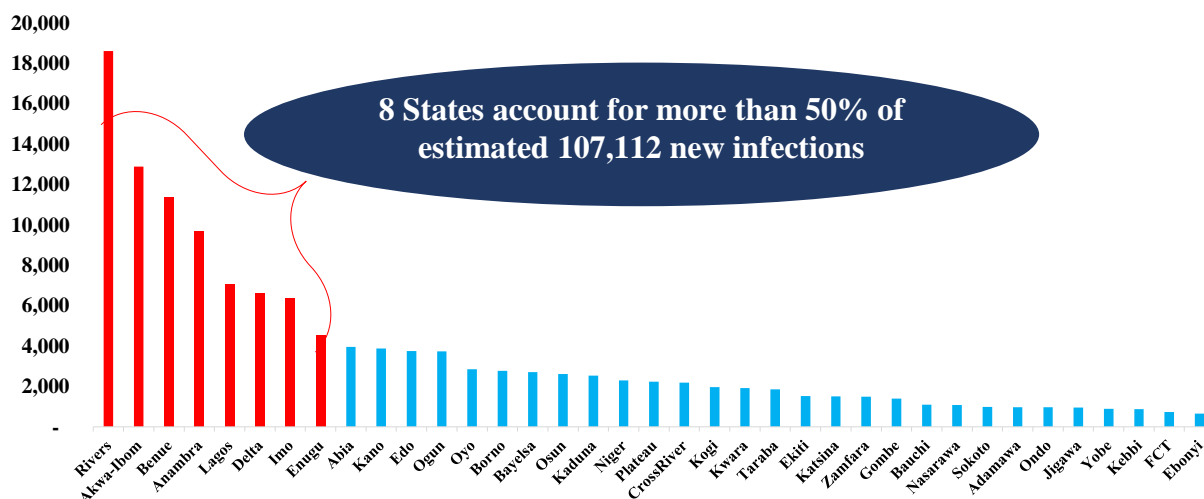


Figure 10: Estimated new infections by state in 2019 (Spectrum estimates with data from NAHS)

In 2019, an estimated 21,002 new infections were due to mother-to-child transmission. The national average mother-to-child transmission rate of 22% is driven by a large number of states with transmission rates above 25% and few states with rates below 15%. [Figure 11]

Estimated Mother-to-Child Transmission Rate by State, 2019

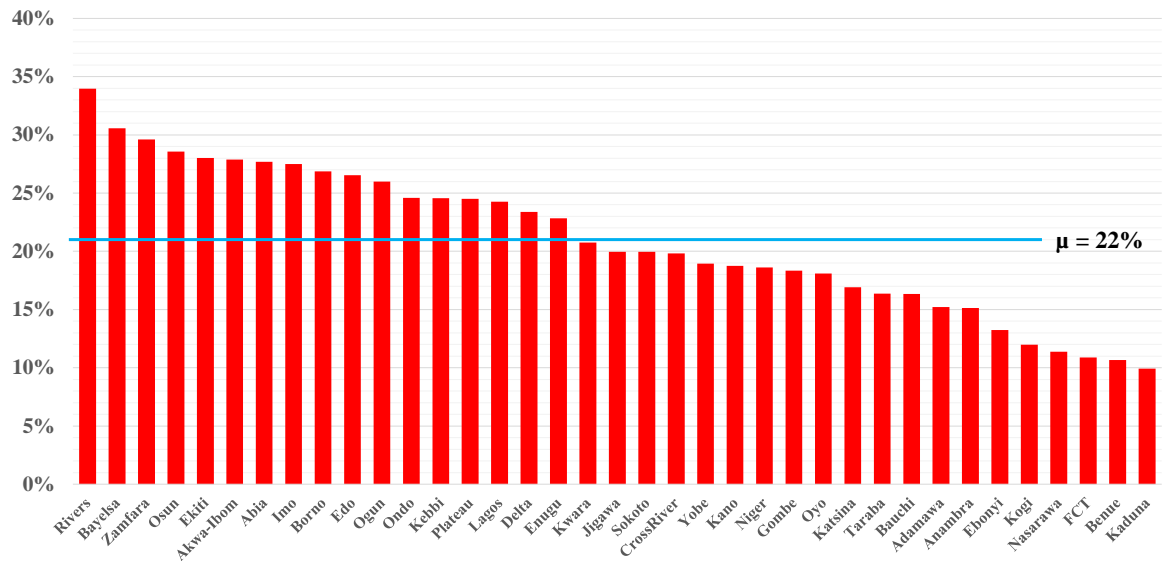


Figure 11: Estimated mother-to-child transmission rates by state in 2019 (Spectrum estimates with data from NAHS)

HIV Incidence by Age and Sex, NAHS 2018

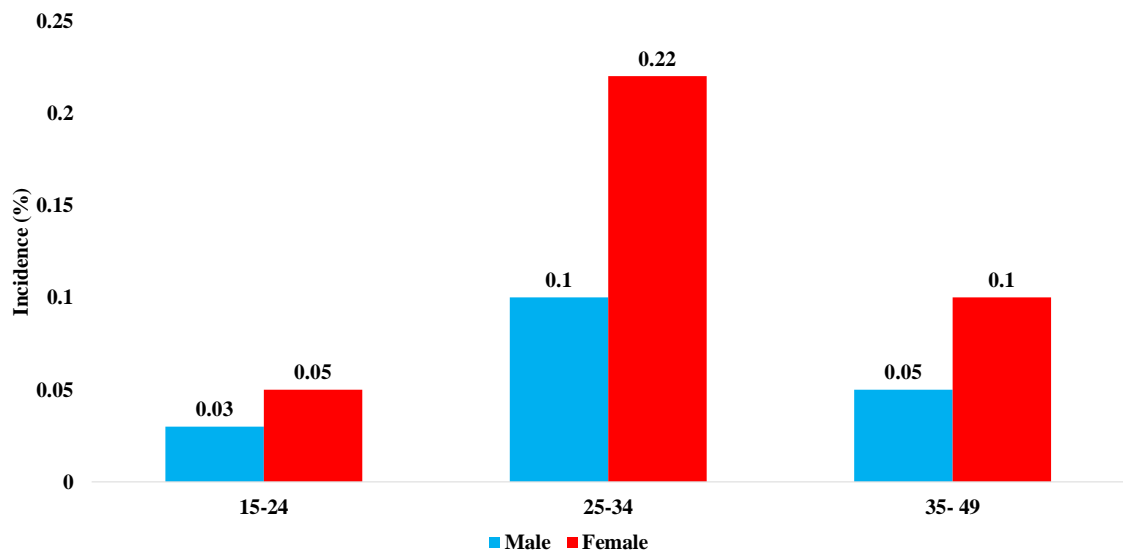


Figure 12: HIV Incidence by age and sex (Spectrum estimates with data from NAHS)

Based on findings from the NAHS, average national HIV incidence across both genders between 15 and 49 years of age is 0.9%. Between 15 and 49 years of age, female incidence, at 0.12%, is twice the level of male incidence at 0.06%. Peak incidence for both males and females occurs in adults aged 25-34, with female incidence significantly higher across all age groups. [Figure 12]

The best available estimates of modes of transmission indicate two-fifths (42%) of infections occur amongst persons practicing 'low-risk' sex, a sub-population that includes cohabiting or married sexual partners. Key population (KP) groups account for a significant portion of new HIV infections.⁵ Directly, FSW, MSM and PWID, together constitute an estimated 1% of the adult population, account for nearly 23% of new HIV infections. Roughly 20% of infections may be attributed to female sex workers, their clients and client partners alone, of which three-fourths may be attributable to brothel-based FSWs.⁶ People who inject drugs (PWID), MSM and their partners respectively are estimated to account for about 9% and 10% of the annual new infections. These KPs and their partners together, who constitute an estimated 3.4% of the adult population, account for as much as 40% of new infections. There remains a high likelihood of HIV transmission amongst people who inject drugs due to continued high rates of needle and syringe sharing amongst them.

Number of Key Population by Type by State

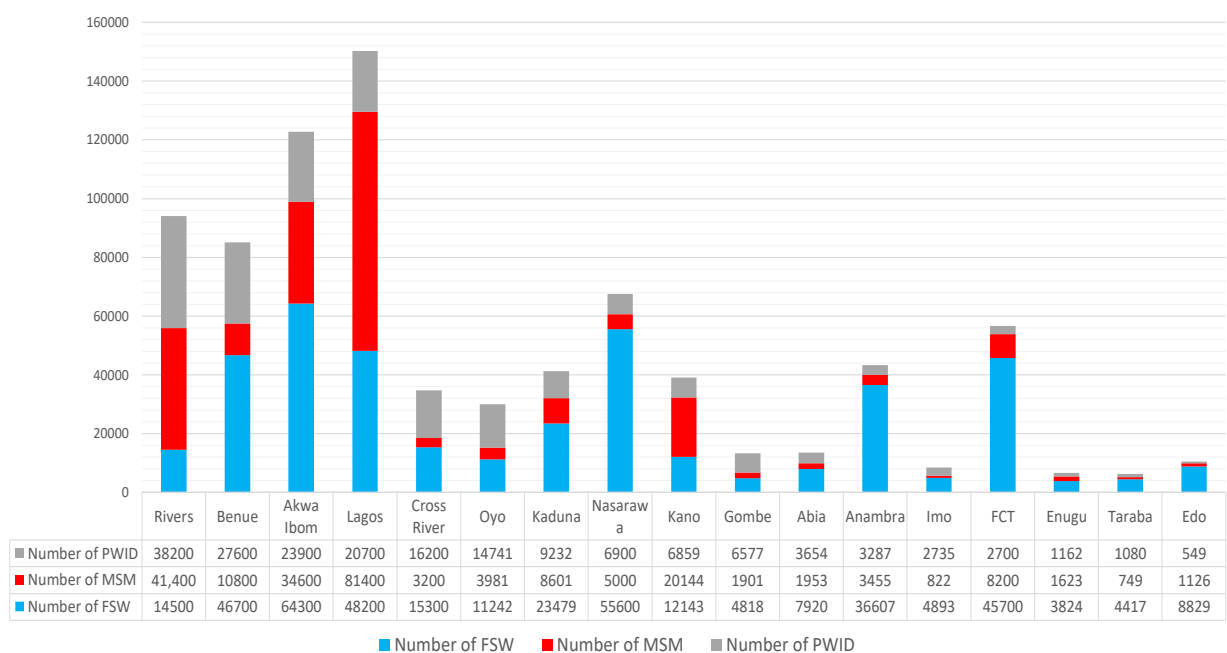


Figure 13: Estimated key populations by state for 16+1 states (Key Population Geographic Mapping and Size Estimation-Nigeria 2018)

The 2018 Key Population Geographic Mapping and Size Estimation study⁷, while limited to sixteen states, makes apparent the heterogeneous composition of key populations and related incidence dynamics across states. [figure13] The study estimated a combined population of 823,503 across all typologies. This includes an estimated 408,472 female sex workers, 228,955 men who have sex with men and 186,076 people who inject drugs respectively across the 16+1 States. In addition, prison and borstal inmates represent a further key population with high prevalence, estimated at 3%, driven by high-risk drug use with sharing of sharps as well as unprotected consensual sex, transactional sex, forced sex/sexual violence and sex with visitors. According to the recent National Assessment of HIV and AIDS and Health Services Situation in Nigerian Prisons⁸, the total prison inmates' population as at July 2018 was 75,772 with total

male prison population of 74,186 and total female population of 1,586. Similarly, transgender populations, for which population size estimate are yet to be conducted, need further consideration.

In rural towns and villages, risk is driven by variations in sexual behaviours such as casual, transactional and sex work⁹. Adolescents and young people are particularly vulnerable to changing perceptions of risk as well as social trends such as the “Marlians”, on-line dating, and transactional sexual activities. Women and girls are particularly vulnerable to structural drivers which play a role in the HIV epidemic in Nigeria. Socio-cultural factors such as poverty, gender inequality, human rights violations and the persistence of HIV and AIDS-related stigma and discrimination increase vulnerability to HIV infection. A number of specific socio-cultural factors contribute to infection, with some variance across geo-political zones of the country. These include:

- Low dissemination of information about HIV, especially in rural areas.
- Low usage of condoms due to cultural beliefs.
- Inability of women to demand condom use. (Male dominance over women’s reproductive rights).
- Extra-marital sex and/or multiple sex partners.
- Levirate Marriage (Widow Inheritance).
- Gender based violence
- Female genital mutilation.
- Gender inequality disempowering women from seeking HIV prevention or treatment services without the permission of their husbands/partners.
- Poverty, which may lead to high risk behaviour such as sex work.
- Males being less disposed to going for testing and seeking treatment.
- Poverty, which limits access to treatment, especially clinics that are distant from people’s homes.
- Recent humanitarian crises with implications for unsafe and violent sexual experiences.

2.4 AIDS Related Deaths

The number of AIDS-related deaths in Nigeria is among the highest of any country in the world. In 2019, an estimated 44,719 persons living with HIV died from AIDS-related causes, with an AIDS-related mortality rate of 21.7 per 100,000 population.

Trend in AIDS-Related Deaths

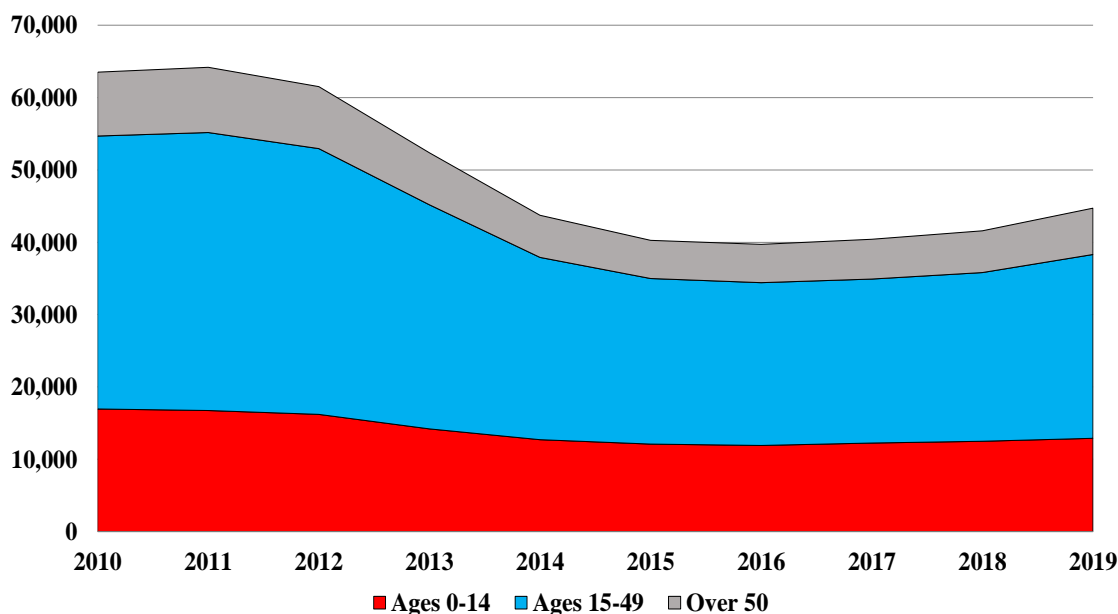


Figure 14: National trend in AIDS-related deaths (Spectrum estimates with data from NAHS)

Since 2010, with the scale-up of treatment and services, AIDS-related deaths have declined by nearly one-third in ages 15-49, while falling nearly 24% in ages 0-14. Estimates indicate that progress has stalled in recent years. [figure 14]

Estimated AIDS related deaths by State, 2019

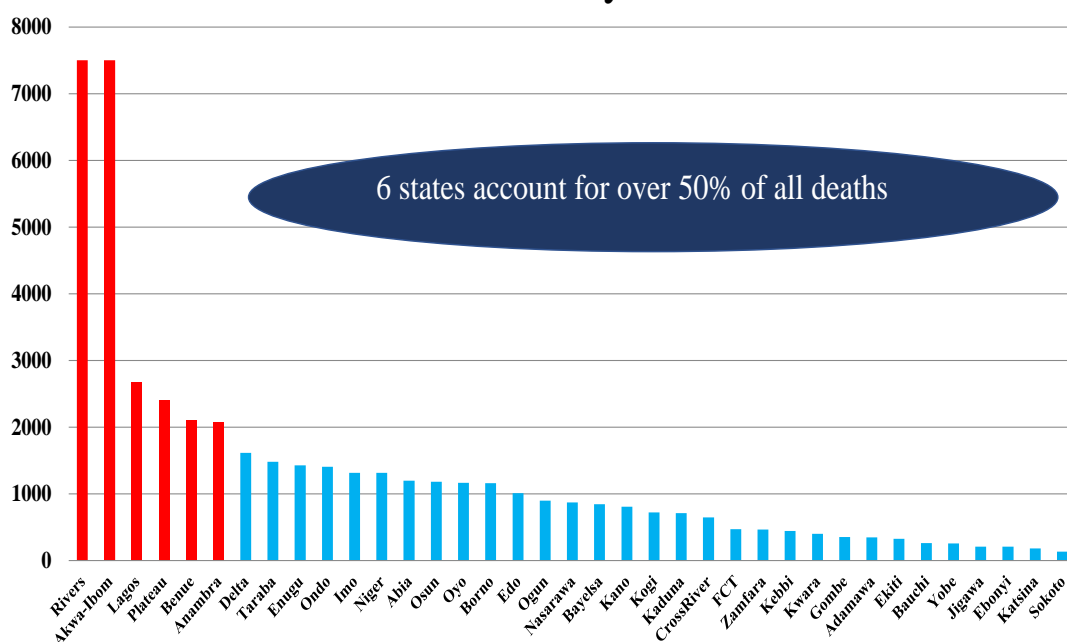


Figure 15: AIDS-related deaths by State, 2019 (Spectrum estimates with data from NAHS)

AIDS-related deaths are highly concentrated, with six states – Rivers, Akwa-Ibom, Lagos, Plateau, Benue, and Anambra – accounting for over half of all deaths. Seventeen states account for 80% of all AIDS-related deaths. [*Figure 15*]

3.0 ELIMINATION OF NEW INFECTIONS AND ACHIEVING THE FIRST 90 AND 95 SUBSEQUENTLY

3.1 Ensuring “HIV Competent” Citizens

NACA’s vision is for Nigeria to be a nation of people with functional knowledge of HIV/AIDS who provide care and support to individuals, families and communities confronted with the epidemic and the Agency solely authorised to facilitate all stakeholder HIV and AIDS activities in the country¹⁰. Ensuring youth, men and women are informed and knowledgeable about the risks of HIV infection and how to protect themselves, get tested and be treated is essential to ending HIV/AIDS epidemic in Nigeria

Research consistently shows that evidence-based communication programmes can increase knowledge, shift attitudes and cultural/gender norms, and drive changes across a wide variety of HIV-related behaviours.¹¹ Communication interventions impact HIV and AIDS response on several fronts and embrace both behaviour change communication and social change communication. Behaviour change communication promotes tailored and culturally sensitive messages, personal risk assessment, greater dialogue and an increased sense of ownership of the response by the individual and the community. Social change communication, on the other hand, involves the strategic use of advocacy, communication and social mobilization to systematically facilitate and accelerate change in the underlying determinants of HIV risk, vulnerability and impact.

Communication interventions contribute towards shaping decision-making at individual and group levels, building risk reduction skills of individuals and populations, promoting appropriate HIV prevention behaviour, addressing stigma and discrimination, and educating health-care providers and other care givers. Furthermore, communication efforts are key to improving both the supply and demand sides of all the HIV-related services – prevention, testing, treatment, care and support.

The recently completed National AIDS Spending Assessment 2015-2018¹² found an average annual expenditure of USD 3.8 million for communication for social and behavioural change over the period 2015-2018. Even with a focus on the most vulnerable 20% of an estimated average sexually active population in Nigeria of approximately 100 million persons over the period, this equates to about 20 cents per person. For reference, WHO/MPOWER has suggested a benchmark of US\$1.50–4.00 per person per year on social and behavioural change communication in developed countries.¹³

UNAIDS knowledge indicator defines comprehensive HIV knowledge as correctly identifying ways of preventing the sexual transmission of HIV (correct and consistent condom use; having one HIV-negative, faithful partner); and rejecting major misconceptions about HIV transmission (HIV can be transmitted by mosquitoes or by supernatural means).

