NATIONAL POLICY ON HIV & AIDS 2020

FOREWORD

In this decade of ending the HIV epidemic in Nigeria, we must reflect on the successes achieved in tackling the scourge and the challenges that lie ahead. Our success will be measured by the number of new infections averted and lives saved which ultimately will culminate in HIV epidemic control for Nigeria. There has been more political commitment from government, strengthened efforts of all stakeholders, more coordinated and stronger partnerships locally and internationally resulting in a multi-sectoral response. The response is breaking the barriers of stigma and discrimination and giving PLHIV their rightful position.

The first National HIV and AIDS Policy developed in 1997 by the Federal Ministry of Health was designed to limit the spread of HIV and AIDS in the country. This was in an era of scarce information and knowledge. By 2001, the country enacted a new National Policy on HIV and AIDS and adopted the multi-sectoral approach to her response in order to ensure the full involvement of all sectors of the economy relevant to the management of the HIV epidemic (in planning, implementation and evaluation of the national HIV response). In addition, all sectors were encouraged to develop plans and operational frameworks to mitigate the impact of the epidemic.

The development of this new policy is necessitated by the emergence of new information on the HIV and AIDS epidemic locally and around the world. Within Nigeria, new evidence has emerged from surveys such as the Nigeria AIDS Indicator and Impact Survey (NAIIS), routine surveys like the IBBSS, ANC and NARHS, as well as smaller studies like the prison study, the National Drug Use Survey etc. Global best practices have also made new recommendations on guidelines for prevention, treatment and care services such as the Test and Treat strategy, new drug regimens, self-testing kits etc. New populations disproportionately identified by the epidemic due to biological or socioeconomic factors have also been identified, making it imperative to develop strategies and guidelines that will address the peculiar needs of these groups.

This current policy on HIV and AIDS is a product of extensive and inclusive participation of all stakeholders. It provides direction for advancing the national multi-sectoral response to the HIV and AIDS epidemic in Nigeria. The shared goal of ending AIDS as a public health threat by 2030 is envisioned for achievement through seven (7) policy strategic thrusts and will be measured by three (3) indices: 90% reduction of HIV incidence by 2030, 20% increase in

domestic funding annually for the entire response and 90% reduction of AIDS related mortality by 2030.

The implementation of this policy will ensure effective coordination of the multi-sectoral response at all levels. It will also enhance synergy and collaboration with national and international partners. Sustaining a unified data management system to inform program planning and decision making at all levels will promote evidence-based policy making.

Looking forward, the utilization of this policy and the advent of an annual increase of domestic funding for a sustainable national response will enhance access, equity, shared accountability, increased political will and leadership.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
CHAI	Clinton Health Access Initiative
CPT	Cotrimoxazole Preventive Therapy
CSOs	Civil Society Organizations
DOTS	Directly Observed Treatment Short Course
EID	Early Infant Diagnosis
FBOs	Faith-Based Organizations
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
FSWs	Female Sex Workers
GIPA	Greater involvement of People with AIDS
HAPSAT	HIV and AIDS Program Sustainability Analysis Tool
HCT	HIV Counseling and Testing
HTS	HIV Testing Services
HEAP	HIV and AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
ICT	Information Communication Technology
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IPT	Isoniazid Preventive Therapy
LACAs	Local Government Action Committee on AIDs
M&E	Monitoring and Evaluation
MAP	Multi-Country AIDS Program
MARPs	Most-at-Risk Populations
MDAs	Ministries, Departments and Agencies
MIPA	Meaningful Involvement of People with AIDS
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission of HIV
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NAIIS	Nigeria HIV and AIDS Indicator and Impact Survey

NARHS	National HIV and AIDS and Reproductive Health Survey
NASCP	National AIDS and STI Control Program
NCDs	Non-Communicable Diseases
NDHS	Nigeria Demographic and Health Survey
NEACA	National Expert Advisory Committee on AIDS
NGOs	Non-Governmental Organizations
NNRIMS	Nigeria National Response Information Management System
NSF	National Strategic Framework
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PABA	People Affected by HIV and AIDS
PHC	Primary Health Care
PHDP	Positive Health, Dignity and Prevention
PITC	Provider-Initiated Testing and Counselling
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
SACAs	State Agency for the Control of AIDS
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive and Health Rights
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TasP	Treatment as Prevention
UNAIDS	Joint United Nations Program on HIV and AIDS
UNGASS	United Nations General Assembly Special Session

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1.0 BACKGROUND

1.1 INTRODUCTION

In 1986, the first case of Acquired Immune Deficiency Syndrome (AIDS) was reported in Nigeria awakening Nigerians to the reality of the evolving global pandemic (Awoyemi, 2018). Between 1986 and now, the Human Immunodeficiency Virus (HIV) has spread throughout the length and breadth of the country affecting children, adults, males and females. Classified as a generalized epidemic with 1,900,000 people living with HIV (PLHIV) (NAIIS fact sheet, 2019), it spared no part of the country, ethnic/religious group, or sub-sector. The combined effects of the disease and its impact took its toll on the country's growth and development, more so on households' and communities' socio-economic, cultural, health and general wellbeing. This has been compounded by the novel Corona Virus, COVID19.

Over the last three decades, the country deployed resources and various interventions as part of a coordinated national response to reduce and mitigate the challenges posed by the epidemic. According to NAIIS fact sheet (2019), 130,000 people were newly infected rising from a previous figure of 120,000 in 2010, and 53,000 people died from AIDS-related illnesses dropping by 26% from the last figure of 72,000 deaths. As at the end of 2018, the envisioned 90-90-90 targets by 2020 promoted by UNAIDS and the global community, implied that 81% of all persons living with HIV would have been on treatment, and about 73% of all HIV positive persons would be virally suppressed. The reality is that as at the end of 2018, only 67% of all the people living with HIV knew their status, with 53% of people living with HIV being on treatment and 42% of these being virally suppressed (unaids.org 2019).

