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UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION (UNGASS) COUNTRY PROGRESS REPORT

NIGERIA

REPORTING PERIOD: JANUARY 2008–DECEMBER 2009

MARCH 2010

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NATIONAL AGENCY FOR THE CONTROL OF AIDS

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FOREWORD

Nigeria is pleased to submit her fourth country progress report on the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS to the Secretary-General of the United Nations.

The country's response is built on partnerships, capacity strengthening and knowledge generation and transfer, to effectively support policy and program development to best address HIV/AIDS and related diseases. Partnerships and collaboration with government at all levels, private sector, non-governmental organizations, people living with and at-risk of HIV and AIDS, and professionals remain the bedrock of Nigeria's response. Governments at all levels are committed to a comprehensive and vibrant response to HIV and AIDS to ensure that the Millennium Development Goal (MDG) of halting and reversing the spread of HIV is achieved.

Nigeria has taken steps towards strengthening the HIV and AIDS national response since the last UNGASS report in 2007. The country's HIV/AIDS Policy (2003) was reviewed and a new national policy (2010) was developed. The National Strategic Framework (NSF) 2005-2009 was reviewed and a new one that incorporates universal access targets was put in place for the period 2010-2015. The overarching goal of the new NSF is to promote prevention measures for reduction of new HIV infections and to foster a comprehensive treatment system for persons already infected. In 2009, the country's National Agency for the Control of AIDS (NACA) led stakeholders to conduct a comprehensive assessment of the national M&E system in a bid to make it fully functional and more effective. The results of the assessment are being used to strengthen the national M&E infrastructure and capacity at all levels.

The 2010 UNGASS country progress report benefited largely from the contributions of all stakeholders in Nigeria, including bilateral agencies, international non–government organizations and civil society. Their contributions are hereby acknowledged and appreciated.

It is hoped that the report will be used to guide the development of strategies and plans by all stakeholders in the country. NACA will intensify her coordination efforts and continue to collaborate with key partners such as NEPHWAN, USAID, DFID, UNAIDS, WHO, the World Bank, the Global Fund to Fight AIDS, TB and Malaria, Civil Society Organizations and other stakeholders for effective HIV and AIDS response.

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Finally, I wish to appreciate the UNGASS team of consultants, Dr Adedayo Adeyemi (the lead National Consultant), Dr Abieyuwa Ogbe and Mrs. Lucy Okosun for their perseverance, diligence and dedication towards the completion of this report.

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ACRONYMS

AAIN	African American Information Network
AAVP	African AIDS Vaccine Program
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Clinic
APIN	AIDS Preventive Initiative in Nigeria
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behavioral Change Communication
BSS	Behavioral Sentinel Survey
CBOs	Community Based Organizations
CHBC	Community and Home Based Care
CiSNAN	Civil Society Consultative Network on HIV/AIDS in Nigeria
CSOs	Civil Society Organizations
CSWs	Commercial Sex Workers
DoC	Declaration of Commitment
DFID	Department for International Development
DHIS	District Health Information System
EPP	Estimation and Projection Package
FBOs	Faith Based Organizations
FCT	Federal Capital Territory
FGN	Federal Government of Nigeria
FHI	Family Health International
FLE	Family Life Education Curriculum
FMOH	Federal Ministry of Health
HAART	Highly Active Anti-Retroviral Therapy
HAF	HIV/AIDS Fund
HCT	HIV/AIDS Counseling and Testing
HEAP	HIV/AIDS Emergency Action Plan
HIV	Human Immune –deficiency Virus
IBBSS	Integrated Biological and Behavioral Surveillance Survey
ICAP	International Center for AIDS Care and Treatment Program

ICASA	International Conference on HIV/AIDS and Sexuality Transmitted Infections in Africa
IDU	Injecting Drug Users
IEC	Information Education and Communication
IHVN	Institute of Human Virology Nigeria
JICA	Japan International Cooperation Agency
LACA	Local Action Committee on AIDS
LAC	Local Government Action and Communication
LDDs	Long Distance Drivers
LGA	Local Government Area
LHPMIP	Logistics and Health Program Management Information Platform
MAP	Multi-Country AIDS Program
MDA	Ministries Department and Agencies
MDG	Millennium Development Goals
M & E	Monitoring and Evaluation
MARPs	Most at Risk Populations
MIPA	Meaningful Involvement of PLWHA
MOT	Modes of Transmission
MSM	Men having Sex with Men
MTCT	Mother-to-Child Transmission
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food Drug and Administrative Control
NASA	National AIDS Spending Assessment
NARHS	National HIV/AIDS Reproductive Health Survey
NARHS Plus	National HIV/AIDS Reproductive Health Survey Plus
NASCP	National HIV/AIDS and Sexually Transmitted infection Control Program
NAWOCA	National Action for Women Coalition and AIDS
NBCC	National HIV/AIDS Behavior Change Communication Strategy
NDHS	National Demographic and Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NEPAD	New Economic Partnership for Africa Development
NEPWAN	Network of People living with HIV/AIDS in Nigeria
NFACA	National Faith Based Advisory Council on AIDS