The latest estimates from the 2018 Nigeria Demographic and Health Survey indicate significant gaps in comprehensive knowledge across all sub-populations examined, with young people having

the greatest gap. [figure16]

Comprehensive knowledge of HIV by Population

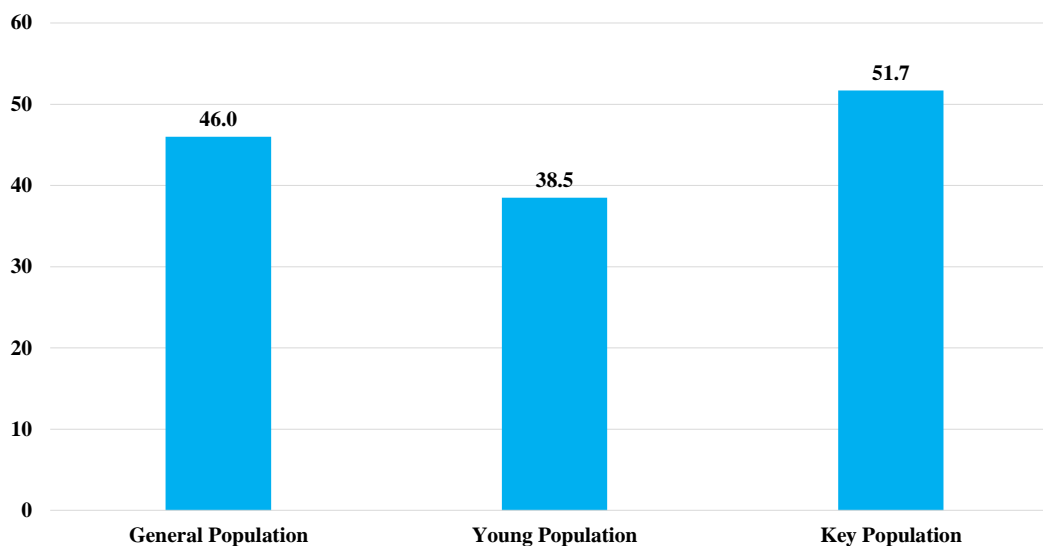


Figure 16: Comprehensive knowledge of HIV in different populations (NDHS 2018)

Comprehensive knowledge of HIV/AIDS increased from 30% in 2008 to 46% in 2018. Among women, comprehensive knowledge increased from 26% in 2013 to 46.2% in 2018; while in men it increased from 37% in 2013 to 45.8% 2018. The 2018 NDHS found an improvement in critical knowledge that using condoms and limiting sexual intercourse to one uninfected partner who has no other partner can reduce the risk of HIV since 2013, from 54% to 71% among women and from 70% to 74% among men. The share of women who know that using condoms and limiting sexual intercourse to one uninfected partner can reduce the risk of HIV varies by age, from 62% among those ages 15-19 to 74% among those ages 30-39. A similar pattern is observed among men (60% and 79%, respectively). There are important differences in knowledge of HIV/AIDS prevention methods by zone. The proportions of women and men who know about both methods are lowest in the North East (62% and 58%, respectively) and highest in the South East (77% and 88%, respectively). The states where less than 50% of women know about both methods include Bauchi, Niger and Yobe. For men, only Bauchi and Plateau states fall below 50%. Among men and women alike, knowledge of both prevention methods increases with increasing education and wealth.

3.1.1 Family Life HIV & AIDS Education

The Federal Ministry of Education plays a crucial role in ensuring comprehensive HIV knowledge, having an established HIV/AIDS unit as well as having introduced the Family Life HIV & AIDS Education (FLHE) curriculum in schools. Family Life and HIV Education is a curriculum-based

process of acquiring information about sexual development and reproductive health issues and life skills to enable young people to be better informed and empowered to adopt positive health and social behaviours. The curriculum is comprised of three components: class room delivery; communication of reproductive health and HIV/AIDS prevention information to students on the school assembly ground; and peer education plus peer-led informal strategies for prevention messaging.

A comprehensive assessment of FLHE Programme was conducted using UNESCO's global Sexuality Education Review and Assessment Tool (SERAT) to gain empirical insight into the extent that FLHE is capable of enabling young people access comprehensive sexuality information and prevent HIV. The assessment revealed weak mainstreaming of FLHE topics in subject curricula, and geared towards knowledge only with little or no emphasis on life skills acquisition. It showed that FLHE curriculum used in schools are obsolete and not comprehensive to capture all the issues that are necessary for adequate sexuality, life skills and HIV prevention among young people. There is a huge gap in the capacity of teachers and other human resources for the roll out of Family Life HIV & AIDS Education; there are also persistent barriers to the acceptance of sexuality education for young people posed by socio-cultural norms. This has limited the sexuality and condom information in the FLHE curriculum. These gaps contribute to the poor disposition to essential life skills and persistent vulnerability of young people to STIs and HIV.

The 2018 NDHS found young people had the lowest level of comprehensive knowledge at 38.5%. Comprehensive knowledge about HIV among young women has increased since 2013 (from 24% to 43%), while the proportion among young men has not changed (34% in both years). These low levels of knowledge are linked to social normative barriers that discourage adolescents and young people from seeking information from reliable sources. In rural areas, only 36% and 28% respectively of young women and men have comprehensive HIV knowledge, at least partly due to a higher degree of isolation from contemporary society, compared to 51% and 42% respectively of young women and men in urban areas.¹⁴

Early adolescent girls in rural areas are particularly vulnerable. The NAIIS found that 24% of girls in rural areas had sex before the age of 15, and that less than 4% of girls aged 10-14 knew that not having sex or using a condom every time they have sex could reduce the risk of getting HIV. More generally, adolescent girls and young women across Nigeria have challenges accessing sexual and reproductive health (SRH) services, have low risk perception, and are more likely to engage in risky sexual behaviours than older adults.¹⁵

The Family Life and HIV Education programme needs to be urgently reinvigorated nationally, better supported, and expanded to reach out of school youth. In the face of continued resistance and prevailing traditional values and norms, there is a great need for robust advocacy with policy makers and community gatekeepers, school governance and other duty bearers, including parents. The programme needs to be linked to all schools public and private, including Almajiri and Christian

schools, working with the Ulama and Christian educators alike to ensure all young Nigerians are given the skills to protect themselves. The curriculum and in-school anti-AIDs club activities should be strengthened and new cost-effective approaches to in-school training of teachers put in place. Above all, on the principle that what gets measured gets done, a strengthened oversight, monitoring and evaluation mechanism for FLHE teachers should be put in place, including consideration of awards or incentives to motivate teachers. Greater involvement of young people and people living with HIV in programme oversight would likely be helpful in strengthening links and results.

In recent years, there have been a considerable number of internationally financed SRH/HIV information projects including IPC sessions; Adolescents Living with HIV support groups to promote comprehensive knowledge (UNICEF 2015-2019); HIV prevention education as part of the Integrated MARPS HIV prevention programme (SFH, Heartland Alliance, FHI) in seven states; the peer educators' programme as part of the Nigeria Business Coalition Against AIDS (NiBUCAA) project; and UNESCO's education for health and wellbeing project entitled Our Rights, Our Lives, Our Future (O3) Programme which is presently implementing the SERAT recommendations and supporting the strengthening of FLHE implementation in eight states plus FCT. O3 is supporting curriculum developers, the training of teacher educators, pre- and in-service teachers to effectively deliver FLHE curriculum in schools; including ensuring effective lessons plan/teaching schemes development and timetable management. O3 is mobilizing the commitment of traditional and religious leaders to show better understanding and support for FLHE among adolescents and young people and orientation of parents-teachers associations, school committees on FLHE and SRH needs and services of AYPs. None of these projects can substitute for sustained national investment at Federal and state levels in ensuring comprehensive knowledge of HIV/AIDS among young and vulnerable people.

The recently completed National AIDS Spending Assessment 2015-2018 found an average annual expenditure of USD 2.5 million for prevention programming focused on in-school and out of school youth over the period 2015-2018. With an average population between the ages of 10 and 19 of approximately 43 million persons in Nigeria over the period, this equates to about 6 cents per person.

3.1.2 Social Media & Traditional Media

Strengthening the use of social media platforms and traditional media to communicate a health promotion agenda, disseminate HIV information and strategic behaviour change messages, including for condom usage during non-marital sex targeted at youth (commercial and social marketing), and tackling stigma is vitally important. Adolescents and young people should be targeted with specific strategic behaviour change communication messages. Meaningful involvement of trained adolescents and young people to lead programming, and manage online interactions is fundamental to reaching target audiences effectively.

3.1.3 Leveraging the Network of People Living with HIV/AIDS in Nigeria

The Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) and its constituencies ASHWAN, and NINERELA+ play a central role in coordinating a social support and information system for persons living with HIV/AIDS. Through its support groups and persons living with HIV/AIDS advocates, NEPWHAN disseminates information and educational products to members about their health needs, which in turn empowers them to demand HIV services. In addition, NEPWHAN and APYIN (Association of Positive Youth Living with HIV/AIDS in Nigeria) can be supported to develop out of school youth cohort cooperative support groups and back to school programmes. Such an approach, with cohorts limited to 10 individuals per group, will directly address one of the most vulnerable groups. NEPWHAN also has a potentially strong role to play in promoting prevention with PLHIV, encouraging newly diagnosed individuals to support index testing of their sexual partners, and support family testing of households with HIV positive members to improve on pediatric testing.

3.2 Combination Prevention Services

The national HIV prevention programme, aligned with the Global HIV Prevention Coalition (GPC) roadmap, strategically focuses on reducing the number of new HIV infections in Nigeria through a three-pronged approach to combination prevention services - biomedical, behavioural and structural. National HIV prevention efforts are geared towards reducing the risk of HIV transmission acquired through high risk sexual behaviours, unsafe blood and blood products, use of non-sterile needles in people who inject drugs, and mother-to-child transmission. Whilst condom usage has generally been an issue, condom programming, which has been extensively implemented in Nigeria, has led to greater use during non-marital sex. Pre-exposure prophylaxis (PrEP) for individuals at high risk is a tool still in its infancy, but with significant potential if made more broadly available.

Broadly speaking, the coverage of combination prevention services must be aggressively strengthened in recognition of coverage indicators which are still lagging. These services need to be targeted, with specific granular location-population approaches to programming tailored to known geographic hotspots and vulnerable and key populations who disproportionately account for new infections.

Our goals are to ensure 90% of the population, including key and vulnerable populations, have access to HIV combination prevention interventions by 2023, and 95% by 2030.

3.3 Priority Prevention Strategies for General and Key Populations

3.3.1 General Population

Despite relatively lower prevalence when compared to key populations, the general population continues to account for a significant proportion of new infections. Women and girls continue to be disproportionately affected. Adolescents and youth are particularly vulnerable and need access to youth friendly services. It is therefore essential to expand the reach to adolescents and youth through

youth friendly services as efforts are also strengthened, particularly at community level, aimed at women and girls and the broader general population, to maximise the linkages to and integration in the primary health care system. Consideration needs to be given to expanding efforts to reach divorced, separated, and widowed persons, who are particularly vulnerable with both targeted prevention messaging and appropriate life transition support. There is need to ensure:

- Support to the delivery of accurate, rights-based and good quality Comprehensive Sexuality Education (CSE) programmes that provide knowledge, attitudes and skills essential for safer behaviours, gender equality, and HIV prevention and in the spirit of leaving no one behind.
- A total market approach for condom access which segments the population based on socio-economic indices to access free, socially marketed (subsidised) or commercial condoms and lubricants.
- Ensure the implementation of HIV Workplace Programming.
- Sustained strategic behaviour change communication for condom usage during non-marital sex targeted at youth and young adults (commercial and social marketing).
- Continued messaging for HIV testing for persons at risk, based on risk profiles including provider-initiated testing and increasing access to HIV self-testing commodities.
- Ensure broad availability of sexual and reproductive health interventions, including contraception, diagnosis and treatment of STIs, as well as cervical screening.

The recently completed National AIDS Spending Assessment 2015-2018 found an average annual expenditure of USD 19.5 million for prevention programming focused on the general population over the period 2015-2018. With an estimated average sexually active population in Nigeria of approximately 100 million persons over the period, this equates to about 20 cents per person. Spending on condom social marketing in particular, at less than USD 50,000 per year, has virtually disappeared.

3.3.2 Key Populations

Ensuring key populations have unfettered access to the full range of combination prevention services is critical to achieving the overall objectives of the HIV and AIDS response. There is need to ensure:

- An enabling environment for access to services without stigma or discrimination.
- A comprehensive service package in community and health facilities (One-stop shop and public /private health facilities) including correctional centres and other closed settings.
- Harm reduction interventions for substance use - needle and syringe programmes (NSP), opioid substitution therapy (OST) and naloxone.
- Adoption of pre-exposure prophylaxis (PrEP) for individuals at high risk of acquiring the infection and enactment of policies for the inclusion of PrEP as part of comprehensive package of services for key populations.
- Prevention and management of co-infections and other co-morbidities, including viral hepatitis, TB and mental health conditions.
- Condom and lubricant programming (total market approach).

- Sexual and reproductive health interventions, including contraception, diagnosis and treatment of STIs, as well as cervical screening.

The recently completed National AIDS Spending Assessment 2015-2018 found an average annual expenditure of USD 4.1 million for prevention programming focused on key populations over the period 2015-2018. With an estimated overall key population of 2 million persons in Nigeria over the period, this equates to about USD 2.04 per person.

More broadly, the National AIDS Spending Assessment 2015-2018 found overall prevention spending, including HIV Testing Services (HTS) to account for 18% of all spending on average over the four-year period. This figure is below the 26% for prevention benchmark recommended by UNAIDS.

3.3.3 Combination Prevention Results Framework

	<u>Indicators</u>	<u>Baseline</u>	<u>Target</u>
Target 1: 90% of the population have knowledge of HIV prevention methods by 2025			
Indicator & Source	Knowledge of HIV prevention methods % [NDHS]	2018	
c	Male 15 – 49 years	74%	90%
d	Female 15 – 49 years	71%	90%
e	Male 15 – 24 years	66%	90%
f	Female 15 – 24 years	67%	90%
Target 2: 90% of the population have comprehensive knowledge of HIV by 2025			
Indicator & Source	Comprehensive knowledge of HIV % [NDHS]	2018	
a	Male 15 – 49 years	45%	90%
b	Female 15 – 49 years	46%	90%
c	Male 15 -24 years	34%	90%
d	Female 15 -24 years	43%	90%

Target 3: 90% of general population practicing safe sex by 2025

Indicator & Source	Percent of persons who had intercourse in the past 12 months with a person who neither was their husband/wife nor lived with them and reported using a condom during last sexual intercourse with such a partner [NDHS]	2018	
a	Male 15 – 49 years	65%	90%
b	Female 15 – 49 years	36%	90%

Target 4: 90% condom use at last paid sexual intercourse by 2025

Indicator & Source	Among men who paid for sex in the past 12 months, percentage reporting condom use at last paid sexual intercourse [NDHS]	2018	
a	Men 15-49	74%	90%

Target 5: 90% of key populations accessing appropriately-targeted HIV combination prevention by 2022

Indicator & Source	Percent who used condom every time last 12 months (consistent use) [IBBSS]	2014	
a	Brothel Based Sex Workers	67%	90%
b	Non Brothel Based Sex Workers	64%	90%
c	MSM	49%	90%
d	Male and Female of the Armed Forces	61%	90%
e	Transport Workers	65%	90%
f	Males and Female who Inject Drugs (PWID)	47%	90%
g	Male and Female of the Police	66%	90%
Indicator & Source	Female Condom Use % [IBBSS]	2014	
a	BBFSW	26%	50%
b	NBFSW	20%	50%
Indicator & Source	PrEP coverage of Key Populations [Programme Data]		
a	Percent Coverage National		20%
b	Percent Coverage by State		20%

Fatima Zanna:
Baseline data provided by Dr. Oki?

Target 6: Allocate 26% of all HIV expenditures on prevention by 2025

Indicator & Source	% of total HIV spending on prevention, all sources [NASA]	2015-2018 Average p.a.	
a	National %	18%	26%

3.3.4 Elimination of Mother-to-Child Transmission of HIV

The 2011 Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive set an ambitious but achievable target. The plan reminded us that it is possible to stop new HIV infections among children and keep their mothers alive if pregnant women living with HIV and their children have timely access to quality life-saving antiretroviral drugs—for their own health, as indicated, or as a prophylaxis to stop HIV transmission during pregnancy, delivery and breastfeeding. When antiretroviral drugs are available as prophylaxis, HIV transmission can be reduced to less than 5%.¹⁶

The 2018 NDHS found the percentage of women who know that mother-to-child transmission of HIV can be reduced by taking special medications increased from 53% in 2013 to 72% in 2018. The percentage among men increased from 52% to 62% over the same period. [figure 17]

Knowledge of mother-to-child transmission of HIV

Percentage of women and men age 15-49 who know that the risk of MTCT can be reduced by mother taking special drugs

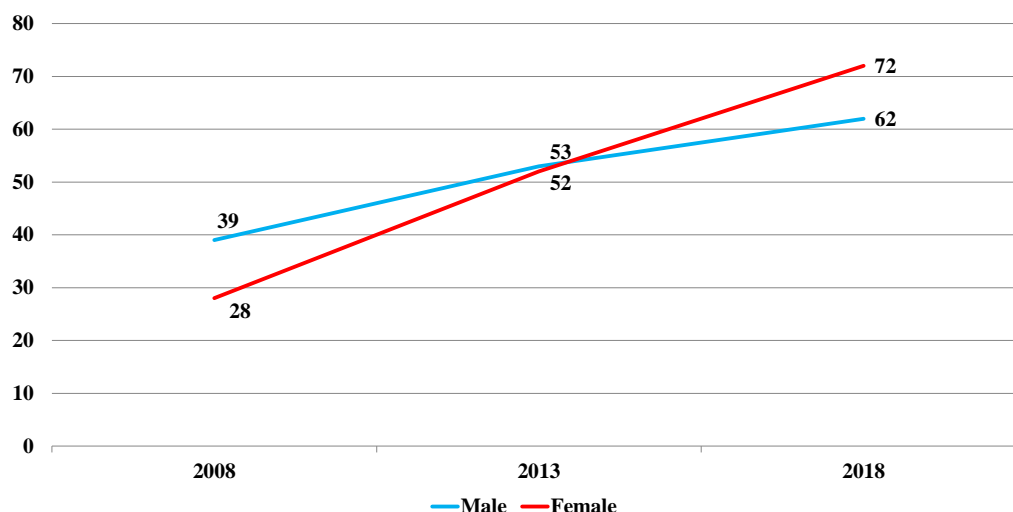


Figure 17: Knowledge of mother-to-child transmission of HIV (NDHS 2018)

Mother-to-child transmission of HIV accounts for 90% of HIV infections in children¹⁷. Nigeria continues to have the highest number of new HIV infections among children. Prevention of mother-to-child transmission programmes at all levels are characterised by poor ownership, with funding gaps and dwindling donor funding. Both PMTCT coverage and new infections are trending in the wrong direction and need to be reversed urgently. [figure 18]

PMTCT Coverage & New Infections Trend

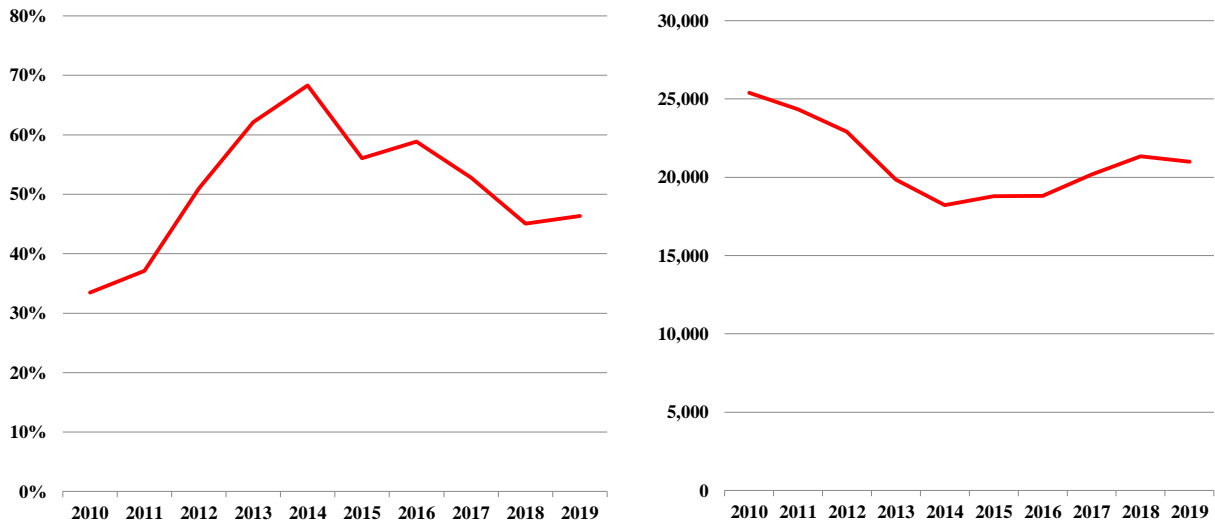


Figure 18: PMTCT coverage & new infections trend 2010-2019 (Spectrum)

Prevention of mother-to-child transmission services remains highly focussed on public health facility clients. A major effort is needed to engage private practitioners, Traditional Birth Attendants, CHIPS, Village Health workers and other community health workers in finding and referring pregnant women for ANC services and sustain advocacy to eliminate user fees. Even in states where HIV counselling and testing coverage is high, it is not accompanied by similarly high coverage for those who received antiretroviral therapy. This can be attributed to weak referral systems, linkages and follow up of positive pregnant women. A further challenge is inadequate coverage of early infant diagnosis (EID). Of the estimated HIV positive pregnant women in 2018, only about 25% of the HIV exposed infants received ARV at birth, and 23% had EID.