Nigeria currently ranks as the country with the 4th highest burden (1,900,000) of HIV infection in the world next to India (2,100,000), Mozambique (2,200,000) and South Africa (7,700,000).Results from NACA (2019), reveal that the key drivers of the HIV epidemic in Nigeria include low personal risk perception, multiple concurrent sexual partnerships,

transactional and inter-generational sex, ineffective and inefficient services for sexually transmitted infections (STIs), and inadequate access to and poor quality of healthcare services as well as concomitant chronic health conditions and acute conditions such as COVID 19. Entrenched gender inequalities and inequities, chronic and debilitating poverty, and persistence of HIV/AIDS-related stigma and discrimination also significantly contribute to the spread of the infection.

Given these realities, there is an urgent need to review the existing national policy to accommodate emerging issues and provide a more comprehensive platform for strategic responses to this and other infections. This would yield the desired outcome that is efficient and effective in the control of this mixed epidemic. This instrument would provide the fulcrum and pathway for the commitments, involvement and participation of all stakeholders within the lifespan of the policy to combat this epidemic within the country.

1.2 EPIDEMIOLOGY

Over the last 28 years, Nigeria has witnessed an increase and subsequent decline in its HIV prevalence. According to Nigeria's Global AIDS Response Country Program Report (GARPR, 2015), between the periods of 1991 and 1999 the HIV burden rose steadily from 1.8% to 5.4% peaking at 5.8% in 2001, before declining to 3.2% in 2013. Rebased epidemic from NAIIS (2019), shows that the prevalence rate is now 1.3%. NACA estimates that 1.9 million people in Nigeria are currently living with the virus; out of which 27% are children. The burden of disease among the group of young people is put at 26,000 new infections (UNAIDS, 2020); Prevalence of HIV among adults aged 15-64 years is now 1.3%, considerably lower than earlier anticipated estimates. Among these, the prevalence in females is 1.7%, while prevalence in males is currently 1.0%. In Children aged 0-14 years, the prevalence is 0.1%.

Generally speaking, the groups most at risk are the key populations (KPs): sex workers and their clients, people who inject drugs (PWID) and other drug users, and men who have sex with men (MSM).Vulnerable groups

which include the young people, physically challenged, prisoners and people in different custodial settings and mobile populations (long-distance drivers, etc.) and uniformed services personnel as well as those with significant comorbidities such as COVID-19 are also at risk. Due to extended security challenges within the country, many stakeholders now also consider those within Internally Displaced Persons (IDPs) camps to be among the vulnerable. The mode of transmission indicates that 42 % of infection is contributed by persons perceived as practicing "low-risk sex" in the general population; this includes sexual partners that are married. KPs and their partners that form 3.4% of the adult population contribute about 40% of the annual new HIV infections (NACA, 2019).

In Nigeria, heterosexual relationships account for over 80 % of the mode through which HIV is transmitted, while Mother-to-child transmission and transfusion of infected blood and blood products rank as the next most common routes of the infection. Other routes of transmission worthy of note include PWIDs and MSMs. It is necessary to recognize and factor them into planning and program development.

Across age groups, HIV and AIDS is disaggregated as follows:

AGE	Contribution
0-14	12%
15-49	75%
50+	13%

NAIIS data shows a 1.5% prevalence among young adults (15 – 29 years). According to the National HIV Strategy for Adolescents and young people 2016 -2020 (2016), Mother to Child Transmission "may account for a fairly high proportion of the infections among adolescents age 10-19 years" in Nigeria.

Geographically, there is significant diversity in how the epidemic is currently distributed. Six states of the country present prevalence of 2.0% and above (Akwa-Ibom, Benue, Rivers, Taraba, Anambra, and Abia); thirteen states including the Federal capital have medium prevalence between 1.0% - 1.9% while the remaining seventeen states have a low prevalence of below 1.0%, (NACA (2019).

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1.3 NATIONAL RESPONSE

The national response commenced with the establishment of the National Expert Advisory Committee on AIDS (NEACA). In 1998, the National AIDS and STI Control Program (NASCP) in the Federal Ministry of Health was established as the health sector led response. In 2000, the National Action Committee on HIV and AIDS was established as a multi-sectoral response under the Presidency. The National Action Committee later transformed into a full agency; The National Agency for the Control of AIDS (NACA) in 2007 by an Act of the National Assembly to further strengthen its coordinating role and the overall national response. The State Agency for the Control of AIDS (SACA) and the Local Government Action Committee on AIDS (LACA) are the equivalent coordinating bodies at the sub-national levels under the offices of the Governors and Local Government Chairmen respectively. Similar to the transformation of NACA, all SACAs converted from Committees to self- accounting government agencies.

As part of the effort to strengthen the national response, national policies on HIV and AIDS were developed in 1997, 2003 and 2009 respectively. The HIV and AIDS Emergency Action Plan (HEAP) was

developed to guide the national response between 2001 and 2003 periods. HEAP was replaced by the National Strategic Framework (NSF) in 2005 and its subsequent revision of 2009. The Nigeria National Response Information Management System (NNRIMS) for HIV and AIDS has also been developed under the multi-sectoral response. These developments enabled the country's national response to operate under the framework of the "Three Ones" principle: one coordinating agency (NACA), one strategic plan (NSP), and one monitoring and evaluation framework (NNRIMS).

Nigeria has recorded breakthroughs in the course of the national response on HIV and AIDS since 1999. One of these breakthroughs was the adoption of a test and treat policy in 2016 which accelerated referrals to treatment facilities particularly for those who test positive to the virus. From 2010–2017 the number of persons who tested positive to the virus that accessed the antiretroviral therapy increased from 360,000 to over a million (NAIIS, 2019). The NAIIS (2019) further indicates that a higher proportion of the population took the test, but that less than 20% of pregnant women received HIV counseling and testing in the context of prevention of mother-to-child transmission of HIV (PMTCT).