Nine states – Edo, Rivers, Benue, Plateau, Delta, Lagos, Abia, Akwa-Ibom, Niger – and the FCT (9 states +1), account for 70% of the unmet need for PMTCT services. [figure 19] Thirty states in Nigeria had EID coverage of less than 30% in 2018.

PMTCT Unmet Need by State, 2019, Spectrum Estimates

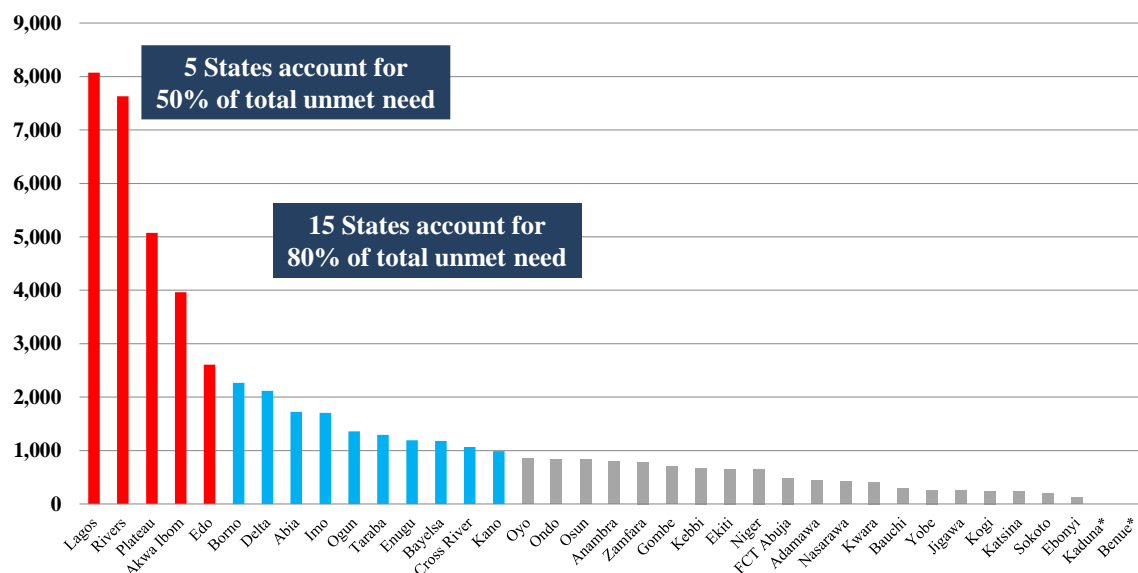


Figure 19: Unmet need for PMTCT services by state (Spectrum)

For the elimination of mother to child transmission of HIV, it is critical to achieve high ART coverage among HIV positive women, ideally before pregnancy. The target among HIV positive pregnant women is 90% ART coverage by 2025. In 2019, only 23% of HIV positive pregnant women started ART before their pregnancy and stayed on ART throughout their pregnancy.

The strategy for elimination of mother to child transmission of HIV (eMTCT) is built on a four-pronged approach:

- 1) Providing primary prevention of HIV infection among women of childbearing age;
- 2) Preventing unintended pregnancies among women living with HIV;
- 3) Preventing HIV transmission from women living with HIV to their infants; and
- 4) Providing appropriate treatment, care, and support to mothers living with HIV and their children and families.

The success of this strategy depends on accelerating both policy-level and programme-level integration of prevention of mother-to-child transmission (PMTCT) with reproductive, maternal, new-born, child and adolescent health services (RMNCAH), supported by the inclusion of prevention of mother-to-child transmission in the minimum service package for RMNCAH services. A concerted effort is needed to engage state primary health care services to reach all pregnant women through an integrated approach going beyond facilities. Priority should be given to the 10 states accounting for 70% of unmet need. The most critical missing element is identifying pregnant women at the community level and linking them to services. It is imperative to continue to strengthen health

systems to ensure sustainability of the National HIV Treatment and PMTCT Programme (NTPP) through effective coordination and adequate mobilization of domestic resources.

3.3.5 Strategic Intervention for eMTCT of HIV

- Reinforcement of HIV prevention communication to increase awareness and knowledge of HIV and AIDS, prevention of HIV for pregnant women, breast feeding mothers and early infant diagnosis (EID).
- Encouragement of pregnant women and girls to attend antenatal care (ANC) by improving access to comprehensive and free services.
- Strengthen contraceptive demand and supply for HIV positive women.
- Ensure all ANC service packages include HIV testing services.
- Promote integration and strengthen referral and linkages between antenatal care, family planning, sexual and reproductive health services, maternal and child health and HIV services, including EID.
- Engage private practitioners, Traditional Birth Attendants, CHIPS, Village Health workers and other community health workers in finding and referring pregnant women for ANC services and testing.
- Foster an enabling environment for HIV positive pregnant and breastfeeding mothers and HIV-exposed infants to access PMTCT services.
- Expand access of HIV positive pregnant and breastfeeding mothers to access antiretroviral treatment.
- Expand access of HIV exposed infants to antiretroviral prophylaxis and cotrimoxazole prophylaxis within 2 months of birth.
- Undertake a concerted effort to expand access and uptake of EID services for HIV exposed infants.
- Promote and equip a mix of conventional laboratory networks to expand access to early infant diagnosis as well as Point of Care testing for EID.
- Expanding access of HIV exposed babies to HIV serological tests at 18 months.
- Strengthen community systems to support care for HIV exposed infants.
- Strengthen community involvement in PMTCT services.
- Institute and strengthen the quality management systems for all eMTCT facilities.
- Conduct appropriate research to identify strategies to facilitate eMTCT.
- Strengthen PMTCT services in correctional centres and other closed settings.

The recently completed National AIDS Spending Assessment 2015-2018 found an average annual expenditure of nearly USD 7 million for prevention of mother-to-child transmission over the period 2015-2018. With an estimated 8 million pregnant women per year in Nigeria over the period, this equates to about 87 cents per person.

3.3.6 EMTCT Result Framework

	<u>Indicators</u>	<u>Baseline</u>	<u>Target</u>
Target 7: 90% of the population have knowledge of mother-to-child transmission of HIV by 2025			
Indicator & Source	Percentage who know that HIV can be transmitted from mother to child during pregnancy, during delivery, through breastfeeding [NDHS]	2018	
a	Male 15 – 49 years	57%	90%
b	Female 15 – 49 years	57%	90%
Target 8: 90% of the population have knowledge of prevention of mother-to-child transmission of HIV by 2025			
Indicator & Source	Percentage who know that the risk of MTCT can be reduced by mother taking special drugs [NDHS]	2018	
a	Male 15 – 49 years	62%	90%
b	Female 15 – 49 years	72%	90%
Target 9: 100% of ANC facilities offering PMTCT by 2025			
Indicator & Source	Programme Data/Facilities Data	2019	
a	National %	16%	90%
b	by State %		90%
Target 10: 90-90-90 for PMTCT by 2025			
Indicator & Source	PMTCT Cascade % [Spectrum/Programme Data]	2018	
a	% of pregnant women tested for HIV	36%	90%
b	% of positive women on ARV	44%	90%
c	% of HEI on ART within 72 hours	56%	90%
d	% of HEI given CTX at 2 Months	41%	90%
e	% of HEI with PCR results received within 2 Months	40%	90%
Target 11: Triple HIV expenditures on PMTCT by 2025			
Indicator & Source	Estimated total HIV spending on PMTCT in USD Million, all sources [NASA]	2015-2018 Average p.a.	
a	National	7	21

4.0 HIV TESTING SERVICES AND ACHIEVING THE FIRST 90 AND 95 SUBSEQUENTLY

4.1 Rationale

A rate-limiting step to fast-tracking the national response towards ending AIDS in Nigeria by 2030 is case finding – ensuring all people living with HIV have access to quality HIV testing and counselling services and use these services to know their status. Linkage of diagnosed people living with HIV to ART is an essential component of HIV testing services and significant gaps still exist in this area. HIV testing services programming is focused on utilizing differentiated testing approaches to maximise efficiency while expanding access to and demand for accurate, high-quality services. Each testing approach is designed to take into account factors such as HIV burden, unmet need, and population characteristics while using a rights-based approach to equitably address disparities in HIV testing services coverage in various relevant subpopulations including adolescents, young adults and key populations who are at risk of HIV infections. Priority strategies should be structured to achieve optimised coverage of interventions, focused on the right areas at macro level and at the right groups at location-population levels, ensuring high intensity and effectiveness of interventions through continuous quality improvement.

4.2 Strategic Objective

The strategic objective is to increase access to and demand for HIV testing services, enabling 90% and 95% of persons living with HIV (PLHIV) to know their status by 2023 and 2025 respectively.

Programmatically, building on the wealth of data from the NAIIS and other studies, case-finding efforts should prioritise states and LGAs with high burden and high unmet need, i.e. the areas where every additional unit of investment in case finding can be expected to yield the largest number of people who do not yet know their status and can be put on treatment. [figure 22]

PLHIV Burden and Treatment Unmet Need

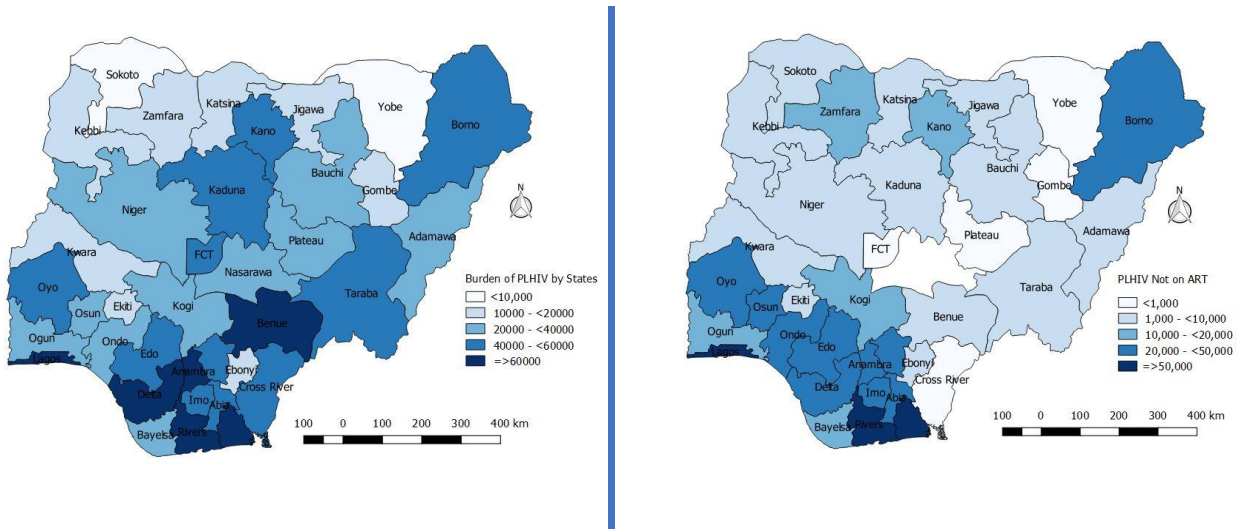


Figure 22: PLHIV Burden & Unmet Need (NAIIS 2018)

Trend in Number of Persons Tested & Yield

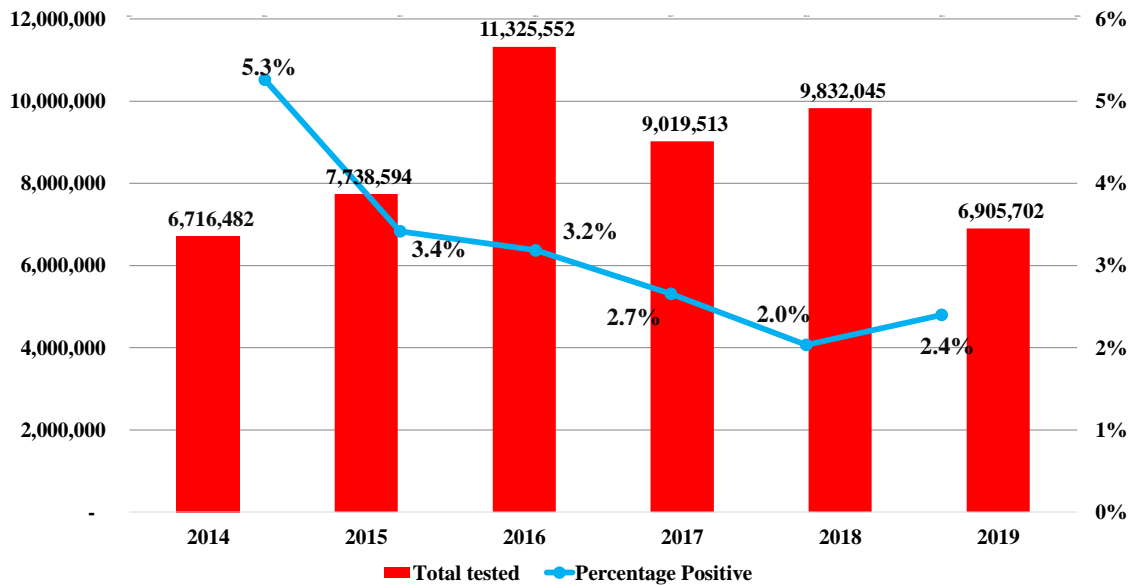


Figure 23: Trend in number of persons tested & yield (2018/2019 HIV Health Sector Programme Statistics)

This is the focus of the PEPFAR and Global Fund supported “Surge”, which aims to saturate LGAs with high unmet need and low coverage with an array of case finding teams drawn from NGOs and community-based organizations. A renewed focus on improving testing yields through differentiated

testing approaches has shown positive results in 2019 after a number of years of declining yields. [figure 23]

Index testing of partners and children, risk stratified and optimised Provider Initiated Testing and Counselling (PICT), HIV self-testing, targeted community testing and hotspot mapping, intensified community paediatric case finding and accompanied referral are key approaches for the general population.

For low and medium prevalence states with lower unmet need, efforts need to be sustained to expand the reach of HIV testing services coverage, especially at community level. In 2019, nearly two-thirds of all people living with HIV newly discovering their status did so through Provider Initiated Testing and Counselling (PICT) or TB voluntary counselling & testing.¹⁸ Community based testing in all modalities accounted for 12% of new HIV+ persons.¹⁹ Ensuring a nationally integrated HIV testing services network at community level should be the longer term objective from a sustainability perspective.

In parallel, it is important that case-finding efforts focussed on key populations across states continue to be supported and expanded. Social Network Testing, where HIV-positive and/or high-risk HIV-negative persons—particularly from key populations—are enlisted as recruiters to identify individuals from their social, sexual, and drug using networks is important for case finding. Testing promotion for key populations through social media dating platforms can help incite key population members not availing themselves of HTS. PrEP services can serve to prevent HIV as well as finding new HIV+ persons. Self-testing can improve knowledge of status in harder to reach key populations.

We continue to have greater challenges in case-finding with men, with significantly more women tested and put on treatment than men. Community-based index testing has, however, shown a much higher proportion of men being reached than through other modalities. Small scale experiences with incentivised testing in East Africa, through associated cash transfers or culturally and socially appropriate non-financial incentives, including lottery tickets, have shown positive returns and merit consideration, particularly for hard to reach populations and age bands.^{20 21 22} Given the high prevalence rates seen in NAIIS, consideration should also be given to targeted case finding, in a stigma sensitive way, among separated, divorced, and widowed persons.

At the end of 2019, the gap in treatment was estimated at approximately 820,000 people living with HIV, including children, to be found, tested and put on treatment. Based on the experience of prior years, it is expected this target would be achieved in 3 years, other things being equal. [figure 24]

Experience from other countries suggests it should be anticipated that case finding will become progressively more difficult as the country gets closer to 90%. Significantly improving the capacity for case finding at community level is likely to be key, not only to closing the gap but to sustaining efforts at lower cost.

Gap in ART Treatment – Adults & Children, December 2019

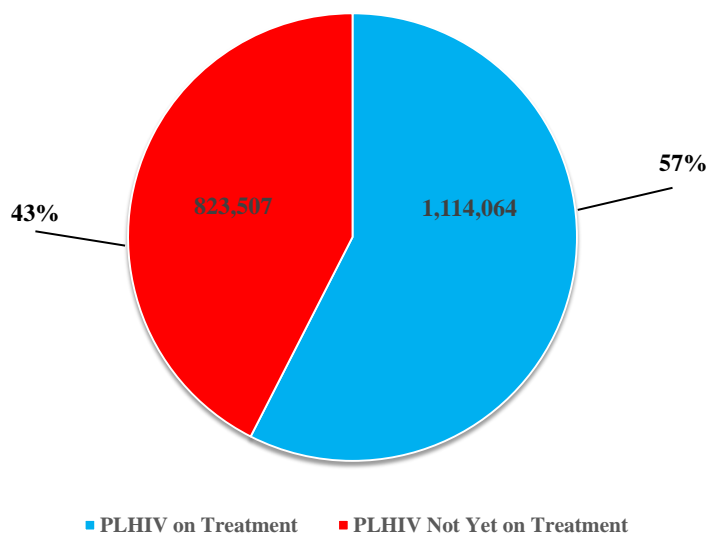


Figure 24: Gap in ART treatment (Spectrum with NAHIS data, programme data at December 2019)

4.2.1 Strategic Interventions

- Support full implementation of national task-shifting/task-sharing policy to address gaps in human resources available for the scale-up of HIV testing services.
- Adopt differentiated service delivery models for HTS that promote improved testing efficiencies, taking into account age, gender, local epidemic characteristics, and careful mapping of hotspots as well as risk screening at micro levels and sexual network testing.
- Key approaches for the general population include index testing of partners and children; risk stratified and optimised Provider Initiated Testing and Counselling (PICT) in high yield streams such as TB, STI and malnutrition clinics as well as ANC; HIV self-testing; targeted community testing and hotspot mapping; intensified community paediatric case finding; and accompanied referral.
- For key populations, Social Network Testing, testing promotion through social media dating platforms, leveraging PrEP services, and self-testing should be urgently scaled up to reach underserved key populations in settings with a high unmet need for HIV testing services.
- Strengthen HIV testing services in correctional centres and other closed settings.
- Where the Community Health Influencers, Promoters, and Services (CHIPS) are being recruited and trained, efforts should be made to ensure they are actively engaged in HIV testing services and referrals.
- Scale up innovative strategies for testing of HIV exposed infants, including use of POC for EID
- Leverage opportunities for HIV testing services scale-up through private sector partnerships, including commercialization of low-cost HIV self-testing kits.
- With the active participation of adolescents and young adults, scale-up youth-friendly HIV and STI testing services nationally, with an immediate priority in high prevalence settings.

- Strengthen facilitated referral and linkage services between HIV testing services, HIV treatment and related care services, including in correctional centres and other closed settings.
- Improve the logistics and supply chain management for all testing commodities.
- Institute and strengthen quality management systems for all HIV testing services sites.
- Strengthen monitoring and evaluation platforms to support use of data for decision making.
- Conduct appropriate research to identify new evidence-based strategies that support improved access to HIV testing services.
- Improve access to HTS in humanitarian and emergency settings in collaboration with the ministry of humanitarian affairs, disaster management and social development.

The recently completed National AIDS Spending Assessment 2015-2018 found an average annual expenditure of USD 44.7 million for Voluntary Counselling and Testing over the period 2015-2018. This represents 8.3% of total spending per year on average over the period.

4.2.2 HTS Result Framework

	<u>Indicators</u>	<u>Baseline</u>	<u>Target</u>
Target 12: 95% of all PLHIV know their status by 2025			
Indicator & Source	% of PLHIV who know their status [Spectrum/Programme Data]	2019	
a	National %	68.7%	95%
b	by State %	See figure	95%
c	by Age Band %		95%
d	by Key Population %		95%
Target 13: Differentiated testing services are broadly available by 2023			
Indicator & Source	Percentage of all testing [Spectrum/Programme Data]	2019	
a	Community based testing - all modes		33%
b	Self testing - used tests in % of total tests		10%

5.0 QUALITY HIV TREATMENT SERVICES AND ACHIEVING THE SECOND 90 AND 95 SUBSEQUENTLY

5.1 Rationale

Over the last decade, increased access and improvements to antiretroviral therapy (ART) have resulted in greatly increased life expectancy, reduced morbidity and mortality among PLHIV as well as reduced transmission rates of the virus. With the adoption of the WHO recommended “treat all” policy in 2016, the number of PLHIV accessing antiretroviral therapy has significantly increased. ART coverage in Nigeria has been significantly scaled-up, with a very high proportion of people who know their status; over 97%, successfully referred and placed on treatment. Linkage to ART has been at similarly high levels for most key populations with the exception of people in closed settings. Unmet need for treatment is very high, with 9 states having unmet need above 25,000 persons and a further 8 states with between 15,000 and 25,000 persons. [figure 25]

Unmet Need for Treatment by State 2019, Spectrum Estimates

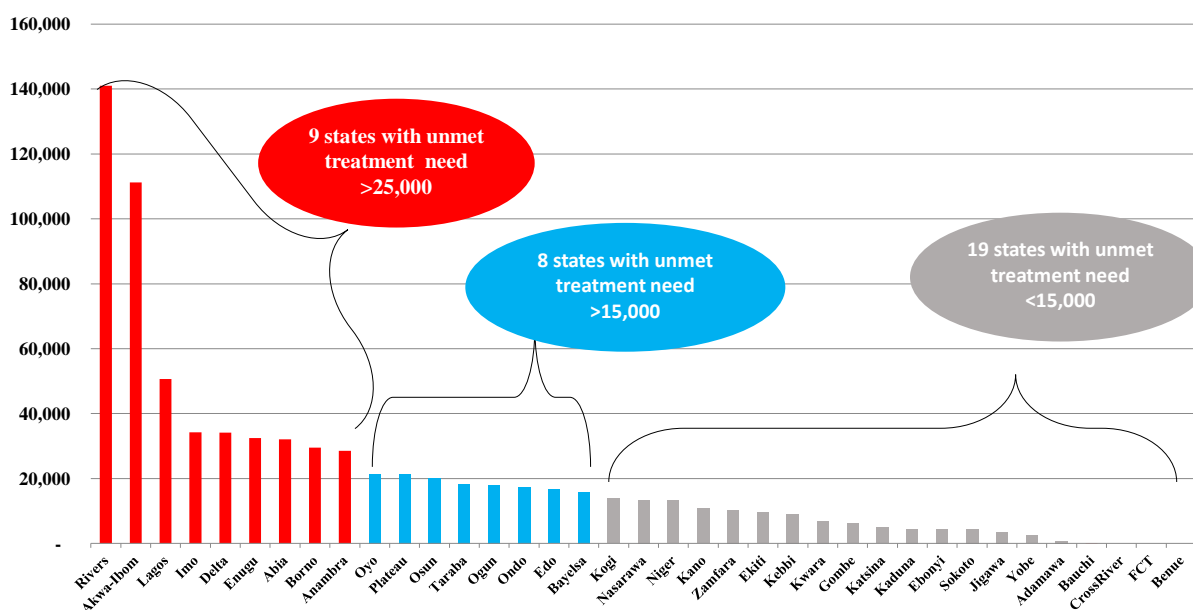


Figure 25: Unmet need for treatment by state 2019 (Spectrum estimates)

Programmatic interventions to improve national achievement across the three 90’s have faced specific challenges, including inefficiencies in the health systems, stigma, insecurity, mobile populations and hard-to-reach populations. There are still delays in reaching too many people living with HIV with essential services. In 2018, nearly one-third of newly initiated ART patients had Advanced HIV Disease (AHD), requiring significantly more care and support and retention follow-up.²³ Among newly diagnosed HIV-positive adults aged 15-64 years not yet on treatment, the NAIIS found 29.5% with CD4 count <350 cells/ μ l.

We also need to strengthen services for ageing HIV patients. All ART patients and especially ageing ART patients and patients with AHD need to receive adherence support. Treatment coverage for children under 15 years is also significantly lower at nearly 50%.²⁴ This requires a specific focus and concerted efforts. All diagnosed PLHIV should have access to sustained, high quality comprehensive antiretroviral therapy services that provide support for prevention of transmission of HIV, prevention of co-morbidities, and protection of their health. Cotrimoxazole prophylaxis needs to be systematically available to all ART patients. Eligible vulnerable children enlisted in care need to be receiving social support services.

An equally critical issue continues to be retention in care. [figure 26] Improving facility-level quality of care in terms of shorter waiting times, staff welcoming patients without stigma and discrimination, elimination of user fees of all types, as well as mother and child friendly treatment centres will help. Ensuring patient literacy through adapted communication materials is fundamental. In the longer run, retention will be facilitated when stable patients can refill prescriptions painlessly without stigmatisation in their community.

Five-Year Retention by Age Band

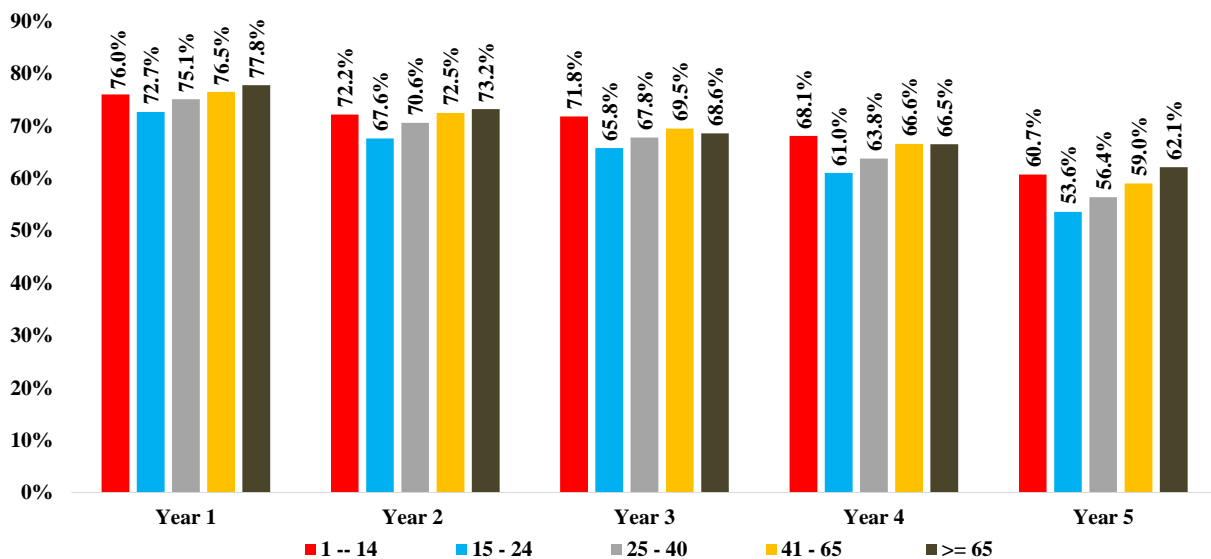


Figure 26: Five-Year Retention in Care by Age Band (2018/2019 HIV Health Sector Programme Statistics)

Expanding differentiated care models tailored to specific vulnerable and key populations, including One Stop Shops, after-hours services, Community Pharmacy Antiretroviral Refill Programme and other community ART/refill models, is essential to reducing barriers to sustained treatment.

The importance of retention-in-care cannot be overstated. Retention increases the probability of receiving antiretroviral therapy, it prevents HIV-associated complications, it improves clinical

outcomes and survival, it decreases population-level transmission of HIV, and it minimises acute healthcare utilization. Retention in care is both the goal and the measure of sustainability and is therefore a vital focus going forward.

5.2 Strategic Objective

The strategic objective is to ensure that 95% of HIV positive persons who know their status are on sustainable and quality HIV treatment services by 2025.

5.2.1 Strategic Interventions

- Support full implementation of national task-shifting/task-sharing policy to address gaps in human resource available for the scale up and decentralization of HIV treatment services.
- Expand access to antiretroviral therapy services to address the geographical areas with high unmet need for antiretroviral therapy.
- Improve access to ART for subpopulations with high prevalence and high unmet need e.g. KPs and persons in closed settings
- Support full implementation of WHO recommended “treat all” policy.
- Ensure cotrimoxazole prophylaxis is systematically available to all ART patients.
- Leverage opportunities for scale-up of treatment services through private sector partnerships
- Scale up access to quality cost-effective antiretroviral regimens.
- Institutionalise youth friendly services that target adolescents and young adults.
- Institutionalise services to support ageing HIV patients.
- Optimise transition to Dolutegravir and more simplified ART regimens especially for children
- Facilities providing HIV treatment services to be included in the initial wave of BHCPF awardees to mitigate cost of eliminating user fees.
- Promote integration and strengthen referral and linkages for HIV, TB, non-communicable diseases and other comorbidities.
- Scale-up of nationally identified differentiated models of patient-centred care for stable and unstable patients (including in-facility and community-based models) to improve patient adherence and retention.
- Support pharmacovigilance and active management of adverse drug reactions.
- Adopt and implement the WHO strategies to monitor evolution of HIV drug resistance in Nigeria.
- Ensure robust logistics and supply chain management for antiretroviral medicines, rapid test kits, viral load test kits and other related drugs, including appropriate temperature-controlled storage.
- Ensure test and treat protocols are clearly communicated and adhered to including baseline CD4.
- Ensure critical equipment is maintained, reagents stocked and expiry dates respected.
- Improve treatment access to PLHIV in humanitarian and emergency settings in collaboration with the ministries of health and humanitarian affairs, disaster management and social development.

- Scale up effective strategies to promote adherence to treatment and prevention of loss to follow up including facility and community interventions (retention calendars, patient appointment cards, tracer cards, shorter waiting times, staff welcoming patients without stigma and discrimination, elimination of user fees of all types, as well as mother and child friendly treatment centres, longer refills, scale up of the Community Pharmacy Antiretroviral Refill Programme and other community refill models, ensuring patient literacy through adapted communication materials, addressing mental health issues and economic support opportunities).
- Actively promote Patient Bill of Rights
- Develop new and strengthen existing community components for keeping the persons on treatment, including community support, addressing user fees issues, inclusion of treatment costs in insurance mechanisms and economic strengthening opportunities.
- Strengthen quality management systems including user feedback for treatment sites
- Conduct appropriate research to identify strategies that support increased access to HIV treatment services, viral suppression and improve quality of life.
- PLHIV satisfying criteria for the Federal Government's Social Intervention Programme - Conditional Cash Transfer (CCT) programme to be identified and linked to existing financial support services for the very poor.

The recently completed National AIDS Spending Assessment 2015-2018 found an average annual expenditure of USD 288.9 million for Care and Treatment including OVC activities over the period 2015-2018. This represents 54% of total spending per year on average over the period.

5.2.2 Treatment Result Framework

	<u>Indicators</u>	<u>Baseline</u>	<u>Target</u>
Target 14: 95% of all PLHIV who know their status are on treatment by 2020.			
Indicator & Source	% of PLHIV who know their status on treatment [Spectrum/Programme Data]	2019	
a	National %	97.7%	95%
b	by State %	See figure	95%
c	by Age Band %	See figure	95%
d	by Key Population %	See figure	95%
Target 15: 95% of PLHIV on ART are receiving co-trimoxazole prophylaxis by 2023			
Indicator & Source	% of PLHIV on ART who received co-trimoxazole during the reporting period [Spectrum/Programme Data]		95%
a	National %	n/a	95%
b	by State %	n/a	95%
Target 16: 95% of PLHIV access care and support services by 2025.			
Indicator & Source	% of PLHIV receiving community-based care services [SOURCE]	TBD	
a	National %	35%	95%
b	by State %	TBD	
Indicator & Source	% of PLHIV receiving adherence support (disaggregated by age and sex) [SOURCE]		
a	National %	19%	95%
b	by State %	TBD	
Indicator & Source	% of eligible vulnerable children enlisted in care receiving social support services [SOURCE]		
a	National %	26%	95%
b	by State %	TBD	

5.3 Reducing Morbidity and Mortality from HIV-TB

Nigeria is among the 14 high burden countries for TB, TB/HIV and Multi Drug Resistant TB. The country is ranked first in Africa with an incidence rate of 219 per 100,000. The estimated incidence of TB among HIV positive patients is 27/100,000 population and mortality among HIV positive TB patients is 16/100,000 population²⁵. While there are many co-morbidities affecting people living with HIV, TB is by far, the leading single cause of death among people living with HIV and requires a singular focus beyond the broader strengthening of HIV service delivery.

In 2018, an estimated 53,000 people developed TB and were co-infected with HIV. 12,700 people were diagnosed with both HIV infection and active TB disease. An estimated 32,000 people living with both HIV and TB died from TB. [figure 28]

Trend in TB-HIV 2010-2018

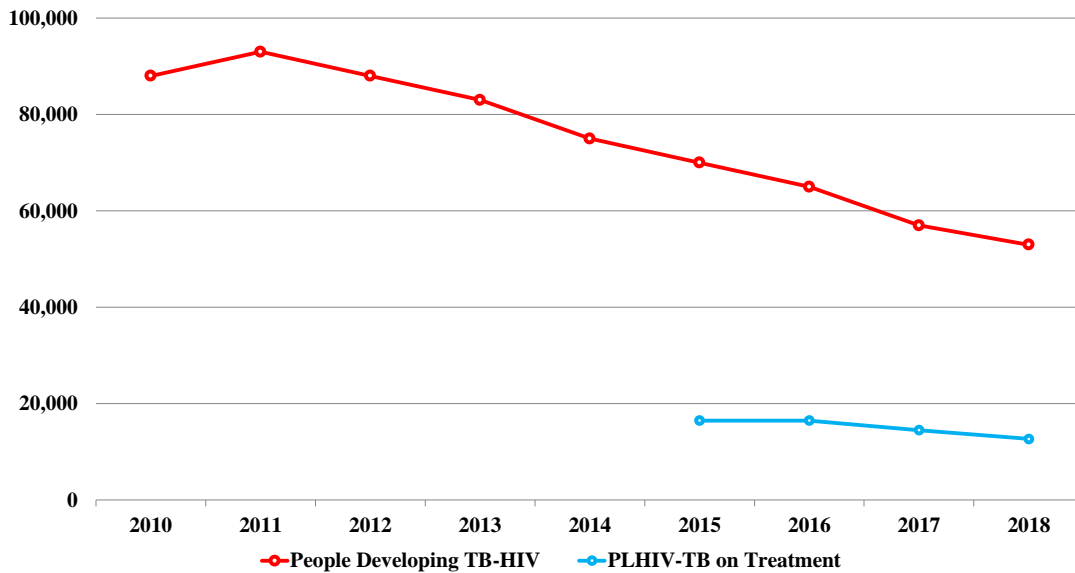


Figure 28: Trend in TB-HIV 2010-2018 (Stop TB)

A national study conducted in 2017 to determine the national prevalence of TB among PLHIV in 22 + 1 states showed that the TB prevalence among people living with HIV at last visit was 4.5% (CI: 4.3%, 4.7%). The study also showed that the mortality among people living with HIV co-infected with TB was three times higher than general population of HIV (11/1000 vs 4/1000)²⁶. The proportion of HIV positives newly enrolled in care on preventive treatment increased from 29% in 2016 to 62% in 2018²⁷, however, this is still sub-optimal. Some of the reasons for low TB prophylaxis therapy (TPT) coverage include few sites providing TPT, limited capacity for implementation (few people have been trained), reluctance of health care workers to implement TPT, logistic challenges such as occasional stock outs at health facilities. [figure 29]

Trend in number and % PLHIV newly enrolled in TPT 2010 -2018

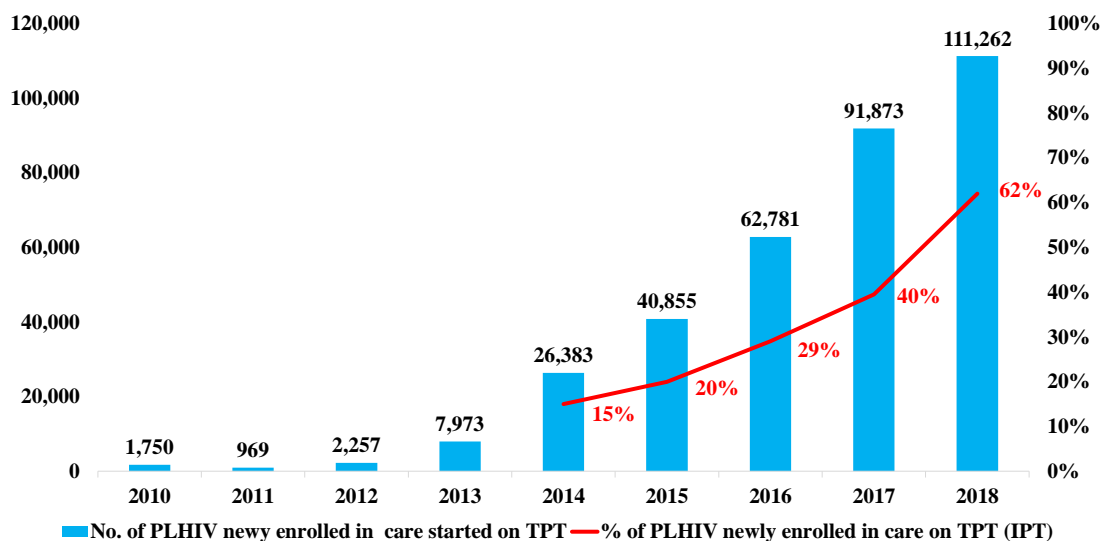


Figure 29: Trend in PLHIV newly enrolled in TPT 2010-2018 (WHO)

The bottlenecks militating against effective TB/HIV programme in Nigeria are limited access to TB diagnostic services resulting in sub-optimal TB screening and case detection among people living with HIV, low uptake of TPT among people living with HIV, inadequate implementation of appropriate TB infection control measures in health facilities, incomplete referral of TB cases from points of diagnosis in HIV clinics due to most direct observed therapy (DOT) services not being co-located with HIV clinics, and inadequate collaboration between the TB & HIV programme at the sub-national levels. Months long stock outs of isoniazid (INH) are also a major issue.

5.3.1 Strategic interventions

- Strengthen collaboration between programmes at state level.
- Strengthen data and monitoring at state level.
- Ensure robust logistics and supply chain management for INH
- Implement and monitor intensified case finding (ICF) cascade in all HIV service delivery centres, including the use of escort services (TB/HIV Referral Coordinators/Volunteers) to ensure complete referral, where necessary, for GeneXpert MTB/RIF diagnosis and linkages to treatment for all people living with HIV and TB. The revised National TB Programme TB/HIV guideline has recommended chest x-ray along with symptomatic TB screening for all newly enrolled people living with HIV in care and treatment.
- The Intensified HIV case finding strategy will ensure that all TB patients, including those with presumptive TB, are tested for HIV and subsequently provided with universal ART coverage (100%) for HIV-infected TB patients as part of an integrated model of care and optimization of linkage and retention in care. Special populations such as paediatrics, people in correctional

centres and other closed settings, miners, migrants, and pregnant women or women at antenatal clinics should be targeted with TB/HIV services.

- Routine household contact tracing (to identify presumptive TB patients) and index HIV testing should be conducted for all TB patients found to be HIV positive. Active case finding is crucial because delays in diagnosing TB disease and initiating TB treatment prevents people living with HIV on ART from attaining viral suppression (impediment to third 90), can increase non-adherence to ART, and can thereby contribute to morbidity, mortality and both HIV and TB transmission.
- Strengthening TB/HIV diagnostic integration within the country’s national tiered laboratory network will be essential to ensure patient access to appropriate testing services. Support should be provided for sample referrals using the established National Integrated Sample Referral Network (NISRN). With a strengthened laboratory systems capacity, it will be important to leverage GeneXpert capacities to improve early infant diagnosis of HIV among HIV exposed babies.
- Programming for TPT should be prioritised. The national guideline recommends that all people living with HIV without active TB should be placed on IPT.