Though a considerable number of persons have already accessed HIV Testing Services (HTS), continuation is needful to improve on the gains made in view of the envisioned 90-90-90 target. This target expects that by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral treatment will have viral suppression. In view of this, Provider Initiated Testing and Counseling (PITC) and retention in care are imperative. There is improving access to antiretroviral therapy (ART); and the number of orphans and vulnerable children (OVC) is rising: fueled additionally by the communal crisis, insurgency, and other societal factors (Tagurum et al., 2015).

Several population-based surveys, including Nigeria Demographic and Health Survey (NDHS 2003, 2008, 2018), National AIDS and Global AIDS response country progress report (GARPR, 2015), and HIV and AIDS Behavioral Surveillance Survey (IBBSS, 2007, 2010, and 2014), have reported

a gap between awareness, and comprehensive knowledge of HIV prevention on the one hand, and between knowledge and behaviour on the other hand.

The report of the 2018 Nigeria Demographic and Health Survey (NDHS, 2018), for example, indicated that while awareness of HIV was almost universal (94% of women and 95% of men have heard of HIV), 73% of women and 78% of men aged 15-49 know that consistent use of condoms is a means of preventing the spread of HIV. 88% of women and 86% of men know that limiting sexual intercourse to one faithful, uninfected partner can reduce the chance of contracting HIV. Finally, 71% of women and 74% of men know that both using condoms and limiting sexual intercourse to one uninfected partner are means of preventing HIV. Women and men in urban areas are more likely to be knowledgeable about HIV prevention methods than their counterparts in rural areas. In general, better-educated respondents and those in the highest wealth quintile are considerably more knowledgeable of HIV prevention methods than other respondents.

Limiting the number of sexual partners and practicing protected sex is crucial in the fight against the spread of sexually transmitted infections, including HIV. 27% of never-married women and divorced, separated, or widowed women had sexual intercourse with a person who was neither their husband nor lived with them. Among women who had multiple sexual partners in the 12 months preceding the survey, 33% used a condom during their last sexual intercourse. Similarly, 36% of women who had sexual intercourse with a person who was neither their husband nor lived with them used a condom during their last sexual intercourse. Women in Nigeria have had an average of 2.1 sexual partners in their lifetime. Among men who had two or more sexual partners in the 12 months prior to the survey, 23% reported using a condom during their last sexual intercourse. 65% of men who had sexual intercourse with a person who was neither their wife nor lived with them used a condom during their last sexual intercourse. Men in Nigeria have had an average of 4.4 sexual partners in their lifetime.

It is important to note that a lot of achievements have been recorded to reverse the trends and magnitude of the epidemic in the country. These

include the establishment of the multi-sector structures and systems that provide the enabling environment for programs implementation and coordination; the institution of several intervention programs including an increasingly robust treatment program; and the mobilization of significant financial and other resources for the national response. However, the diversity of players in the national response to the epidemic, and their range of activities, have also generated coordination challenges between hierarchies of institutions and among program categories.

1.4 IMPACT OF THE HIV AND AIDS EPIDEMIC

While precise data is lacking in terms of quantification of impact in many areas of national life, there is absolutely no doubt that the HIV and AIDS epidemic has impacted several areas of the Nigerian society (Awoyemi and Olusegun, 2018). The most obvious impact is in the area of morbidity and mortality. Over the last decade, there has been a 26% decrease in HIV and AIDS related deaths; from 72,000 deaths to 53,000. Conversely, the number of new HIV infections has increased from 120,000 to 130,000 within the same time period. There is need for a more purposeful commitment from all stakeholders to a more aggressive response so as to achieve the elimination target of 95-95-95 by 2030 (UNAIDS, 2018).

The life expectancy in the country had increased from 45 years in 1963 to 51 years in 1991 and by 2005 it had decreased to 46.5 years. However, according to the WHO, (2016) report, the life expectancy of Nigerian male increased to 55 years and female 56 years, showing an improvement over the last decade. The national HIV and AIDS response could be a significant contributor to this increase in life expectancy of Nigerians. Unfortunately, given the current coexisting pandemic of COVID 19, this life expectancy could well fall.

USAID, (2016) reports that there were an estimated 17. 5 million Orphans and Vulnerable Children in the country as of 2008 who were faced with health and development challenges. The report also stated that about 95% of the OVC do not have access to medical, social, emotional, material, or school-related assistance. Childhood morbidity and mortality is a consequence of childhood malnutrition. The report making further

reference to a cross-sectional study in 2015, states that over a quarter of OVC studied showed symptoms of mild to moderate malnutrition. Tagurum et al., (2015), reports that about 70% of OVC experienced household food insecurity which put them at risk of malnutrition. It also reports that one in every 10 household is estimated to be providing care for an Orphan.

The country has made admirable progress with the support of the US government through PEPFAR, the Global Fund for HIV/TB and Malaria, multilateral and several bilateral partners, including contributions from local and international foundations and the corporate private sector. The continued decline in the HIV prevalence that peaked at 5.8% but now is at 1.3% indicates clearly that the country is on the right path towards eliminating HIV as a public health concern in the country. The robust treatment program and the "treat all" campaigns and interventions show promise in breaking the transmission cycle and enabling the country to achieve globally agreed elimination targets by 2030. Reaching this final mile of elimination is going to be very challenging as greater resources will need to be invested to achieve these targets.

1.4 THE RATIONALE FOR THE POLICY

The rationale of the National Policy on HIV and AIDS (2020) is to eliminate HIV and AIDS in Nigeria as a significant public health threat and mitigate its social and economic impact. The policy focuses on seven strategic components. The National strategic framework and the National Strategic Plan will provide a broad structure for multi-sectoral implementation of the policy.

However, new and emerging issues including novel infections causing poorer health, will require altered strategic responses if the country must make the desired progress towards the elimination of HIV and AIDS and its impact keying into the UNAIDS led vision 95-95-95 by 2030. Underscoring the fact that as at 2020 the country did not meet the 90-90-90 targets, this means that the country needs to be more strategic and targeted in the allocation and utilization of increasing scarce resources, promote greater integration in service delivery, and leverage maximally on use of technology for achieving greater efficiencies and value for money.