5.3.2 HIV/TB Results Framework

<u>Indicators</u>	<u>Baseline</u>	<u>Target</u>
Target 17: Ensure 95% of all PLHIV are screened for TB, treated for active TB or placed on TPT by 2025		
Indicator & Source	% of PLHIV placed on treatment for active TB within the last 12 months [Spectrum/Programme Data]	
a	National %	TBD
b	by State %	TBD
Indicator & Source	% of PLHIV screened for TB found negative for active TB and placed on TPT within the last 12 months [Spectrum/Programme Data]	
a	National %	TBD
b	by State %	TBD
Indicator & Source	% of newly diagnosed PLHIV newly enrolled in TB preventive therapy (TPT) [Spectrum/Programme Data]	
a	National %	62%
b	by State %	TBD
		95%

6.0 CARE AND SUPPORT AND ACHIEVING THE THIRD 90 AND 95 SUBSEQUENTLY

6.1 Rationale

HIV and AIDS care, support and adherence programme is the holistic and comprehensive client-focused, community centred care service provided by a multidisciplinary team at all stages of the HIV infection. It is an integral part of the HIV and AIDS continuum of care that facilitates access of people living with HIV (PLHIV), people affected by HIV (PABA) and children vulnerable to HIV (VC) to HIV care services outside of the health care facilities. It also facilitates the retention of clients in care. The issue of retention in care, especially with focus on ARV, is addressed under this strategic thrust.

The access of PLHIV, PABA and VC to HIV and AIDS care, support and adherence services has so far been facilitated by the Hub-and-Spoke model (integrated cluster system) adopted by the Federal Ministry of Health for the delivery of comprehensive health care for all Nigerians. This health care delivery approach recognises the potential impact that engagement of PLHIV-led organizations, and the engagement of PLHIV in the delivery of care for their peers.

This NSF is designed to facilitate, among others, the implementation of the 2011 comprehensive guidelines on nutritional care for PLHIV, the 2014 Act to Protect the Rights of the People living with HIV (HIV and AIDS Anti-discrimination Act), the 2014 guidelines on care and support of PLHIV, the 2016 plan of action on the removal of legal and human rights barriers to HIV and AIDS response in Nigeria, and the 2015 National Plan of Action for orphans and vulnerable children. Furthermore, the Framework will support the implementation of the 2013-2020 National Priority Agenda for Vulnerable Children by adhering to the vulnerable children's standard of services. The Framework also incorporates the prevention of HIV re-infection interventions into routine care for PLHIV as part of positive health, dignity and prevention (PHDP) strategy.

The targets for this strategic thrust recognise the critical need to effectively address the issues of HIV-related stigma and discrimination; the high premium that is laid on improving the quality of life of people living with HIV; and the need to achieve the third 90 and 95 subsequently.

6.2 Strategic Objective

To improve access of People living with HIV (PLHIV), vulnerable children (VC), and people affected by HIV/AIDS (PABA) to comprehensive rights-based care.

6.2.1 Strategic Interventions

- Foster an enabling environment for PLHIV, PABA and VC to access HIV care and support services.

- Expand access of all PLHIV to facility- and community-based care and support services, including nutritional assessment, counselling and services (NACS), adherence counselling, mental health, sexual and reproductive health, rights and psychosocial care.
- Strengthen the quality assurance mechanisms for community-based care and support services.
- Integrate NACS, mental health, sexual and reproductive health and rights and psychosocial services into routine care for PLHIV.
- Strengthen referral and linkages between care and support social services addressing the needs of VC.
- Strengthen the coordination mechanism for care and support services for VC.
- Capacity building for health care workers and other service providers on relevant codes of conduct and respect for human dignity.
- Strengthen behaviour change communications targeted at reducing stigma and discrimination against people living with HIV and AIDS.
- Advocate for strengthened implementation of the HIV and AIDS anti-discrimination Act.
- Promote access to justice for PLHIV and PABA through use of community-based and institutionalised mechanisms.
- Conduct appropriate research to identify strategies for improved care and support for PLHIV and OVC, and for the reduction of HIV-related stigma.

6.2.2 Care and Support Result Framework

	<u>Indicators</u>	<u>Baseline</u>	<u>Target</u>
Target 18: 90% of PLHIV access care and support services by 2025.			
Indicator & Source	Percent of PLHIV receiving community-based care services [Source]	TBD	90%
	Percent of PLHIV receiving adherence support (disaggregated by age and sex) [Source]	TBD	90%
Target 19: 90% of vulnerable children enlisted for care and support services access those			
Indicator & Source	Percent of eligible vulnerable children enlisted in care receiving social support services [Source]	TBD	90%
Target 20: 100% of States + FTC having domesticated anti-stigma and discrimination law			
Indicator & Source	Percent of States with anti-stigma and discrimination law [Source]	TBD	100%
Indicator & Source	Percent of children aged 5-14 years willing to care for people living with HIV [Source]		
a	5-9 years	TBD	90%
b	10-14 years	TBD	90%
	Percent of men and women age 15-49 years willing to care for people living with HIV [Source]	TBD	90%
Target 21: 90% of PLHIV access PHDP-related services by 2025.			
Indicator & Source	Percent of PLHIV provided with ‘prevention with positives’ services [Source]		
a	Male	TBD	90%
b	Female	TBD	90%

6.3 Rationale for achieving the third 90

Viral load has been adopted by Nigeria as the gold standard of ART monitoring in line with WHO recommendations. Coverage of viral load services must continue to be scaled up to achieve targets as currently (end 2019), only thirteen (13) states have coverage above 60% for adults and five (5) states above 60% for children. Challenges encountered in improving the expansion of viral load services include operational inefficiencies, insufficient demand creation for viral load services, PCR laboratory equipment downtime, poor turnaround time and non-receipt of viral load results.

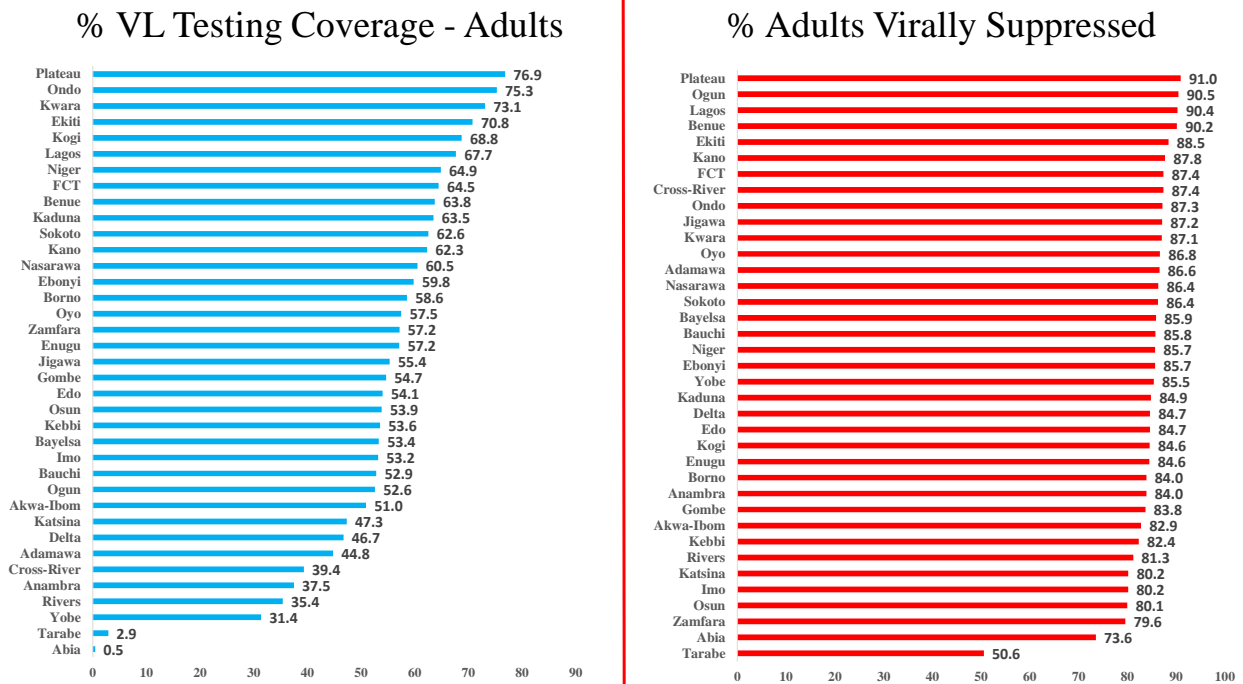


Figure 27: VL Testing Coverage & Viral Suppression (2018/2019 HIV Health Sector Programme Statistics)

Where viral load testing has been available, viral suppression progress has generally been quite positive. [figure 27] The exception is for children and adolescents up to age 19 where viral suppression rates are consistently lower, with the exception of female infants under 1 year. This Strategic Framework underscores the need for deliberate interventions to ensure timely access to viral load testing services, efficiency of the viral load systems and improved viral suppression rates for all client groups, especially among children and adolescents.

6.4 Strategic objective

The strategic objective is to ensure that 95% of HIV positive persons on antiretroviral therapy are virally suppressed by 2023. To this end, retention rates need to rise to close to 10

6.4.1 Strategic Interventions

- Scale up viral load access and coverage, with special attention to children.
- Strengthen the national integrated sample referral network (NISRN).
- Increase demand for viral load services by improving patient viral load literacy and health care facility operational efficiencies.
- Improve maintenance and support to PCR labs to ensure adherence to appropriate standards and optimal operation with minimal downtime.
- Improve the logistics and supply chain management for viral load commodities and consumables

- Tracking of unsuppressed patients
- Scale up of electronic medical records-laboratory information management system (LIMS) to improve the management and dissemination of patient results from PCR labs to healthcare facilities and improve turnaround time.
- Scale up of dried blood spot specimen and point of care testing for viral load, especially in healthcare facilities in hard to reach communities.
- Integration of HIV services into routine health service provision.
- Integrate non-traditional service delivery (maternities/traditional birth attendants) with formal health systems.
- Integration of HIV services into routine health service provision in correctional centres.

6.4.2 Viral Suppression Result Framework

	<u>Indicators</u>	<u>Baseline</u>	<u>Target</u>
Target 22: >95% of PLHIV on treatment are retained in care by 2023			
Indicator & Source	% five year retention in care, by year and age band [Programme Data]	2019	
a	National %	< 80%	> 95%
b	by State %		> 95%
Target 23: 95% of PLHIV who are on ARV have achieved sustained Viral Suppression by 2023			
Indicator & Source	% viral load testing coverage [Spectrum/Programme Data]	2019	
a	National %	85.60%	95%
b	by State %	See figure	95%
Indicator & Source	% of PLHIV on ART that have sustained virological suppression(<1000c/ml) [Spectrum/Programme Data]		
a	National %	TBD	95%
b	by State %	See figure	95%

7.0 ENABLING ENVIRONMENT & BUILDING SYNERGIES

7.1 Enabling Full Engagement

As stated previously, the success of the strategies for preventing new infections and reducing premature morbidity and mortality will be conditioned by the ability of the response to enable the full engagement of all who are concerned, whether infected or vulnerable. Every barrier to full engagement, including stigma, discrimination, disempowerment and social exclusion must be overcome. These barriers are major risks to programmes and will need greater attention to foster an enabling environment through implementation of policies and legislation that address stigma and discrimination in all settings.

The development of policies, up-to-date protocols, guidelines to support provision of youth, adolescent, and key population-friendly HIV prevention services and one-stop services is urgently needed. Advocacy for the modification of relevant laws, such as reducing the age of consent for HIV testing, enforcement of supportive legal provisions such as the HIV and AIDS Anti-discrimination Act, and support for the integration and building of linkages needed by key and vulnerable populations will all be essential.

7.2 Gender and Human Rights

The respect for the rights of all citizens in Nigeria is fundamental to ensuring equitable access to HIV prevention, treatment, care and support programmes. Equitable access to HIV programmes can also be enhanced through the recognition of gender differences that may serve as barriers to access of programmes and commodities, or hamper effective programming across the continuum of HIV prevention, testing, treatment, care and support. Strategies in this Framework take into account the relative powerlessness and unequal socioeconomic status of women compared to men; the risk that gender-based violence poses to the ability of women to negotiate safer sex, prevent HIV or mitigate the impact of AIDS; and acknowledges that differences in sexual orientation and sexual practices should not limit access of anyone to HIV programmes. It recognises the negative impact of inadequate attention to rights and gender issues on access to HIV prevention, treatment, care and support services; and how this worsens the impact of HIV on specific population groups, especially adolescents and young women. The Framework recognises the particular vulnerability of persons living with disability or persons who are separated, divorced, or widowed. It acknowledges that the lower rate of retention in care among males living with HIV is a pertinent gender-related issue. Therefore, efforts should be made in identifying these barriers in responding to the impact of gender dynamics on the HIV response programming.

This Framework was therefore developed with a focus on respecting the rights of all persons regardless of age, gender, socio-economic status and sexual orientation. It also recognises stigma and discrimination as human rights violations that pose significant challenge to effective HIV response, and thus commits to addressing stigma and discrimination against all people living with, presumed to be living with, at risk of, and affected by HIV, as a critical element in the national response. It

aligns its programmes with the Guidelines for Gender Mainstreaming in the National HIV and AIDS Response and Training Manual for Capacity Building for Gender Mainstreaming in the national HIV and AIDS Response. The Framework also upholds that the HIV and AIDS response “can be fast-tracked by protecting and promoting access to appropriate, high-quality, evidence-based HIV information, education and services without stigma and discrimination and with full respect for rights to privacy, confidentiality and informed consent.” Therefore, it provides for gender-sensitive and gender-responsive programming which improves access of people living with HIV, vulnerable children, and people affected by AIDS to comprehensive, rights-based care; it fosters an enabling environment for people living with HIV, people affected by AIDS, and vulnerable and key populations to access HIV services; while strengthening interventions targeted at reducing stigma and discrimination against people living with HIV, vulnerable and key populations. The Framework also promotes advocacy for strengthening implementation of the HIV and AIDS Anti-discrimination Act; and, promotes access of all persons including people living with HIV, vulnerable, disabled, and key populations to justice through use of community-based and institutionalised mechanisms.

7.3 Community Systems Strengthening

Community involvement and participation are well-recognised approaches in public health for improving programme effort and outcomes. Engaging communities is key to expanding access to HIV services, improving programming in the HIV response, and ensuring greater accountability of results. Community systems have been defined as community-led structures and mechanisms used by communities through which community members and community-based organisations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities. Community systems strengthening (CSS) is an approach that promotes the development of informed, capable and coordinated communities, and community-based organisations, groups and structures by addressing six core component areas:

- 1) enabling environments and advocacy;
- 2) community networks, linkages, partnerships and coordination;
- 3) human resources and capacity building;
- 4) community activities and service delivery;
- 5) organisational and leadership strengthening; and
- 6) monitoring, evaluation, research and planning.

Further programming should strengthen formal and informal community level structures including networks of people living with HIV, mentor mothers, community and religious leaders, to enhance their capacity in supporting community level engagement.

This Framework embraces strengthening community systems as a critical enabler for achieving the Fast-Track targets, and incorporates relevant strategic interventions in each of its core component areas, including:

- **Enabling environments and advocacy:** The strategic interventions include community engagement and advocacy for improving the policy, legal and governance environments, relating

to every area of HIV prevention, treatment and care. This includes advocacy for more rigorous implementation of the HIV and AIDS Anti-discrimination Act, advocacy for review of laws creating barriers to access of HIV programmes, and advocacy for increased political support; and investment in and ownership by national, state and private organisations of the HIV response.

- **Community networks, linkages, partnerships and coordination:** Building linkages and partnerships between networks of people living with HIV, key populations, community-based organisations, and other community actors, and strengthening coordination mechanisms for optimal impact.
- **Human resources and capacity building:** Building the knowledge and capacity of community actors, service providers, community-based organisations, and supporting them technically to function effectively in HIV prevention, treatment, and care services.
- **Community activities and service delivery:** Expanding access to HIV prevention, treatment, and care services at community level using relevant and context-specific formal and informal community structures, including people living with HIV networks, mentor mothers and traditional birth attendants; strengthening adherence counselling and support systems at community levels; and, strengthening the quality assurance mechanisms for home-based care and support services.
- **Organisational and leadership strengthening:** Strengthening formal structures such as the ward development committees, LACAs, and networks for improved leadership role and performance in the HIV response and strengthening accountability within the community systems.
- **Monitoring, evaluation, research and planning:** Generating local data to monitor and drive quality assurance of community-based services, ensuring effective participation of community actors in the monitoring and evaluation of the HIV response, and conducting research to generate evidence needed for efficient and cost-effective programming.

7.4 Social Protection Programmes

Effective social protection is essential to addressing the social determinants and inequalities that make people vulnerable to HIV infection, enabling PLHIV to live healthy lives and remain on treatment, and mitigating the impact of HIV and AIDS on individuals and families.

Nigeria has a number of different health insurance programmes for the formal and informal sectors as well as specific vulnerable groups (pregnant women, children under five, correctional centre inmates, retirees, and the aged). A relatively small proportion of the population is covered by these schemes and out of pocket costs represent over 70% of health expenditures. HIV and TB testing and treatment are in principle free but ‘ancillary’ user fees have been an impediment to access.

Several contributory social insurance schemes and funds for the formal sector exist. This includes the National Social Insurance Trust Fund, and public sector pension systems under the Pension Reform Act of 2014. These schemes cover unemployment, work-related injuries and disability compensations, death benefits and subsidised healthcare. A framework for a micro-pension scheme for informal sector workers and self-employed individuals, who are not covered by the mandatory pension, was also recently introduced.

Nigeria also operates several non-contributory social safety-net programmes at both federal and state level, most of which have limited coverage. The main programmes available at the federal level, and in a number of states, are the N-Power Job Creation Scheme, Home-grown School Feeding Programme, Conditional Cash Transfer Programme and the Government Enterprise and Empowerment Programme. In addition, the Youth Employment and Social Support Operation (YESSO) is coordinated by the National Social Safety-Nets Coordinating Office (NASSCO), in collaboration with the National Directorate of Employment. YESSO provides re-orientation, and life skills and job training through public works programme to adolescents.

Financed through a \$500 million World Bank loan, the Conditional Cash Transfer Programme will provide a NGN 5,000 (\$16 per month) cash transfer to households living in poverty throughout Nigeria. The most vulnerable households will be eligible for an additional monthly benefit of NGN 5,000 (\$16) on condition that they attend skills training, attend medical appointments and ensure that their children remain in school.²⁸ The entire project is national in coverage and federal in funding.

In addition, a number of state governments are introducing their own social protection programmes, working together with non-governmental actors, as well as international organisations. Faith Based Organizations support informal social safety nets and provide support to vulnerable population groups.

None of the existing health insurance programmes or social insurance schemes explicitly covers PLHIV. Rather, participation in any of the programmes is linked to status as a member of targeted groups by profession, age, disability, or employment status, etc. PLHIV face stigma, discrimination, and a range of other barriers in trying to access these programmes.²⁹

It is essential that people living with and affected by HIV be given improved access to these existing social protection schemes. This will require focused advocacy for both policy and regulatory changes. Securing facilitated access to the Conditional Cash Transfer Programme for PLHIV is among the highest priorities.

7.5 Legal & Policy Advocacy

Legal and policy advocacy is critical for the success of efforts promoting national ownership and sustainability of the HIV response in Nigeria, as it aims, among others, to secure the support of stakeholders and mobilise resources for the HIV and AIDS responses. This Framework recognises advocacy for policy formulation and review as key to creating the required enabling environment for effective HIV response. It also recognises that the enactment of appropriate and supportive laws and development or revision of guidelines that will facilitate improved access of key, vulnerable and general populations to comprehensive and high- quality HIV prevention intervention, testing services, treatment, care, and support is required. Advocacy is also critical to the effective and continued engagement of relevant local, state, zonal and national stakeholders, including the leadership of

people living with HIV communities and networks of key and vulnerable populations. At the political level, policy advocacy is critical to ensuring Nigeria's fulfilment of her regional and international obligations, including the Abuja 2001 and Abuja +12 declarations for increased funding of the health system, and the 2016 political declaration on ending HIV to “Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030”. Thus, this Framework recognises the need for review of laws and advocacy for policy formulations and revisions for all the strategic thrusts of the national HIV response and affirms the need for development of an advocacy strategy that would increase public and private sector investment in the response. This will also include the need to invest in research that promotes development and access to HIV prevention, treatment, care and support services. Ensuring increased and sustained local investment is a critical element of the 2021-2025 response.

7.6 Enabling Environment & Building Synergies Results Framework

<u>Indicators</u>		<u>Baseline</u>	<u>Target</u>
Target 24: 90% of all people displaying non-discriminatory attitudes towards PLHIV and PABA by 2025.			
Indicator & Source	Percentage age 15-49 with discriminatory attitudes towards people living with HIV [NDHS]	2018	
a	Male	58%	90%
b	Female	59%	90%
Indicator & Source	% of states with HIV anti-stigma and discrimination law enacted	22%	100%

7.7 Health Systems Strengthening & Sustainability

Under the Nigerian Constitution, health care is a shared responsibility of the federal, state and local governments. Nigeria operates within a system of fiscal federalism characterised by fiscal decentralization and responsibility attributed to State and Local governments. The federal, states and LGAs have independent revenue sources recognised by the constitution, and the states' budget are not subject to federal control and scrutiny. Most States are highly dependent on statutory transfers from the Federation Account Allocation Committee (FAAC): as many as 14 states fund at least 90% of their budgets with their FAAC allocations. Their internally generated revenues form a very small share of their overall revenues.^{30, 31}

Improving the quality and reach of Nigeria's primary health care system is critical to achieving sustainable development and improving the quality of life of people living in Nigeria. Improving the decentralised health system in Nigeria faces challenges relating to governance and accountability in the use of resources and services. More than 50% of Federal public health financing goes to the tertiary level.³² Primary health care services are the primary responsibility of LGAs, with federal and

state administrations participating in some aspects of management and financing of these services, such as public health goods and special programmes, which may be financed and/or managed by them. The Federal Ministry of Health's influence on funds allocated by State and local governments to secondary and primary health care is limited. Similarly, despite the constitution giving states primarily a supervisory role over LGAs, state governments have immense influence over how LGAs allocate resources towards primary health care. This structure of governance places a premium on voluntary coordination and management of health care policies as expenditure decisions of the three tiers of government are taken independently.

The delivery of critical HIV interventions that impact on HIV risk, transmission, morbidity, and mortality is dependent on the effective performance of the response, especially at State and LGA levels. Access to services needs to be expanded by scaling-up service delivery points, diversifying service delivery approaches, and improving service delivery quality in order to achieve the Fast-Track targets and the goal of ending AIDS as a public health threat by 2030. Based on the significant level of external investment, the AIDS response in Nigeria should be the tip of the spear in contributing to the development of Nigeria's healthcare system, drawing other investments forward in a coordinated manner. However, the majority of international HIV investments align only incidentally with the Paris Declaration.

Integrating HIV services into existing government health programmatic and financing strategies is important in taking HIV out of isolation and ensuring efficiency gains in public health programmes. Health delivery platforms providing primary health services will be strengthened by greater integration of services within a resilient and sustainable health system. The HIV, TB and Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition (RMNCAH+N) programmes in particular must collaborate better in joint planning, implementation, monitoring and evaluation. At State and LGA levels they need to fully embrace the Primary Health Care Under One Roof (PHCUOR) initiative. Well-coordinated investments across programmes can create meaningful synergies, improving access and quality of service delivery and ultimately reducing morbidity and mortality associated with HIV related-diseases.

Previously, there was proliferation of parallel HIV programming and reporting systems, however, recent efforts have focused on improving coordination and harmonizing reporting systems such as the DHIS, harmonised national tools, EMR etc. There has also been a notable improvement in Government ownership and coordination of the entire response, which has resulted in a number of gains including the implementation of the largest population based HIV/AIDS survey in the world, the NAIIS, the NACA Comprehensive AIDS Programme for States (NCAPS), the continuous placement of additional 50,000 people on treatment annually, the creation of the HIV Trust Fund, the adoption of global best practices such as the transition of the treatment regimen to dolutegravir, the abolition of user fees in a number of states, the introduction of dual-kits for testing pregnant women and the NTPP.

7.8 The National Treatment and PMTCT Programme (NTPP)

The Federal Ministry of Health (FMoH) in collaboration with NACA re-established the National Treatment and PMTCT Programme (NTPP) in February 2018, to facilitate improved health sector coordination and capacity strengthening at national and sub-national levels.

The National AIDS and STIs Control Programme (NASCP) of the Federal Ministry of Health, in partnership with State AIDS and STIs Control Programme (SASCP), is mandated to coordinate the health sector response to HIV/AIDS across the 36 States plus FCT in Nigeria, as well as coordinate the activities for the control of sexually transmitted infections (STIs) and Hepatitis.

The NTPP can serve as a bridge between Federal health sector coordination and state level implementation by going beyond plans and policies. Successful programmes everywhere require more than plans and policies – much of which exist. While developing capacity, systems and incentives, the NTPP is designed to work within the broader multi-sectoral HIV response coordinated by NACA. The programme also leverages on NPHCDA investments in renovating primary health care facilities and developing the CHIPS programme to align incentives and build professionalised, integrated, and disciplined systems.

7.9 Community Health Influencers, Promoters, and Services Programme (CHIPS)

In order to improve critical health outcomes and deliver Universal Health Coverage in Nigeria, high-impact interventions need to be implemented nationally, at scale, to bring primary health care services close enough to households in communities. The interventions need to be locally contextualised and driven, connected to community level accountability structures, as well as the local, state and national health system. To achieve this goal, the National Primary Health Care Development Agency (NPHCDA) and partners are developing the CHIPS programme - Community Health Influencers, Promoters, and Services.

CHIPS transitions polio resources and harmonises existing community-level service structures - the volunteer community mobilisers, the Village Health Workers, Traditional Birth Attendants - into an improved, better focused, and coordinated approach to stimulate and support communities to demand and obtain primary health care services. Apart from harmonizing about 25,000 community health workers, government is now taking leadership through CHIPS to scale-up access to services at the community level. The aim is to have up to 200,000 CHIPS – 10 to 20 per ward – across the country, including in hard-to-reach areas.

Services provided by the CHIPS agents will include demand generation, behaviour change communication, referral and community engagement; WASH and first aid; maternal new-born and reproductive sexual health; disease-specific care for malaria, diarrhea & fast breathing; disease-specific prevention referral support and surveillance for TB, HIV, Hepatitis, and NCDs; nutrition, immunization & growth monitoring; and data management. The CHIPS programme focusses on women and children and will help in the achievement of the educational and economic empowerment of women serving as CHIPS agents.

The implementation of the CHIPS programme will be driven by states under national guidelines, coordinated through a model that brings all stakeholders at all levels under one roof to minimise duplication of efforts, reduce inefficiencies, strengthen effectiveness, and deliver results.

To be successful, the CHIPS programme will need the active engagement and coordination of partners and other stakeholders to ensure:

- High-level advocacy to the various stakeholders at all levels for political commitment, resource mobilization and buy-in for the CHIPS programme.
- The mobilization of development partners to realign their existing investments to ensure efficient use of resources with the goal of attaining the PHC revitalization objectives through the CHIPS programme.
- Leveraging the strengths and competencies of stakeholders in terms of human resources and technology to improve the functionality of the CHIPS programme.

For the HIV and TB response in Nigeria, CHIPS has potential to scale-up self-testing, case finding and referral services; improved ANC attendance to drive EMTCT; and improved retention in care.

7.10 Ownership and Sustainability of the HIV and AIDS National Response

As Nigeria moves towards achieving epidemic control in the HIV and AIDS response, the need to put in place mechanisms to ensure ownership and sustainability of the response has become imperative. LaPelle et al., 2006¹ provides a definition of sustainability of public health programmes by the USAID as the capacity to maintain program services at a level that will provide ongoing prevention and treatment for a health problem after termination of major financial, managerial and technical assistance from an external donor. The importance of ensuring sustainability of health interventions is because programmes that are able to sustain themselves are more likely to produce lasting outcomes and result in healthier outcomes. Furthermore, maximising the benefits accrued from studying the sustainability of evidenced-informed interventions is an essential task for researchers and programme planners.² In planning for instituting this mechanism, there is need for the country to take full stock of existing structures, infrastructure and resources. Additionally, due to the complexity of the country and the autonomy enjoyed by the states in their health sector, any proposed mechanism must, in addition to being comprehensive, allow flexibility for adaptation to different settings. This further highlights the country's need for a multi-sectoral response as discussed earlier in Chapter 9. Experiences shared by several countries have highlighted the importance of such an approach, especially in countries where different aspects of the health systems still need strengthening and not all members of the population have access to health facilities due to their geographical location, sociocultural beliefs and/or economic constraints.

¹ LaPelle NR, Zapka J, Ockene JK. Sustainability of public health programs: the example of tobacco treatment services in Massachusetts. *Am J Public Health.* 2006;96(8):1363–9

² Schell SF, Luke DA, Schooley MW, Elliott MB, Herbers SH, Mueller NB, Bunger AC. Public health program capacity for sustainability: a new framework. *Implement Sci.* 2013;8:1.

Figure 30 below is a simple schematic showing a simplified version of the sustainability mechanism that will be used to guide the country towards owning and sustaining the response over time. Following the principles of the health systems and community systems building blocks, it outlines important blocks, each with strategies speaking to the health and non-health sector response. Financing, being one of the most important aspects of the sustainability mechanism due to the role it plays in all the other blocks, is further discussed in Chapter 10 of this Framework.

Responsibility for coordination and implementation of these strategies will bring together different stakeholders from different levels of governments and sectors of society, with the overall responsibility for coordination at the national level belonging to NACA, and SACA at the state level. Lastly, the mechanism does not isolate the role of donors and IPs due to recognition of their commitment to working with different stakeholders, aligning with country priorities and functioning within its strategic frameworks and plans.

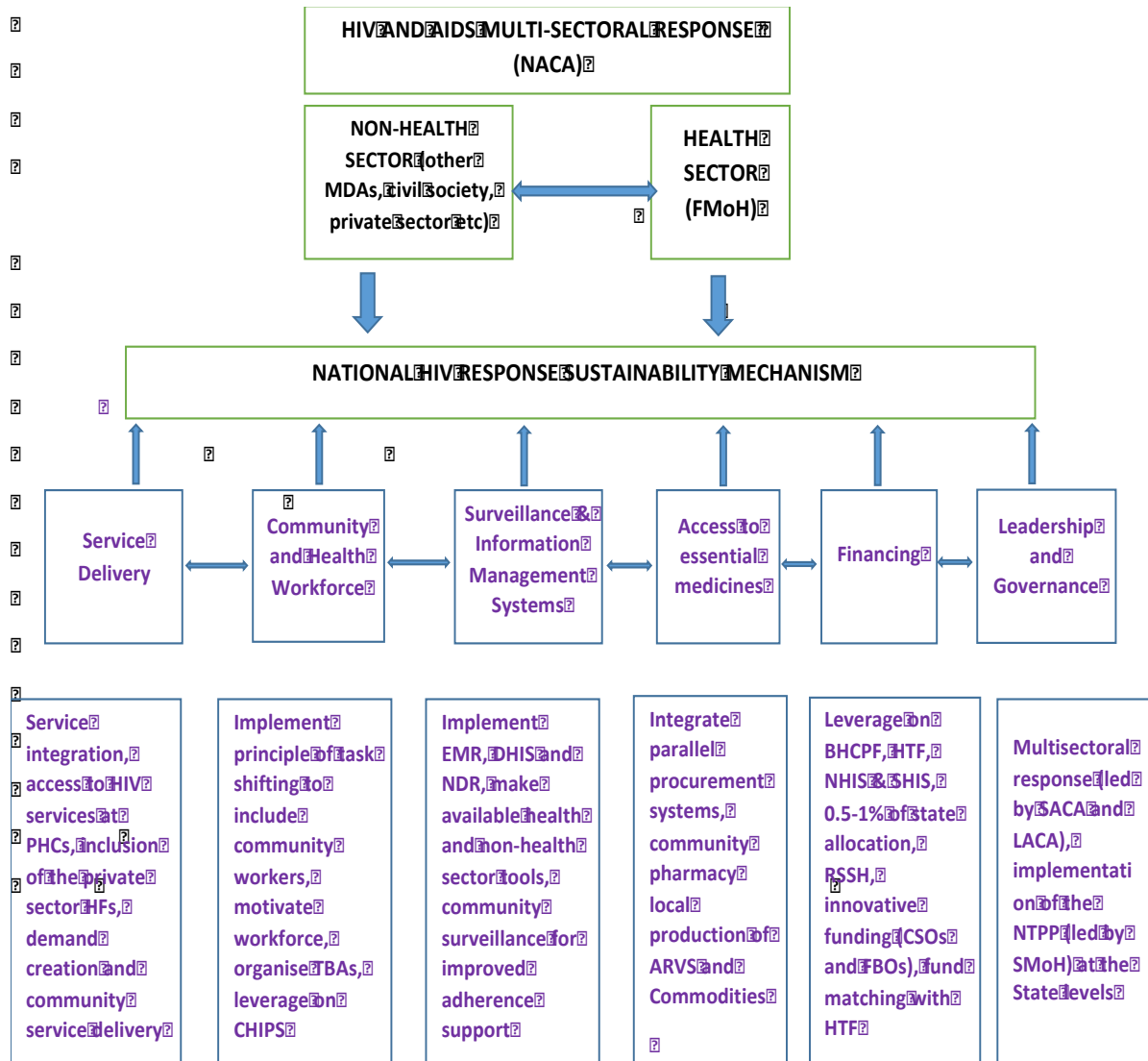


Figure 30: National HIV Response Sustainability Mechanism.

8.0 RESEARCH AND KNOWLEDGE MANAGEMENT

8.1 Rationale

The national HIV and AIDS response is evidence-informed. Adequate resources – human, financial and material – should be provided to generate relevant evidence that can be used to improve knowledge of the trends of the epidemic, the drivers of the epidemic, the coverage and quality of interventions. This will enhance the effectiveness and efficiency of programming in each of the thematic areas of the NSF, as well as the cross-cutting issues. Resources also need to be invested in the design and implementation of local and collaborative HIV prevention and treatment clinical trials that will increase access of Nigerians to effective and efficient prevention and treatment products. Resources also need to be mobilised to support the conduct of locally relevant, multi-centre studies that would help to identify effective strategies and tools for HIV and AIDS management. The national HIV research policy and agenda has been revised to support the generation of evidence to ensure efficient and cost-effective HIV prevention, treatment, care and support programming. In this regard, a wide variety of relevant research shall be encouraged, including basic research, implementation research, clinical trials, social science research and systematic reviews.

The research programmes should, among others, identify cost-effective mechanisms to promote reduction of risky behaviour among key, and vulnerable populations, and to enhance prevention-for-positives programmes. Translational and implementation research are needed to improve the application and use of effective, new biomedical HIV prevention tools and strategies.

Multiple platforms should be created and supported for the dissemination and use of research findings. Systems also need to be created to facilitate the prompt translation of the research findings into policies and programmes in ways that ensure that the HIV response is fast-tracked to achieve the national targets in a cost-effective way, and contribute appropriately to global progress.

8.1.1 Strategic Intervention

- Conduct appropriate research to identify strategies that support improved access to HIV prevention services
- Conduct appropriate research to identify strategies that support improved access to HTS
- Conduct appropriate research to identify strategies to facilitate the elimination of mother to child transmission of HIV
- Conduct appropriate research to identify strategies that support the access of PLHIV to HIV treatment services and adherence to ART;
- Conduct research to identify strategies for improved care and support for PLHIV and OVC for the reduction of HIV related stigma
- Deepen the current knowledge eco-system leveraging of newer technologies i.e. EMR, AI, data analytics and big data in making decisions that better responds to the epidemic.
- Facilitate the routine collection, analysis, dissemination and utilization for decision relevant HIV data

- Harmonise all data and information management systems in country to allow for interoperability.

8.1.2 Research and Knowledge Management Framework

<u>Indicators</u>	<u>Baseline</u>	<u>Target</u>
Target 25: Conduct and facilitate at least 10 operational researches annually from 2021.		
Indicator & Source	Number of operational researches conducted [Source]	2021 10
Target 26: Ensure 100% of Comprehensive Public and Private Health Facilities are implementing the EMR and reporting on the NDR by 2025		
Indicator & Source	Number of facilities implementing EMR [Source]	TBD 100%
	Number of facilities reporting on the NDR [Source]	TBD 100%
Target 27: Strengthened capacities for use of new data technologies in analyzing HIV and HIV related data by 2021.		
Indicator & Source	Number of HIV and HIV related information products developed using new data technologies [Source]	TBD 100%

9.0 COORDINATING THE HIV AND AIDS RESPONSE

9.1 National HIV Response System and Structure

In line with the three-tier governance structure, Nigeria's national response involves key actors at the federal, state, and the LGA levels. The national response in Nigeria is coordinated through a system involving state and non-state actors. In line with the Principle of “Three Ones”, NACA is the coordinating entity, and leads the multi-sectoral coordination of the response. The state level has the State Agency for the Control of AIDS (SACA) as the coordinating body, while the Local Action Committee on AIDS (LACA) is the coordinating body at LGA level. At every level of governance, the HIV response is multi-sectoral, with each state agency engaged in the response in line with its specified mandate. Relevant federal ministries, departments and agencies in principle implement HIV/AIDS activities in line with their sectoral focus. The federal ministry of health is responsible for the health sector response. NACA interfaces principally with five domains in its coordination responsibilities: Civil Society Organizations, the private sector, the public sector, development partners, state and LGA levels. [figure 30]

At the national level, Technical Working Groups have been established to plan and provide technical advice on thematic areas within the national response. Civil society coordination arrangements are established in the form of Constituency Coordinating Entities (CCEs), including the Civil Society Coalition, Faith Based Organisations and Network of People Living HIV/AIDS in Nigeria (NEPWHAN). The private/for-profit business sector is organised as the Nigeria Business Coalition against AIDS (NIBUCCA). The CCEs are responsible for reporting on activities of their constituency to NACA.

The national response is accountable to the National AIDS Council that meets annually with all SACAs, Sectors, and CCEs in line with the stipulations of the 2007 Act that established NACA. The agency is situated in The Presidency and reports through the Office of the Secretary to the Government of the Federation (OSGF). There is also the Senate Committee on primary health and communicable diseases and the AIDS, Tuberculosis and Malaria Committee of the House of Representatives. These bodies all play roles as coordination and accountability structures for the national response.

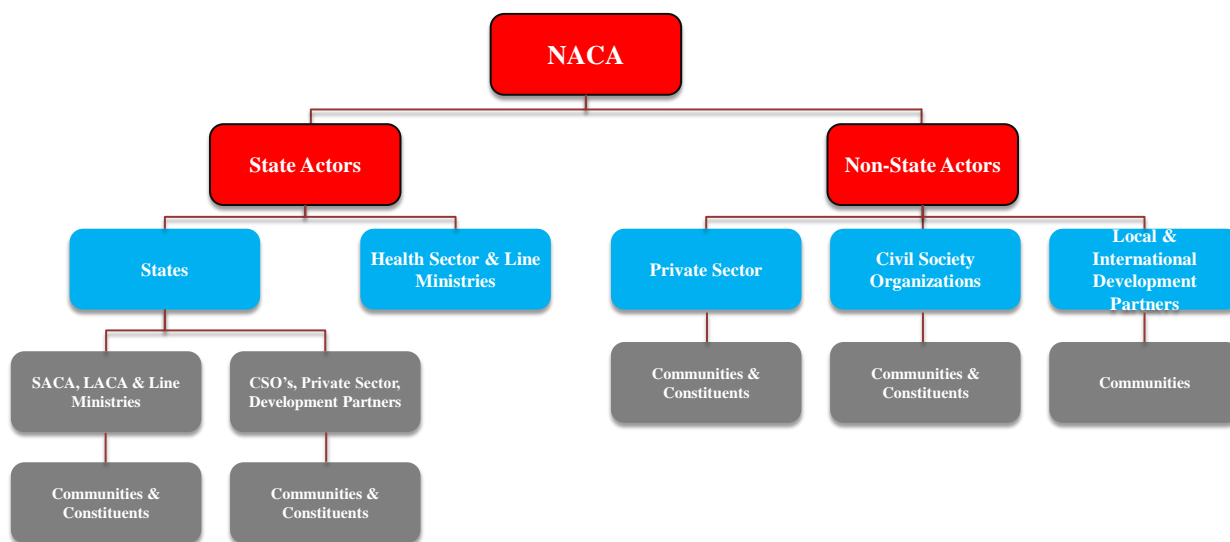
9.2 Mandates of NACA

The specific mandates of NACA as stipulated by the 2007 NACA Act are to:

- Plan and coordinate activities of the various sectors in the National Response Strategic Framework;
- Facilitate the engagement of all tiers of government and all sectors on issues of HIV/AIDS prevention, care and support;
- Advocate for the mainstreaming of HIV/AIDS interventions into all sectors of the society;

- Formulate policies and guidelines on HIV/AIDS;
- Support HIV/AIDS research in the country;
- Mobilise resources (local and foreign) and coordinate equitable application for HIV/AIDS activities;
- Provide and coordinate linkages with the global community on HIV/AIDS;
- Monitor and evaluate all HIV/AIDS activities in the country;
- Facilitate the development and management of the policies and strategies of all sectors to ensure the human, financial and organizational resources to support the successful execution of the national HIV/AIDS response programme.
- Establish, encourage and promote training programme for the employees of the Agency and other appropriate persons from public or private organizations;
- Perform such functions as may, from time to time be assigned to it by the Government; and
- Facilitate collaboration for the management of HIV and opportunistic infections.