2.0 POLICY FRAMEWORK

2.1 POLICY CONTEXT

This revised policy has been developed within the context and in agreement with selected key national and international frameworks that are relevant to the national response to HIV and AIDS in Nigeria:

- The 1999 Constitution of the Federal Republic of Nigeria, which affirms the national philosophy of social justice and guarantees the fundamental right of every citizen to life and to freedom from discrimination. The constitution recognizes a three-tier level of governance.
- NACA Act/respective SACA Legislative Laws, National Gender Policy, Revised National HIV and AIDS Strategic Framework 2019 – 2021, Economic Recovery and Growth Plan 2017-2020.
- This policy also responds to government ratification of and commitment to numerous international conventions including Universal Declaration of Human Rights (1948), the Convention on Economic, Social and Cultural Rights (1976), the Convention on the Elimination of All Forms of Discrimination against Women (1979), Convention on the Rights of the Child (1989), and the African Charter on Human and People's Rights (July, 2003).
- The Security Council of UN resolution 1820 (2008), addressing sexual violence in conflict situations and other subsequent follow-up resolutions, 1888 (2009), 1889 (2009), 1960 (2010), that focused on preventing and responding to conflict-related sexual violence, and which established the United Nations architecture towards the achievement of the aforementioned.
- The agreed goals of the international community to fight the epidemic and mitigate its impact which Nigeria ratified. These include: Program of Action of the International Conference on

Population and Development ICPD (1994), Political Declaration at the World Summit for Social Development (1995),The Political Declaration and further action and initiatives to implement the Beijing Declaration and Platform for Action (2000).Others are the Greater Involvement of People with AIDS (GIPA) and Meaningful Involvement of People with AIDS (MIPA) Principles, The Abuja Declaration and Framework for Action for the Fight Against HIV and AIDS, Tuberculosis and other related diseases in Africa (April, 2001) and The United Nations General Assembly Special Session on HIV and AIDS (UNGASS) (June, 2001) at which countries committed to ensuring an urgent, coordinated and sustained response to HIV and AIDS.

- The policy's goal and focus is also derived from Nigeria's commitment to Universal Access to comprehensive HIV prevention, treatment, care and support as enunciated in the following: the 2005 Gleneagles G8 Universal Access Targets, the 2006 United Nations Political Declaration on HIV and AIDS, the African Union's Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS(2006), and the 2006 Brazzaville Commitment on scaling up towards Universal Access to HIV and AIDS prevention, treatment, care and support services in Africa by 2010.
- The SDG 3, 4, 5, and 10. [SDG 3 (Ensure healthy lives and promote wellbeing for all at all ages), Target 3.3 (end AIDS as a public health threat by 2030), Target 3.8 (end AIDS as a public health threat by 2030), SDG 4 (Quality Education: including targets on comprehensive sexual and reproductive health (SRH) education and life skills), SDG 5 (Gender Equality: including targets on sexual and reproductive health and rights (SRHR) and the elimination of violence, harmful gender norms and practices), SDG 10 (Reduced gender inequality: including targets on protection against discrimination, and the empowerment of people to claim their rights and enhance access to HIV services), SDG 10 (Peace, Justice

and strong institutions: including reduced violence against key populations and people living with HIV), UNAIDS Fast-Track strategy, (2014) to meet the SDG 3 target to end AIDS by 2030].

2.2 POLICY CONSIDERATIONS AND GUIDING PRINCIPLES

The following are some of the key considerations and guiding principles which inform the articulation of this Policy:

- HIV and AIDS epidemic in Nigeria threatens the well-being of many Nigerians, burdens families, impoverishes communities, and weakens institutions and threatens the social and economic development of the country.
- As a public health issue, HIV and AIDS directly affects the health and economy of millions of infected and affected persons, contributes to maternal and under-five mortality rates, and places additional stress on the already overburdened healthcare system.
- Combination of different prevention approaches including Family Life and HIV and AIDS Education (FLHE), providing treatment for all persons, and integrating this with care, support, and impact mitigation are mutually reinforcing elements of a comprehensive response to HIV and AIDS.
- Significant sections of the population are most at risk of infection due to social, cultural and economic conditions that create and sustain vulnerability to HIV infection. The most vulnerable are women and girls, young people, persons with disability, mobile populations, and those incarcerated or forced to live in closed settings.
- HIV and AIDS-related stigma has seen significant improvements but persists despite the enactment of relevant laws.
- Culture, traditions and religion have a strong influence on behaviour, attitudes and practices of the majority of Nigerians, and traditional and faith-based institutions act as gate keepers of attitudes and behavior, and as joint facilitators of social

transformation remain critical assets in the fight against the disease.

- Effective response to HIV and AIDS requires respect for, protection of, and fulfillment of all human rights, civil, political, economic, social, and cultural tenets, upholding the fundamental freedoms of all people following the country's constitution and existing international human rights principles, norms and standards.

2.3 GOAL

The overall goal of the National Policy on HIV and AIDS is to provide direction for advancing the national multi-sectoral response to the HIV and AIDS epidemic in Nigeria.

The above can be achieved through elimination of new infections, ensuring equitable and sustainable care and support for those infected and affected, and mitigating the impact of the infection, thereby enabling all people in Nigeria to achieve socially and economically productive lives free of HIV and its effects.

2.4 TARGET

The target of this policy is to eliminate new infections and sustain the reversal of the impact of HIV; provide quality treatment for people living with HIV; and offer care and support to people infected and affected by HIV and AIDS by 2030.

To this end the country will focus on the following three indices as measures for assessing the progress of this policy and the national response:

1. Reduction of HIV incidence by 90% by 2030
2. Funding for the entire national/sub-national response from domestic sources should increase annually by 20%.
3. To reduce by 90% AIDS related mortality by 2030

2.5 STRATEGIC THRUSTS

The strategic thrusts of the policy are as follows:

- **Elimination of new infections of HIV:** focuses on elimination of new infections through the adoption and use of safer preventive technologies and health-promoting services, including sexual and reproductive services, and empowering individuals and communities to drive an inclusive and participatory social process. This will address the elimination of mother to child transmission, pre-and post-exposure prophylaxis and using treatment as prevention.
- **Treatment of HIV and AIDS and related health conditions:** addresses issues of immediate and comprehensive access to effective antiretroviral drugs, tuberculosis/HIV collaborative activities and prevention and management of opportunistic infections for all persons diagnosed as HIV positive.
- **Care and support for infected and affected persons:** relates to provision of holistic care and support to various groups of infected people as well as the affected, including children orphaned by AIDS and other vulnerable children; it also involves empowering communities to provide support structures for PLHIV.
- **Resourcing the national response:** the focus is on the design and strengthening of the structure of the coordinating mechanism of the multi- sectoral response within the framework of Nigeria's federal system and the issue of sustainability through adequate resource mobilization and allocation of human resources, finance and infrastructure; HIV and AIDS will be mainstreamed in the work of key public sector ministries, departments and agencies.
- **Critical enablers for full engagement:** focuses on addressing legal issues, legal rights and advancing the rights of people living with HIV and those affected by the infection; it will also address issues of gender, policy advocacy, health and community systems strengthening.

- **Coordination and harmonization of the response:** This focuses on the "three-ones" principle of one national response, one coordinating body, and one reporting system. Mandates of central agencies will be strengthened and technology leveraged to promote greater efficiency and reporting fidelity. The integration of service delivery will also be promoted in all instances possible. Data ownership and governance will also be addressed here.
- **Research, knowledge management:** focus on generation and dissemination of knowledge to provide required support for evidence-based policy-making and programming.

3.0 ELIMINATION OF NEW INFECTIONS OF HIV AND PREVENTION OF OTHER EMERGING HEALTH AND DEVELOPMENT CRISIS

3.1 RATIONALE

While the country has made considerable progress in response to HIV and AIDS impact, indicators show that deliberate effort to consolidate gains must be made to reverse the trend and forestall incidences of new infections that threaten to change success stories. To achieve the elimination of the incidences of the new HIV infections, a combination prevention programming is required.

Combination prevention programs are those that need "strong community empowerment element and specific efforts to address legal and policy barriers, as well as the strengthening of health and social protection systems, plus actions to address gender inequality, stigma and discrimination". (UNAIDS, 2015). Combination prevention programme calls for complementary interventional strategies that incorporate behavioral, biomedical and structural intervention strategy. The intervention program should take into consideration related issues like infrastructure, cultural setting, traditions and the most affected populations by HIV. This should be implemented at individual, community and population levels within the country with the aim of making substantial and sustainable impact on the elimination of new HIV infection.

COVID-19 is a novel virus in the family of corona viruses with a similar multi-sectoral public health response to HIV and AIDS. The pandemic was first reported in Wuhan province of China in December 2019 and has since spread to every part of the world leaving a huge death toll in its wake. Persons with underlying health conditions are particularly more at risk. Persons living with HIV who are yet to know their status are at greater risk of morbidity and mortality from COVID-19. Integrating primary prevention strategies of COVID-19 into the HIV and AIDS response is an investment opportunity that the government should explore. Furthermore, prevention strategies and service integration of other comorbidities such as

Tuberculosis, Hepatitis and Human Papilloma Virus (HPV) should be given due consideration in developing holistic prevention program for PLHIVs.

3.2 THEMATIC GOAL

To eliminate new HIV infections by 2030 and prevent other emerging health and development crisis.

3.3 FOCUS AREAS

Behavioural, Biomedical and Structural interventions including:

- Sexual and reproductive health (condom programming, HTS, awareness campaigns, STI management, cervical cancer management).
- EMTCT/Early infant diagnosis.
  PrEP/PEP.
- Blood transfusion safety.
- Mental health.
- Harm reduction
- COVID-19, TB, Hepatitis and HPV.

3.4 KEY OBJECTIVES

- Promote safer behavior that would eliminate new HIV infections through behavior change communication intervention programming, targeting PLHIV, KPs, Vulnerable and Marginalized groups, as well as the general population.
- Promote local production of consumables.
- Promote HIV combination prevention services that would eliminate new HIV infections through biomedical interventions targeting the KPs, Vulnerable and Marginalized groups, as well as the general population.
- All persons should have access to HIV prevention services by 2030.
- All KPs, AYPs and other vulnerable groups should have access to combination prevention interventions by 2030.
- Promote psychosocial support for the overall emotional, psychological and social well-being of PLHIV.
- Every person should have access to safe blood transfusion and needle/syringe programs.

All adolescents, young persons, KPs, infected and affected populations and other vulnerable groups, should have age-appropriate comprehensive knowledge of HIV, sexual reproductive health and rights and access to services.

Leverage HIV infrastructure and systems in responding to other public health challenges and emerging health and development crisis eg. COVID-19

3.5 POLICY STATEMENTS

The Government shall:

- Promote safer sexual behavior through behavior change communication-related intervention programming.
- Promote appropriate prevention services including biomedical interventions that eliminate the risk of new infections of HIV.
- Promote the local production of test kits, ARVs and condoms.
- Facilitate all modes of HIV testing ensuring accompanying counseling and linkage to treatment, care and support for all persons who present for testing as appropriate.
- Facilitate self-testing as an option to reach the last mile especially among key and vulnerable populations including AYPs.
- Promote the psychosocial support for the overall emotional, psychological and social well-being of PLHIV.
- Promote the mainstreaming of HIV treatment into the national health insurance scheme.
- Promote access to safe blood transfusion and needle/syringes programs.
- Promote good knowledge on HIV, sexual reproductive health and rights to all infected and affected persons, AYPs, KPs and other vulnerable populations.

- Sensitize and promote knowledge on HIV and other viral diseases including COVID-19 using community structures.
- Facilitate social mobilization for COVID-19 response and reduce its stigma through appropriate interventions.