Coordinating Structures of the National HIV/AIDS Response



Source: NACA 2014

Figure 31: Coordinating structures of the national HIV/AIDS response (NACA, 2014).

9.3 Roles and Responsibilities of the States Agencies for the Control of AIDS (SACAs)

Effective coordination of the national response will thrive on the active involvement, participation and cooperation of the state's actors and stakeholders in a multi-sectoral framework. At the state level, the State Agency for the Control of AIDS (SACA) takes the leadership role to ensure proper coordination of interventions across sectors to achieve desired objectives at the states.

The SACAs are expected to proactively take on the following listed roles and responsibilities at the states:

- Design, coordinate, control, and implement, in collaboration with the stakeholder, the state actions plans for the prevention and control of HIV and AIDS programme.
- Support the state Antiretroviral Therapy (ART) programme;
- Design and prosecute an intense multi-sectorial approach to HIV and AIDS prevention and control;
- Provide technical support to the planning, implementing and management of HIV and AIDS response;
- Provide necessary reports to stakeholders in their efforts to private and control HIV and AIDS;
- Promote and coordinate operational research on their efforts to prevent and control HIV and AIDS;
- Encourage multi-disciplinary collaboration and network among all stakeholders including the civil society organizations, Faith Based Groups, Traditional Institutions and Private sectors against HIV and AIDS;
- Organise training for personnel involved in the control and prevention of HIV and AIDS in the state

9.4 Critical Multi-sectoral Coordination Issues

There are a number of critical multi-sectoral coordination issues where new solutions need to be developed and put into action.

Harmonised National Operational Planning - First is the absence of a harmonised national multi-sectoral operating plan. Development partners and implementing partners have their own plans, but there is no effective process to harmonise plans and support monitoring and accountability across sectors. Developing a harmonised Nigeria AIDS country operational plan starting from 2021 to guide joint annual performance reviews of the response will be helpful. It will also help foster accountability, transparency and measure progress towards national and global targets while supporting national ownership of the response. It is essential that such a process is integrated in the National HIV/AIDS Response Operational Plan.

Strategic Information Management - Second is broadening the frame of data collection and coordination beyond HIV programme and EPI data and ensuring full command of the tools needed for analysis. Examples include TB-HIV data; NPHCDA data on facilities and human resources; Education Ministry data on Family Life HIV & AIDS Education activities; key population services specific data on platform utilization from one-stop shops and the Community Pharmacy Antiretroviral Refill Programme; inventory and status of laboratory equipment by site.

Quickly leveraging the broad set of multi-sectoral data to guide action and investment is essential. Finalizing, disseminating and utilizing the results of the NAIIS, new estimates incorporating NAIIS results, and other ongoing and planned studies to inform strategic and operational planning at national and state levels is urgent.

A functional and effective monitoring and evaluation (M&E) system has been put in place to provide data and guide planning, coordination, and implementation of the HIV response; assess the effectiveness and identify areas for programme improvement. There is need to scale up reporting on the system from both public and private stakeholders to enhance accountability to those infected or affected by HIV/AIDS, as well as the funders.

The implementation of the Nigeria National Response Information Management System (NNRIMS) Operational Plan (2011-2016) has resulted in improved functionality of the national HIV M&E system. However, gaps remain for ensuring the generation and use of quality M&E data for decision-making. Inadequate coordination mechanisms and systems at the sub-national level limit routine data collection and obtaining quality data at all levels and from all sectors, including private sector and civil society. Insufficient financial resources for monitoring and evaluation activities at all levels have also been a gap. Similarly, the infrastructure to underpin the national and sub-national M&E databases, routine HIV programme monitoring, programme evaluation, and research are still inadequate. Furthermore, the national response still contends with multiplicity of M&E sub-systems which are mostly donor-driven and not responsive to NNRIMS. The low participation of the private sector, especially the private-for-profit players, in the submission of information using the National Health Management Information System including the National HIV/AIDS data collection tools is another critical issue as a huge chunk of information is lost from the services rendered by this group. It may be an opportunity to explore legislative/regulatory approaches to addressing some of these issues.

Strengthened multi-sectoral coordination at State and LGA levels - Intensifying work with SACAs and LACAs to strengthen their multi-sectoral coordination with State Ministries of Health (SMOH), State Primary Health Care Development Boards, other relevant MDAs, HIV and TB implementing partners, community platforms, and services targeting key populations is critical. NACA needs to develop mechanisms that motivate and incentivise partnership towards strengthening state structures. States will be strengthened to leverage on central and international procurement systems to make scarce state funds go further. It will also be important for states to leverage on the National Primary Health Care Development Agency structures.

Key Population & AYP Programmes – These programmes are intrinsically multi-sectoral and require intensive coordination for the delivery of KP and AYP friendly services outside health facilities. Civil society, private sector, and communities themselves need to be deeply involved in designing, implementing and monitoring services. This merits the full attention of dedicated staff.

9.5 Coordination Results Framework

	<u>Indicators</u>	<u>Baseline</u>	<u>Target</u>
Target 25: Strengthened State level coordination and integration with State Ministries of Health and Primary Health Care Development Agencies/Boards			
Indicator & Source	SACA plans integrated in State-level Annual Operating Plans [NACA Analysis]	2019	
a	Percent of States	0	100%
Target 26: Strengthened National Multisectoral HIV Information System operational by 2023			
	Clear agreement on design for NACA/NTPP		
a	complementarity of efforts		2020
b	Single data architecture established & implemented		2023
	All significant Implementating Partners and LGAs		
c	fully integrated		2025

10.0 SUSTAINABLE FINANCING OF THE HIV RESPONSE

10.1 Sustained Support to the Response from Donors

International resources account for over 80% of all resources allocated to HIV response in Nigeria , with PEPFAR and the Global Fund the leading contributors with an annual investment of \$300-500 million since 2004.³³ Nigeria is the largest recipient of Global Fund resources due to its large disease burden for the three diseases (HIV, TB and Malaria) with investment of over \$2.5 billion since 2002. Similarly, the US government has invested over \$5 billion in Nigeria through the PEPFAR Country Operational Plans. Currently, financing the HIV response in Nigeria still requires the continued support of international partners. The Government of Nigeria will continue to rely on the support of partners in a framework of shared responsibility and global solidarity to maintain the trajectory towards achieving the 2030 targets. [figure 31]

Expenditure Trend on HIV by Source of Funding
2007 to 2018 in USD Millions (NASA)

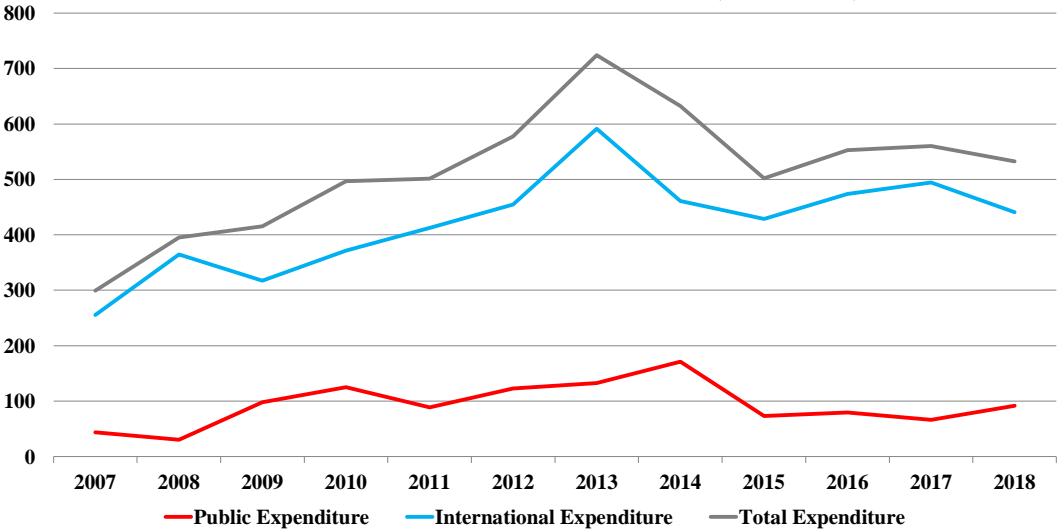


Figure 32: Expenditure Trend on HIV by Source of Funding 2007-2018 (NASA)

10.2 Increasing Financing from Domestic Sources

In a recent study of the potential for additional government spending on HIV/AIDS in 137 low-income and middle-income countries, Nigeria was identified as one of the 10 middle-income countries (along with Argentina, China, Colombia, India, Indonesia, Mexico, Russia, South Africa, and Vietnam) having the greatest fiscal space potential to increase domestic resources for HIV.³⁴ The modelling indicated potential for Nigeria to quadruple spending on HIV from 2016 levels. These estimates are consistent with estimates of relatively low overall government expenditure to GDP, at

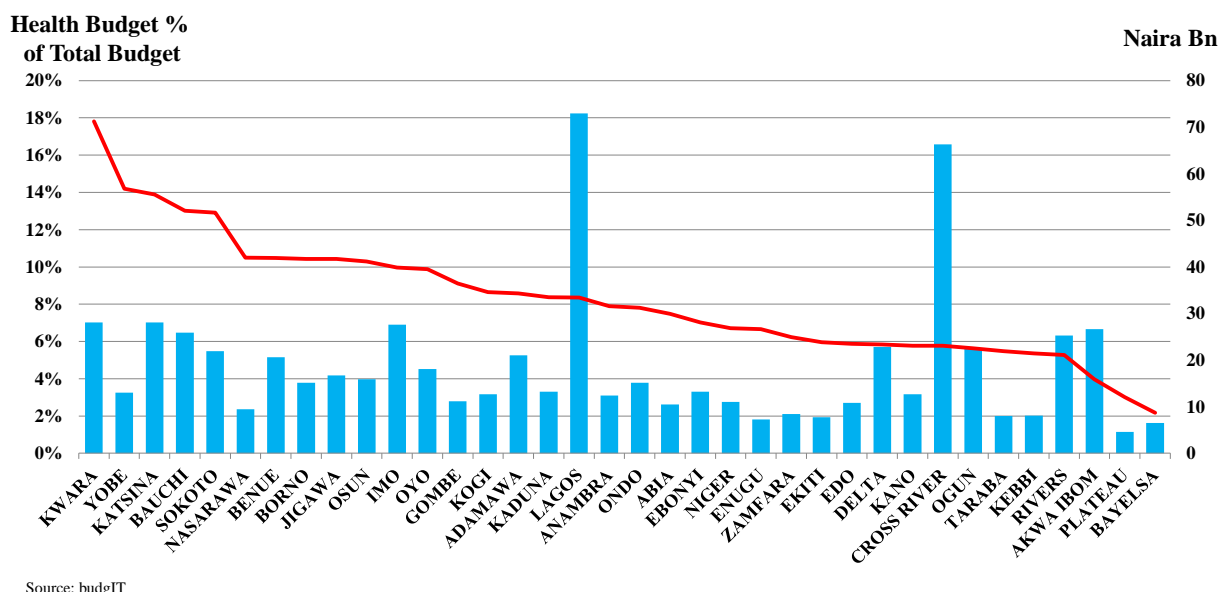
roughly 13% in 2019, as well as low estimated government expenditure on health, at roughly 1% of GDP and 5% of government expenditure in 2017.³⁵

Following a significant decline in domestic funding in 2015, the Federal Government has increased federal budget allocations for the HIV response for several years, with a commitment of His Excellency the President of the Federal Republic of Nigeria to maintain 60,000 people living with HIV currently on treatment and to place an additional 50,000 persons on treatment annually using Federal resources. This increased commitment is evidenced by the ₦12.5 billion (approximately US\$35 million) allocated in the appropriations budget bills since 2018 as well as the establishment of the National Treatment and PMTCT programme (NTPP).

The NTPP marks a potentially important milestone in ensuring sustainable ownership of the HIV treatment programme. Additionally, in June 2017, the National Economic Council (NEC) of Nigeria approved the resolution of the 59th National Council of Health for at least 0.5% to 1% of the monthly Federation allocation to states to be earmarked for financing the implementation of the HIV/AIDS sustainability roadmaps at sub-national levels. The Council further recommended free antenatal services universally in all states and the abolishment of user fees associated with accessing PMTCT services. The inclusion of HIV testing and treatment as an indicator in state health insurance schemes was also recommended.

In October 2014, the National Health Act was signed into law in Nigeria, also establishing the Basic Health Care Provision Fund (BHCPF) as part of commitment to developing Universal Health Coverage for all Nigerians. The main source of financing the BHCPF is from a Federal Government annual grant of at least 1% of the Consolidated Revenue fund. The BHCPF will cover a Basic Minimum Package of Health Services (BMPHS) in eligible primary and secondary health care facilities through the National Health Insurance Scheme (NHIS). The Basic Minimum Package of Health Services for Nigeria consists of nine interventions, including four Maternal Health interventions for pregnant women. There is ongoing advocacy for the inclusion of EID and paediatric treatment into the Basic Minimum Package of Health Services as part of the post-natal mother and baby care interventions.

State & LGA Health Budgets, 2019



Source: budgIT

Figure 33: Health Budgets by State, 2019 (budgIT)

Of the total N8.9tn budgeted by the Federal Government in 2019, N420bn (4.7 per cent) was allocated to health. At State and LGA level, of the total N9.0tn budgeted for 2019, N671.5bn (7.43 per cent) was allocated to health, with significant variation across states. Actual expenditures on health are greater at state and LGA level, both in absolute terms and as an average percentage of public spending across all states. Some states have been increasing the share of their budgets allocated to health, with Kwara, Yobe, Katsina, Bauchi and Sokoto states either above or within range of the Abuja declaration target of allocating at least 15% of their annual budget to improve the health sector. [figure 32] As Nigeria looks to increase financing from domestic sources, there is need to be mindful of the potential for greater investment at state and LGA levels. However, budget allocation and releases disaggregated by disease area are still a challenge.

The recent National AIDS Spending Assessment 2015-2018 found State and LGA expenditure on HIV averaged less than USD 14 million per year from 2015 to 2018. Clearly, States are on the front line and have direct responsibility for primary health care. Working with states to increase their investments, including leveraging funding from the Federal Government and donors to incentivise greater state investment is a priority.

10.3 The National HIV/AIDS Trust Fund

The Government of Nigeria has worked with the Nigeria Business Coalition Against AIDS (NiBUCAA) to establish an HIV/AIDS trust fund. The trust fund is intended as a private sector contribution to fill current and future HIV programmatic funding gaps with an emphasis on closing the commodities gap. It is envisaged that this will result in significantly increased private sector HIV

investment, with a goal of contributing at least 10% to overall domestic funding. This initiative, which is purely managed by the private sector, will initially focus on contributing to the elimination of mother-to-child transmission of HIV, scaling up paediatric HIV treatment and contributing HIV commodities to the national pool.

With increasing numbers of PLHIV on lifelong treatment, the HIV/AIDS trust fund is an important mechanism to ensure sustainable financing for treatment. In this regard, consideration should be given to going beyond annual contributions to seeking an endowment of monetizable assets. Land is an example of a monetizable asset which is owned at all levels of government. Public land and building assets are also acquired by the Economic and Financial Crimes Commission (EFCC) as a result of investigations. Data from the Department of Petroleum Resources (DPR), Nigeria's oil and gas industry regulator, indicate that out of 390 oil blocks in the country, 211 are yet to be allocated by the federal government. Such monetizable assets could be put to good public use in ensuring the sustainability of lifelong treatment for PLHIV.

10.4 Domestic production of HIV Commodities

Nigeria has a large and growing pharmaceutical market served by a significant number of domestic producers, principally formulating and packaging essential medicines. Domestic condom production accounts for the majority of condoms marketed in Nigeria.

With HIV now a chronic but manageable disease requiring life-long treatment, addressing the financing needs for treatment in a sustainable manner is critical. It is worth noting that with more than 1,000,000 patients on HIV treatment in Nigeria, almost all antiretroviral drugs are today imported with no local value-added, and treatment costs currently account for not less than 60% of the funding requirements. It is therefore important for the Government of Nigeria to lay the necessary policy, fiscal and regulatory environment for cost-competitive domestic production of antiretroviral drugs meeting WHO prequalification requirements. This can eventually be a significant game changer for Nigeria and the entire West and Central African region but it must be envisaged as a large-scale industrial development initiative that will take time and sustained efforts. Simple packaging and local formulation are unlikely to bring competitiveness vis-a-vis integrated volume suppliers producing their own active ingredients.

A critical element in the development of local production is the promotion of brands consumers can trust. To this end, the Federal Ministry of Health through NAFDAC will facilitate the setting up of a bioequivalence studies laboratory to ensure that all essential medicines produced locally in Nigeria will be quality assured for their desired pharmacological efficacy.

10.5 Strengthening interregional collaboration with border countries and related funding mechanisms i.e., Lagos-Abidjan corridor project

The importance of regional collaboration on HIV programmes has reached unprecedented levels. This has arisen as a result of the recently adopted UN migration compact that enforces free migration as a human right, as well as other ECOWAS and African Union Policies that are geared towards ensuring free- movement between member Countries. The impact of migration as a driver of the spread of HIV has led to the development and deployment of initiatives to which Nigeria is a party. Such initiatives include the West African Health Organisation (WAHO) Initiative, and the Lagos-Abidjan Corridor Project to mention a few. The latter in particular, is aimed at increasing access along the Abidjan-Lagos transport corridor, to HIV/AIDS prevention, basic treatment, care and support services by underserved vulnerable groups. Particular attention is given to the transport sector workers, the migrant population, commercial sex workers and the local populations living along the corridor, especially at the border towns. This project is an essential component of NACA’s operational plan and shows the Agency’s drive to strengthen regional collaboration.

With the increasing ease of migration in the region, regional collaboration is of crucial importance, with the attendant need to ensure uniformity in development and deployment of inter-regional funding mechanisms such as the Abidjan-Lagos Corridor Project which addresses the needs of key populations in the region. Nigeria will continue to take part in such regional public health initiatives to strengthen regional cooperation, collaboration and seek the establishment of similar projects along its transport/transmission corridors.

10.6 Sustainable Financing Result Framework

	<u>Indicators</u>	<u>Baseline</u>	<u>Target</u>
Target 27: GoN effectively increases annual contribution to cover treatment costs of at least 50,000 PLHIV per year			
Indicator &			
Source	GoN annual contribution to treatment costs [NHA]	2019	
a	ARV person-year treatments purchased		

11.0 INDICATIVE COSTING FOR THE NATIONAL HIV/AIDS PROGRAMME 2021 - 2025

The financial estimates of the National HIV/AIDS Strategic framework (NSF) 2021-2025 are essential for mobilizing adequate resources to fast-track the national response towards ending AIDS in Nigeria by 2030. These estimates also provide an indicative framework for leveraging and prioritization of planned investments and the design of appropriate measures to finance the resource gaps that may emerge as Stakeholders at federal and sub-national levels undertake to implement.

In determining the indicative Cost of the NSF, primarily as it only provides the overarching objectives and strategies, a costing approach robust enough to estimate the cost of the HIV service targets, defined for the NSF, was adopted. The UN-Onehealth Costing Tool was applied to estimate the Cost of planned HIV Services Packages for Prevention, Treatment, and Care. Also, HIV program management activity costs not defined in the framework was determined as a percentage of the HIV services costs using historical assumptions. The HSS utilization cost for the NSF was also determined for both labor cost and Out-patient visits required to deliver the Package of the Services. While the labor Cost was informed by the estimated full-time equivalent required to provide the planned HIV service package at Facilities and Communities, the estimates for out-patient visits, adjusted for facility running costs are based on estimates generated by a WHO study on cost for inpatient and out-patient health service delivery³.

The NSF HIV Services Packages for Prevention, Treatment, and Care costed include:

A.) Prevention service Packages:

- Key Population intervention targeting PWID, Female sex workers, MSM
- Youth-focused interventions targeting Out-of-school & AGYW
- HIV Testing Services (including Self-testing)
- Condoms Services
- PMTCT
- Management of STI for Key-Pop

Other Policy-based prevention interventions estimated as part of the HIV program management activity include Mass media, Community Mobilization, Youth-focused interventions - In-school, Workplace programs, Gender and Human Rights including Social inclusion interventions, and Stigma Reduction initiatives.