4.0 TREATMENT OF HIV AND AIDS AND RELATED HEALTH CONDITIONS

4.1 RATIONALE

ART prevents HIV from replicating itself and infecting new immune system cells which consequently reduces the viral load in the individual's body. When people diagnosed with HIV are placed on ART immediately after diagnosis, they are likely to remain in good health. The rationale for the WHO's guideline for a "Test and Treat" policy was predicated on the effectiveness of Treatment as Prevention (TasP) whose strategy employs increasing testing and coverage of treatment; this principle deploys the initiation of all persons that test positive to HIV on ART irrespective of their CD4 count or viral load. The TasP strategy has been found to have the capacity to not only reduce new HIV infections but also decrease community viral load (i.e. the average viral load among a certain population). This philosophy formed the anchor for the UNAIDS' 95-95-95 to end AIDS by 2030: 95% of all people living with HIV know their HIV status, 95% of all people diagnosed are on ART and 95% of all people on ART are virally suppressed. This viral suppression also helps in prevention and indeed faster recovery from other viral infections such as COVID 19.

HIV prevention methods and programs that deploy ART as a means to prevent the risk of transmission of HIV is referred to as TasP. The viral load in semen, blood, vaginal fluid and rectal fluid can be suppressed by the sustained use of ART to an undetectable level, if consistently adhered. With this scenario, it becomes apparent that the transmission of HIV should not take place and the quality of patient health improves. TasP is a patient-specific strategy whose effectiveness is indisputable and is adopted as a public health intervention strategy. A major challenge is limited access by the key populations, marginalized and vulnerable groups to Pre-Exposure prophylaxis or Post-Exposure prophylaxis. For some of these groups, the legal climate (human rights), stigma/discrimination and fear of disclosure of status without consent are likely barriers to access.

Combination therapy (ART and PrEP) with other interventions for mixed-status heterosexual couples is highly recommended for further reduction in HIV transmission. Funding for the sustenance/scale-up of this intervention is low and impacts directly the availability (point of care), acceptability and accessibility (3 A's) programming (resource [finance, human & infrastructure] mobilization). Weak healthcare systems have also impacted access and the need to strengthen the healthcare system is very urgent. Facility stigma also constitutes a barrier to access to HIV/STI services.

For effective treatment intervention, it is imperative to link treatment to testing both at the facility and the community levels as well as linking testing to treatment services so that the gap between testing and access to ARV is bridged, with the implication that immediate treatment is offered as soon as the diagnosis is made. The success of this is predicated on task shifting and task sharing at the secondary and primary healthcare facilities, occasioned by the decentralization deployed by the tertiary facilities. Setting up of systems for individual viral load and drug-resistant testing is urgent to monitor the efficacy and effectiveness of the drug administration.

As part of intervention strategy and programming, the management of TB, and opportunistic infections (Hepatitis B & C), SRHR, Mental health and NCDs management are to be integrated

4.2 THEMATIC GOAL

To ensure that all persons living with HIV are identified and immediately placed on ART and have continuous access to treatment for STIs and opportunistic infections, including SRHR, mental health and NCDs services.

4.3 FOCUS AREAS:

- HIV testing services.
- Access to treatment and adherence
- Laboratory services, drugs and supplies
- Human resources

4.4 KEY OBJECTIVES

- Ensure 95% of people living with HIV know their HIV status; 95% of people who know their HIV status are receiving antiretroviral therapy; and 95% of people on treatment have a suppressed viral load by 2030.
- Ensure that treatment regimens are optimized for best outcomes.
- Ensure that all patients placed on treatment are also retained on treatment for life.
- Promote the availability, acceptability and accessibility of ART, and treatment for STIs, and opportunistic infections, including SRHR, Mental health and NCDs services.
- Promote the linkage to treatment from HIV testing services and monitoring of treatment outcomes during treatment both at the facility and community levels.
- Promote the integration of HIV services with other health care services

4.5 POLICY STATEMENTS

The Government shall:

- Provide enabling environment and adequate resources towards achieving treatment success for all by 2030.
- Ensure that the anti-retroviral regimens provided to patients must be the most effective with the least side effects.
- Promote the enabling environment for healthcare providers to ensure that patients are not lost to follow up once treatment commences, and that the patients continue to take their medication as prescribed.
- Promote the availability, acceptability and accessibility of ART, STIs, TB, and other opportunistic infections, SRHR, 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 (Hepatitis B & C), SRHR, Mental health, Maternal, newborn, child and adolescent health (MNCAH) and NCDs services into treatment intervention programming.

5.0 CARE AND SUPPORT FOR INFECTED AND AFFECTED PERSONS

5.1 RATIONALE

The emotions experienced when informed of positive status or the knowledge of living with HIV can be overwhelming. These emotions can range from anger to despair, denial, frustration, psychological trauma, therefore patients would require some form of care and support to improve their quality of lives, as well as to adhere to and access treatment and prevention interventions. The impact of HIV has social, economic, education, and structural implications besides health on the PLHIV and PABAs. There is also the increased burden of Vulnerable Children (VC) fueled additionally by the communal crisis, insurgency, and other societal factors.

All these challenges combined can further make the PLHIV and PABAs more vulnerable and impact negatively on the envisioned 95-95-95 by 2030 targets if concerted efforts are not deliberately directed at mobilizing resources (finance, human and materials) to provide Care and Support to these persons in addressing their social, economic, education, and structural needs.

5.2 THEMATIC GOAL

To contribute to the improvement in the quality of care and quality of life of the people living with HIV, their family members, and vulnerable communities.

5.3 FOCUS AREAS

- Vulnerable Children.
- Key Affected Populations.
- Family of PLHIVs.
- PLHIVs.
- Care-givers.
- Adolescents and young persons.

- The elderly.
- Persons with disability.
- Persons in closed settings/incarcerated populations.
- Community structures.

5.4 KEY OBJECTIVES

- All PLHIVs should have access to [affordable] quality ART services and are supported to remain in care.
- All children infected and affected by HIV should have access to comprehensive HIV services as well as social services.
- All persons infected and affected should have access to basic education and vocational skills.

5.5 POLICY STATEMENTS

The Government shall:

- Promote all activities and actions that would improve the quality of lives of the vulnerable communities (IDPs, Illegal migrants & incarcerated populations, persons with disability), PLHIV and PABAs.
- Promote access for PLHIVs to [affordable] quality ART services.
- Promote access to comprehensive HIV services as well as social services to all Children, AYPs, KPs infected and affected by HIV and other vulnerable populations.
- Promote access to basic education and vocational skills to all persons infected and affected.

6.0 CRITICAL ENABLERS FOR FULL ENGAGEMENT

6.1 RATIONALE

For policy and program interventions to be successful, removal of barriers to implementation and the establishment of an environment that fosters mutual trust, accountability and full and meaningful engagement is essential. Recognition of the power dynamics that makes women more vulnerable to HIV and its impacts, and the protection of the rights of persons who are infected from stigma and discrimination at home, in the community or workplace are the requirements for delivering effective interventions. It is also necessary that policy advocacy is carried out to duty bearers and budget holders on the importance of allocating adequate resources for setting up functional and efficient health and community systems, for the delivery of HIV and other services.

6.1.1 POLICY ADVOCACY

The increased gains of the national response are predicated on the commitment of stakeholders to own and sustain the response through resource mobilization and optimization. In order to achieve this, it is imperative to have a legal framework backed up by legislation that provides clear pathways for the effectiveness and efficiency of the HIV response in Nigeria. Thus, the importance of advocacy to policy makers for sustained change must always be fostered.

6.1.2 GENDER AND HUMAN RIGHTS

Mobilizing and engaging stakeholders to pull resources together to address barriers to HIV elimination is key, because it is the root cause of the HIV enablers. Evidence shows that women and girls bear the brunt of HIV infection; our cultural, traditional, social and even religious settings are enablers of the stratification. There are also indications of partner and gender-based violence, trans and intersex people which

also enables HIV infection. Often times however, these fall through the crack in HIV programming. This alongside poor concepts of gender, gender norms, and sexuality have fueled the HIV epidemic and should be deliberately addressed. The spectrum of the programming should include men and boys. It is important to fight for human rights if the fight against HIV must succeed. Evidence shows incidences of violence, discrimination, stigmatization, persecution, criminalization and harassment against PLHIV, and the key populations have led to the obstruction of access to essential healthcare services consequently increasing the risk of HIV transmission, not to mention facility stigma prevalent in healthcare centers that ought to be a haven of care. Therefore, the safe-guarding and protection of human rights must be ensured through program mainstreaming.

6.1.3 HEALTH SYSTEMS STRENGTHENING (HSS)

The core purpose of the national HIV response is to strengthen the healthcare systems through increased funding, infrastructure support, human resources and materials for effective and efficient service delivery, that would expand access through the scaling up of service centers. Delivery of HIV services must be carried out within well developed and integrated health systems and should leverage at all times on possible complementary health programs.

6.1.4 COMMUNITY SYSTEMS STRENGTHENING

It is imperative to ensure community involvement and participation as well as owning the response as a thrust of the national response, by the establishment of structures facilitated by the communities for interaction and engagement, service delivery, program coordination and monitoring, partnership and resource mobilization.

6.2 THEMATIC GOAL

To create an enabling gender/human rights responsive environment by stimulating domestic ownership, engaging relevant stakeholders and supporting continuous review and response to the progress of all critical enablers of the national response.

6.3 FOCUS AREAS

- Health systems.
- Gender and Human Rights.
- Policy advocacy.
- Community systems.

6.4 KEY OBJECTIVES

- To facilitate equitable access to HIV prevention treatment care and support.
- To promote national ownership, leadership and sustainability of the HIV response.
- To facilitate the effective performance of the health system to improve program efforts and outcomes.
- To improve program efforts and outcomes through community involvement and participation.
- Ensure that the rights of all persons are protected.

6.5 POLICY STATEMENT

The Government shall:

- Promote the engagement of all stakeholders (government, donors, civil society and the private sector) in addressing barriers to HIV elimination.
- Ensure that the human rights of all persons are protected irrespective of their disease, social, educational, or economic status.
- Promote the new Patient Bill of Rights and other legal protections for PLHIV and other vulnerable populations.
- Protect the rights of adolescents, young girls and women from inequities in access to services and ensure freedom from violence and harm resulting from dangerous social and traditional norms.
- Capacitate communities to improve their understanding of HIV and

AIDS and how to provide safe spaces, care and support for all persons in need.

- Ensure that the health system is able to meet the unique needs of all segments of society

7.0 COORDINATION AND HARMONIZATION OF THE NATIONAL RESPONSE

7.1 RATIONALE

NACA has over the years provided strong coordination of the national HIV and AIDS response. However, there is a need for the agency to strengthen its leadership and coordination roles for greater efficiency. Part of the challenges with coordination emanate from the very complex nature of the 3-tier governance system of the country where each tier is supposed to be autonomous according to the constitution. NACA is thus unable to enforce compliance when other tiers of government are failing to respond to collectively agreed actions. The second challenge arises from the fact that HIV/AIDS is largely seen as a health issue, thus shielding the impact of multi-sectoral participation in the National response. The final and most important challenge results from the fact that the bulk of the resources made available to address program challenges come from donors and external sources. These sources have different funding cycles, develop their own data and reporting systems, and often cannot be compelled to share details of their activities and financial commitments.

These challenges are enormous and compounded by dwindling resources and weakened health and governance systems. The national response has been largely donor-driven and is now faced with donor fatigue. Therefore, there is an urgent need to modify the institutional architecture and resource mobilization strategy for a more effective response, monitoring, coordination, collaboration and partnerships that would translate to a robust and sustainable programming. It is also necessary to map key stakeholders, identify and assign roles and responsibilities so as to have a robust resource base for the response with great emphasis on mobilizing in-country resources to support the National Response.