B.) Care and Treatment Packages:

- ART for Adults (Men & Women)

³ https://www.who.int/choice/cost-effectiveness/inputs/country_inpatient_outpatient_2010.pdf?ua=1

- Cotrimoxazole for children
- Pediatric ART
- Diagnostics/lab costs for HIV+ in care
- Management of OI assoc. with HIV/AIDS (including TPT provision)
- Collaborative HIV/AIDS and TB interventions
- Screen HIV+ cases for TB
- HIV prevention for TB patients

Other assumptions considered in arriving at the Cost of the NSF include the population projection of 219,150,289 based on 2019 World Population Prospects. The currency of ₦306⁴ to the dollar. The assumption also posits that HIV services under the Strategy will be delivered in existing health infrastructure and by the current providers. For HIV commodities, such as ART, HIV RTK, and other supplies, were projected towards the attainment of the 90-90-90 in 2023 and 95-95-95 targets by 2025. HR labor cost was estimated as the share of full- time equivalent committed to HIV service delivery with each staff working for 260days at 8hrs/day. Annual Salaries for front-Line staff (Doctors, Nurses, including Laboratory staff) was derived from the estimates applied during the recently conducted National Health Sector Strategy Costing. Health Infrastructure utilization costs were estimated based on visits using the adjusted cost per out-patient visit of (\$4.7 in 2020 US dollar). This amount was further adjusted for only running cost @\$0.16 in 2020 US dollars.

Policy-based prevention programs such as Community Mobilization, in-school intervention, Human Rights & Gender were estimated at share cost of the Health Sector Cost (25%). Treatment Protocol applied in the NSF cost estimation was based on the National guidelines. Unit costs for medications and supplies were derived from the Global Fund-supported medicine and Commodities database GF WAMBOO Platform.

Identified setback to the desired output of the costing process is the absence of an implementation plan (Matrix) that indicates the intervention or key activities that have been proposed to achieve the Strategies and Objectives of the NSF. Hence, Cost for Programme Management was estimated as a share of the total cost using historical estimates. Thus, the total cost must be interpreted with caution.

⁴ Currency exchange rate to the dollar as at 11/3/2020

Total Cost of the NSF 2021 -2025:

HIV NSF (2021-2025) Program Cost	2021	2022	2023	2024	2025	Total
Intervention costs	₦103.29B	₦115.75B	₦126.45B	₦134.02B	₦140.96B	₦620.47B
Programme costs	₦25.82B	₦28.94B	₦31.61B	₦33.51B	₦35.24B	₦155.12B
Total HIV Programme Cost	₦129.11B	₦144.68B	₦158.06B	₦167.53B	₦176.20B	₦775.59B
Total costs in US\$	\$0.42B	\$0.47B	\$0.52B	\$0.55B	\$0.58B	\$2.53B

Figure 34: Total cost of the National Strategic Framework 2021-2025

The NSF total cost was estimated at the sum of ₦776Billion (Seven hundred and Seventy-five billion Naira). With HIV intervention cost accounting for eighty percentage of the proposed investments for the five the year duration of the plan. The sum of ₦155Billion was allocated to address HIV program Management activities, including policy-based prevention intervention.

Prevention Service Package accounted for 34% of this amount with ₦210 Billion (two hundred and ten billion Naira). The major cost drivers in the prevention cost category are the allocations to Condom services, with 45% of the cost. Interventions targeting Key population; PWID, Female sex workers, MSM accounts for the next highest allocation with 27%.

For the Treatment and Care cost category with over 60% of the HIV intervention cost, provision of ART for Adults accounted for 46% of the treatment and Care cost, being the highest cost driver for this service category. Likewise, the Cost for Diagnostics/lab costs for HIV+ in care estimated at 26% of the cost is the next largest allocation. This investment profile provides the national financing framework for the attainment of the much anticipated 90-90-90 by 2023 and 95-95-95 by 2025.

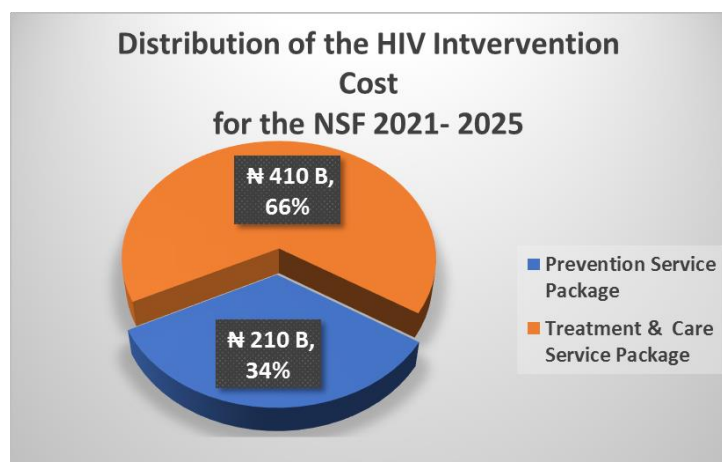


Figure 35: Distribution of the HIV Intervention Cost for the NSF 2021-2025

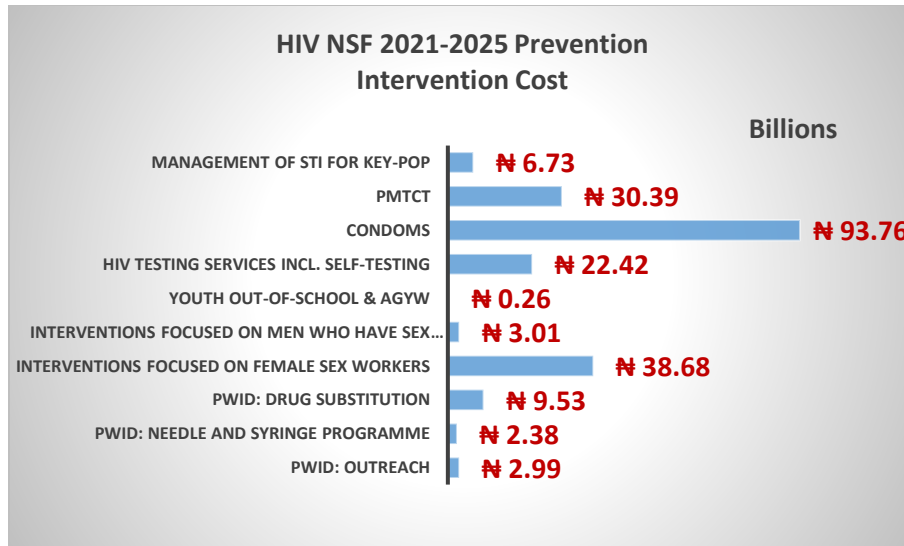


Figure 36: HIV NSF 2021-2025 Prevention Intervention Cost

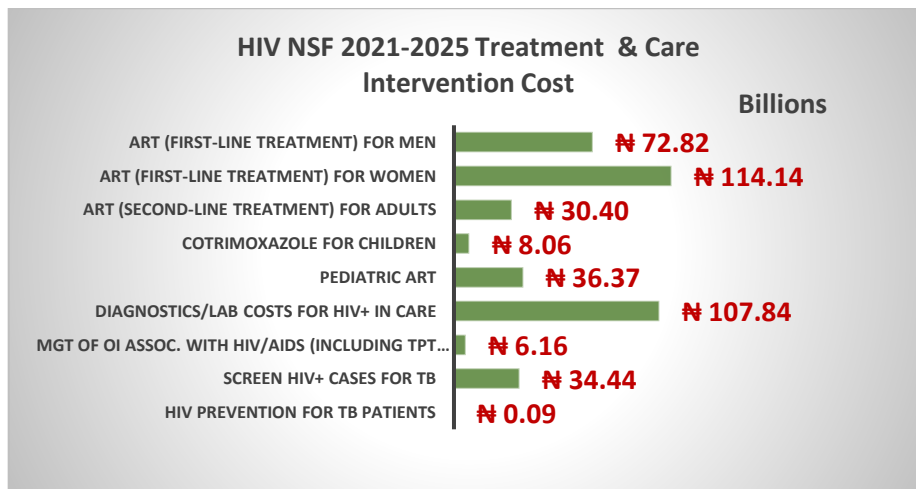


Figure 37: HIV NSF 2021-2025 Treatment & Care Intervention Cost

HIV HSS Utilization Cost

HIV shared Health System's Cost was equally estimated to demonstrate the required HSS contributions to the implementation of the NSF 2021 -2025. Labor (HR) and Infrastructure; running cost, required for the delivery of the Prevention, Treatment, and Care service package was estimated at the sum of the One hundred and sixteen billion Naira (₦116 Billion)

HSS Utilization/shared Cost	2021	2022	2023	2024	2025	Total
Labor costs	₦17.63B	₦21.34B	₦21.73B	₦21.83B	₦21.14B	₦103.68B
Inpatient and outpatient visit costs	₦2.06B	₦2.37B	₦2.54B	₦2.63B	₦2.69B	₦12.29B
Total costs in Naira	₦19.69B	₦23.71B	₦24.27B	₦24.46B	₦23.83B	₦115.97B
Total costs in US\$	\$0.06B	\$0.08B	\$0.08B	\$0.08B	\$0.08B	\$0.38B

Figure 38: HSS Utilisation Cost NSF 2021-2025

With both estimates, HIV specific program cost, and HSS Utilization cost aggregated, the Total Cost of the NSF is estimated at Eight hundred and ninety-two Billion (₦892 Billion), with HSS shared cost accounting for the 13% of the cost.

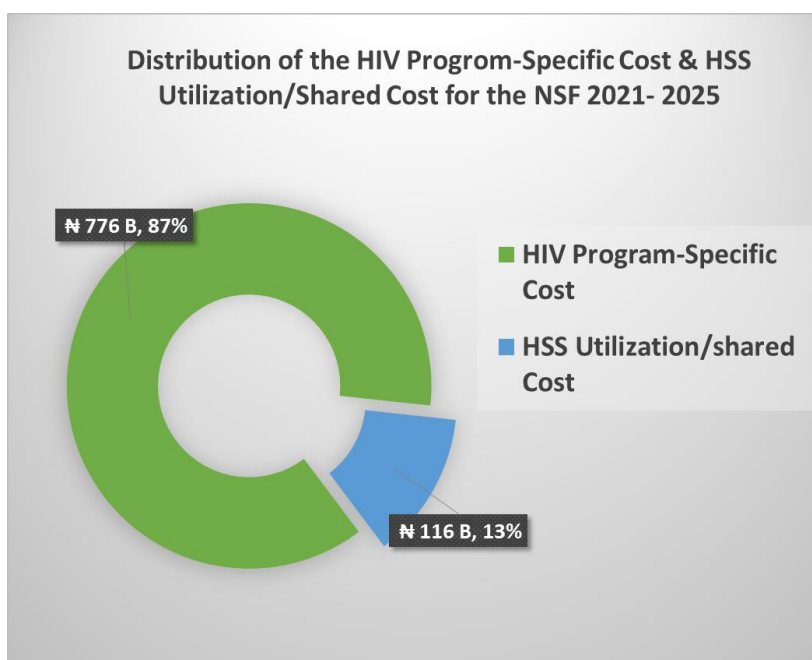


Figure 39: Distribution of the HIV Programme-Specific Costs and HSS Utilisation Costs for the NSF 2021-2025

From the estimates provided above, the Cost of the HIV NSF 2021 to 2025 is ₦892 Billion, covering both the HIV Program-specific and HSS shared cost. The combined mean per capita cost (HIV and HSS shared cost) was calculated at ₦752 (\$2.5). Investments in condom services accounted for 45% of HIV Prevention cost estimates, followed by intervention targets key population with 27% as the

next significant cost drivers. These prevention investments underscore the government's policy commitment to reverse the epidemic trend by targeting the critical mode of transmission and drivers of the epidemic as backed by evidence.

On treatment, the provisions of ART for Adults accounted for 50% of the treatment cost as the highest cost driver. The cost of diagnostics/lab costs for HIV+ in care is estimated at 42% of the cost as the second largest cost driver. These allocations are tailored towards ensuring the government's commitment to 90-90-90 targets is realized.

With the financial framework of the NSF 2021 - 2025 defined, it is critical for the national HIVAIDS program to carry the process forward. The logical next step would be to develop costed Federal Level and sub-national Strategic plans that would guide resource mobilization and implementation at these levels.

12.0 CONCLUSION

This National Strategic Framework provides a new direction for the HIV and AIDS response in Nigeria. After many years of collective efforts, a much better understanding of the epidemic is at hand together with the tools to target efforts with greater precision. Over the coming 5 years, achieving the 90-90-90 and subsequently 95-95-95 Fast-Track targets will put the country firmly on the path to ending AIDS as a public health threat by 2030.

Working together, as Federal and State Governments, partners and communities, the Nigeria HIV and AIDS response can achieve it's goal and bring the benefits of it's success to all people in Nigeria. Furthermore, utilizing this strategic framework will undoubtedly contribute to achieving the vision of an AIDS-free Nigeria, with zero new infections, zero discrimination and stigma and zero AIDS-related deaths.

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ANNEX I: RISKS AND ASSUMPTIONS

Increased donor fatigue and fund withdrawal. Deepened ownership of the national HIV response by the government of Nigeria will be essential to ensuring timely HIV services, funding sustainability, credibility of the National appraisal system and the affirmation of the legitimacy of HIV data and reports. Effectively implementing the resource mobilization plan to generate increased domestic funds from public non-profit and development focus foundation for sustainability is essential.

Increased new infections due to negative behaviour modification as a result of perceived low vulnerability. Promotion of behaviour change and prevention of new HIV infections, updating the mapping and size estimation of key and vulnerable population, revising and implementing the minimum prevention package intervention, developing targeted and appropriate HIV prevention communication plan and promoting work place programmes to support workers of organised sectors to access HIV prevention services are key.

Reduced political will to prosecute the fight against HIV. Strong political leadership of the National and State HIV/AIDS response, country's determined ownership of the HIV response and strong Civil Society Organisations role as government watchdog will help mitigate.

Loss of key technical expertise to other programme areas. An emerging issue (e.g., a global pandemic or geopolitical conflict) could significantly divert attention of technical expert from HIV programmes. This will require advocating for the continued need to invest in the HIV response, strengthening political commitment and accompanying resource allocations to the response. The epidemic may draw more attention towards end of HIV/AIDS by 2030.

Reduced access to HIV services. Map and increase community base care and support service sites to improve the coverage of targeted social and behaviour change communication for people living with HIV, build the capacity of people living with HIV and networks for service delivery and provide resources to people living with HIV support groups and networks for home based care. This should be integrated into HIV health services into routine health services.

Integration of HIV health services into routine health services. Government to come up with legislation to integrate HIV health services into routine health services that will ensure availability of HIV services, accessibility of HIV services, and affordability of HIV services and removal of all bottlenecks around accessing HIV services.

Opportunities

- NTTP
- HIV Trust Fund
- New CSO Coalition and plans for targeted CSO mobilization projects
- Patient education and empowerment agenda
- National Data Repository and streamlining of national programme data reporting systems and processes
- Improved and streamlined coordination arrangements
- Renewed commitment to improve programme efficiency by adopting less expensive funding and programme support arrangements.
- New Patient's Rights Act

ANNEX II: COSTING ASSUMPTIONS

HIV Prevention Services	2021	2022	2023	2024	2025
PWID: Outreach	12	16	19	22	25
PWID: Needle and Syringe Programme	12	16	19	22	25
PWID: Drug Substitution	0.0	0.1	0.3	0.4	0.5
Interventions focused on female sex workers	19	24	28	33	38
Interventions focused on men who have sex with men	14	16	18	21	25
Youth focused interventions - Out-of-school & AGYW	5	18	18	22	21
HIV Testing Services	100	100	100	100	100
Condoms	57	64	70	75	80
PMTCT	100	100	100	100	100
Management of STI for Key-Pop	34	35	36	37	38

Intervention coverages - HIV NSF (2020-2025) in Percentage (%)

Care and treatment Services	2021	2022	2023	2024	2025
ART for men	70	80	90	93	95
ART for women	86	88	90	93	95
Proportion of adults on ART using Second-Line ART	5	5	5	5	5
Cotrimoxazole for children	100	100	100	100	100
Pediatric ART	100	100	100	100	100
Diagnostics/lab costs for HIV+ in care	80	85	90	93	95
Mgt of OI assoc. with HIV/AIDS (including TPT provision)	80	85	90	93	95
Screen HIV+ cases for TB	100	100	100	100	100
HIV prevention for TB patients	100	100	100	100	100

Total number of services by service package, HIV/AIDS

HIV NSF						
Services	2021	2022	2023	2024	2025	Total
Prevention - Other						
PWID: Outreach	42,438	54,876	67,983	81,781	96,289	343,367
PWID: Needle and Syringe Programme	42,438	54,876	67,983	81,781	96,289	343,367
PWID: Drug Substitution	138	354	910	1,405	1,926	4,733
Interventions focused on female sex workers	186,392	237,624	291,582	348,350	408,008	1,471,956
Interventions focused on men who have sex with men	46,854	56,170	67,324	80,680	96,667	347,695
Youth Out-of-school & AGYW	226,932	907,884	907,962	1,134,955	1,134,871	4,312,603
HIV Testing Services incl. Self-Testing	8,228,290	14,535,533	13,408,638	12,186,553	9,357,040	57,716,053
Condoms	15,112,268	17,355,917	19,522,458	21,635,743	23,712,961	97,339,346
PMTCT	94,242	94,137	98,693	97,335	95,610	480,017
Management of STI for Key-Pop	590,039	622,881	657,405	693,708	731,869	3,295,902
Care and treatment						
ART (First-Line Treatment) for men	450,149	521,188	592,538	616,868	640,969	2,821,713

Total number of services by service package, HIV/AIDS

HIV NSF						
Services	2021	2022	2023	2024	2025	Total
ART (First-Line Treatment) for women	809,574	847,807	883,979	921,932	959,081	4,422,373
ART (Second-Line Treatment) for adults	66,301	72,052	77,711	80,989	84,213	381,268
Cotrimoxazole for children	165,788	160,353	153,968	147,160	139,247	766,516
Pediatric ART	169,079	161,142	154,789	148,030	140,082	773,124
Diagnostics/lab costs for HIV+ in care	1,026,465	1,190,516	1,367,795	1,466,991	1,569,276	6,621,044
Mgt of OI assoc. with HIV/AIDS (including TPT provision)	238,069	252,227	259,009	266,352	264,128	1,279,785
Screen HIV+ cases for TB	1,834,155	1,860,774	1,880,890	1,898,284	1,912,156	9,386,258
HIV prevention for TB patients	99,690	99,690	99,690	99,690	99,690	498,450
Total	29,429,301	39,086,000	40,561,309	41,988,586	41,540,373	192,605,569

Average Annual Cost per Case

Prevention Services Package	Average Cost in NGN	Average Cost in US\$	% of Prevention Service Cost
PWID: Outreach	₦ 8,699.1	\$ 28.43	0.4%
PWID: Needle and Syringe Programme	₦ 6,928.4	\$ 22.64	0.3%
PWID: Drug Substitution	₦ 2,012,710.5	\$ 6,577.49	94.5%

Interventions focused on female sex workers	₦ 26,167.5	\$ 85.51	1.2%
Interventions focused on men who have sex with men	₦ 8,352.2	\$ 27.29	0.4%
Youth focused interventions - Out-of-school & AGYW	₦ 61.1	\$ 0.20	0.0%
HIV Testing Services in Self-Testing	₦ 347.3	\$ 1.14	0.0%
Condoms	₦ 963.2	\$ 3.15	0.0%
PMTCT	₦ 63,313.2	\$ 206.91	3.0%
Management of STI for Key-Pop	₦ 2,043.3	\$ 6.68	0.1%

Average Annual Service Cost per Case

Care and treatment Services	Average Cost in NGN	Average Cost in US\$	% of Tx & Care Service Cost
ART for men	₦ 25,808.6	\$ 84.34	12.5%
ART for women	₦ 25,808.6	\$ 84.34	12.5%
Proportion of adults on ART using Second-Line ART	₦ 79,743.1	\$ 260.60	38.5%
Cotrimoxazole for children	₦ 3,550.4	\$ 11.60	1.7%
Pediatric ART	₦ 47,043.9	\$ 153.74	22.7%
Diagnostics/lab costs for HIV+ in care	₦ 16,287.0	\$ 53.23	7.9%
Mgt of OI assoc. with HIV/AIDS (including TPT provision)	₦ 4,809.9	\$ 15.72	2.3%
Screen HIV+ cases for TB	₦ 3,669.5	\$ 11.99	1.8%
HIV prevention for TB patients	₦ 183.5	\$ 0.60	0.1%

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