7.2 THEMATIC GOAL

To ensure all stakeholders are provided clear guidance and strategic direction to work with a shared vision, mutual responsibility &

accountability.

7.3 FOCUS AREAS

- One national framework.
- One coordination entity.
- Harmonization (Implementation/Reporting).
- Unified data monitoring and evaluation system.
- Decentralization
- Oversight and accountability

7.4 KEY OBJECTIVES

- To ensure joint reviews, planning & reporting.
- To ensure harmonization and transparency.
- To ensure national ownership.

7.5 POLICY STATEMENTS

The Government shall:

- Ensure effective coordination of the multi-sectoral response at all levels.
- Enhance synergy and collaboration with national and international partners.
- Unify and strengthen monitoring and evaluation platforms to support use of data for decision making.
- Develop and adopt a sustainable unified data management system to inform program planning and decision making at all levels leveraging on best available technology.
- Through NACA own and facilitate clearance for all HIV and AIDS related data.
- Promote decentralization of service delivery to enhance access and equity.
- Ensure shared accountability for reporting success or failures.
- Ensure the development and implementation of a unified country operational plan.

8.0 RESOURCING THE NATIONAL RESPONSE

8.1 RATIONALE

HIV and AIDS is an epidemic that affects all sectors of the economy and targets the most productive segments of the population, limiting productivity and imposing additional burdens on already overburdened public health and social services. Driven by social drivers of poverty, vulnerability and imbalances in power relationships that propel risky behaviours, human and financial resources should be mobilized from all sectors to contribute to interventions that are in the interest of all sectors. As interventions cannot be delivered in a vacuum, it is also important that appropriate infrastructure is provided to facilitate efficient deployment of programs.

To this end it is important to also identify and mobilize all available national and international human and financial resources, from the public, private, and international donor agencies to support the national response.

8.2 THEMATIC GOAL

To achieve national ownership and sustainability

8.3 FOCUS AREAS

- Finance.
- Human resources.
- Infrastructure.
- Local content/technology.

8.4 KEY OBJECTIVES

- Identify new financing sources.
- Leverage on existing financing mechanisms (e.g. Basic Health Care Provision Fund, National Health Insurance Scheme, Saving One Million lives, Primary Health Care under one roof etc.)
- Provide enabling environment for external financing and support.
- Employ robust systems for recruitment and equitable deployment of

Human Resources so that the best talents are attracted and retained.

Implement continuous capacity building for all Human Resources integrating into existing platforms in all instances

8.5 POLICY STATEMENTS

The Government shall:

- 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 services.
- Mandate governments at all levels to meet their counterpart financing for all external funding sources.
- Promote public-private partnerships to mobilize additional financial resources and leverage on the core competencies of the private sector.
- Build capacity and mobilize community resources to ensure sustainability.
- Demonstrate national ownership through appropriation and deployment of financial and other resources to meet program needs.
- Support infrastructure needs for program implementers at all levels.
- Develop and utilize locally produced solutions.
- Implement best practices for human resource acquisition and utilization.

9.0 RESEARCH, KNOWLEDGE MANAGEMENT

9.1 RATIONALE

The need to bridge the data gap and generate data to make informed decision is critical in the national response. This has implication for coordination at federal, state and local government levels, setting up systems for the approval of ethical consideration of the social tools and designs. Furthermore, this component would focus on generation and dissemination of knowledge to provide required support for evidence-based policymaking and programming. The need for this objective inquiry which would stimulate innovation and novelty in the national HIV response is the focus of this area. Research findings can be used as a basis for decision making. It is also imperative to incorporate the element of operational research at program delivery levels to contextualize programmatic activities targeting groups' specific needs and realities that are evidence and result-based (program segmentation).

9.2 THEMATIC GOAL

To establish a framework for Research, and Knowledge management

9.3 FOCUS AREAS

- Basic Science,
- Operations Research.
- Clinical Research.
- Epidemiological Surveys.

9.4 KEY OBJECTIVES

- To support use of scientific evidence for decision making and planning through research by building and strengthening research capacity.
- Ensure the translation of research findings to policy relevance.
- Share knowledge generated from research both locally and internationally.

9.5 POLICY STATEMENTS

Government shall:

- Facilitate appropriate research to identify strategies that support increased access to HIV treatment services, viral suppression and improve quality of life.
- Facilitate the building of robust systems for supporting research in the country.
- Promote open and early sharing of research findings.
- Facilitate the subjecting of research findings to broader peer review before adoption of policy implications.

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GLOSSARY

Combination prevention programs: UNAIDS defines combination prevention programs as those that require "strong community empowerment element and specific efforts to address legal and policy barriers, as well as the strengthening of health and social protection systems, plus actions to address gender inequality, stigma and discrimination.

Behavioral intervention: An intervention targeted at promoting behavior change with the aim to reduce risk of HIV infection. This intervention can be deployed at the individual, group, and/or community level. Component of this intervention also include Intensive behavioral counseling – which provides information about sexually transmitted infections (STIs) and ways in which they are spread.

Biomedical intervention: Is the use of a mix of clinical and biomedical approaches to reduce HIV transmission.

Structural intervention: This is a public health intervention which promotes health by altering the structural strata in which health is produced and reproduced as a strategy for HIV/AIDS prevention.

Vulnerable and Marginalized groups: these include Disadvantaged, vulnerable and/or marginalized adolescents (DVMAs) as well as individuals aged 10–19, KPs, who are excluded from social, economic and/or educational opportunities relative to other adolescents in their community through factors beyond their control.

Treatment as Prevention (TasP): HIV prevention methods and programs which deploy ART as a means to decrease steadily the risk of transmission of HIV is referred to as TasP

Vulnerable communities: include IDPs, Illegal migrants & incarcerated populations, persons with disability, PLWHIV, KPs, women and youths.