NGOs	Non Governmental Organization
NHIS	National Health Insurance Scheme
NiBUCAA	Nigeria Business Coalition Against AIDS
NNRIMS	Nigeria National Response Information Management System
NOP	NNRIMS Operational Plan
NPT	National Program Team
NSF	National Strategic Framework
M&E NTWG	National Monitoring and Evaluation Technical Working Group
NURTW	National Union of Road Transport Workers
NYAP	Nigeria Youth AIDS Program
NYNETHA	Nigerian Youth Network on HIV/AIDS
NYSC	National Youth Service Corps
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PABA	People Affected by AIDS
PAC	Presidential AIDS Council
PCA	Presidential Commission on AIDS
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PESSPs	People Engaged in Same Sex Practice
PLWHA	People Living with HIV/AIDS
PMM	Patient Management Monitoring
PMTCT	Prevention of Mother to Child Transmission
PSSP	People with Same Sex Partners
PSRHH	Promoting Sexual and Reproductive Health and HIV/AIDS
SACA	State Action Committee on AIDS
SFH	Society for Family Health
SIPAA	Support to the International Partnership against AIDS in Africa
SNR	Strengthening National Response
SOP	Standard Operating Procedures
STIs	Sexually Transmitted Infections
SWs	Sex Workers
SWAAN	Society for Women and AIDS in Africa Nigeria
TB-DOTS	Tuberculosis Direct Observation Treatment Scheme

TWG	Technical Working Groups
UN	United Nations
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations International Children Education Funds
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crimes
USAID	United State Agency for International Development
USDOL	United State Department of Labor
VCT	Voluntary Confidential Counseling and Testing
WANASO	West African Network AIDS Serving Organization
WHO	World Health Organization
WSW	Women having Sex with Women
YBSS	Youth Behavioral Sentinel Survey

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EXECUTIVE SUMMARY

A Declaration of Commitment (DoC) on HIV/AIDS at the twenty-sixth special session of the General Assembly was adopted in June 2001 by 189 member states including Nigeria as a formidable response to HIV/AIDS. The United Nations General Assembly Special Session (UNGASS) 2010 report provides an opportunity for member states to appraise progress in reducing the spread of HIV and its impact. Nigeria is therefore committed to monitoring progress in the prevention and control of HIV in accordance with the targets set out in the 2001 Declaration of Commitment on universal access to comprehensive prevention, treatment, care and support.

The process of developing UNGASS 2010 report started in October 2009 with country-wide consultations involving National Agency for the Control of AIDS (NACA), Joint United Nations Program on AIDS (UNAIDS), line ministries and Civil Society groups. It was participatory and involved all stakeholders.

HIV/AIDS is a global crisis. Nigeria with a population of 152.6 million people and estimated HIV prevalence of 3.6 % in the general population, has the second largest population of people living with HIV/AIDS after South Africa. It is estimated that 2.98 million people are living with HIV/AIDS in Nigeria as at the end of 2009. Nigeria is experiencing multiple HIV epidemic showing different features by age, gender, rural and urban areas, and geopolitical zones. The reasons for these differences are difficult to understand although socio-cultural factors may play a key role. The main mode of transmission among adult population in Nigeria is heterosexual intercourse; however, other forms of transmission include IDU and homosexuality.

Relevant response systems have been established at the national, state and local government levels involving all sectors, constituencies, national and international partners under the overall coordination of NACA. The country has developed a multisectoral response mechanism for prevention of new infections, treatment and mitigation of the impact of the disease.

Similarly, national responses have been significantly scaled-up to all parts of the country. Institutional and technical capacities have also been strengthened. Surveys and surveillances among relevant populations including pregnant women, most at risk populations, and the general population have been strengthened and sustained for effective monitoring and coordination of the response. Consequently, the country's success model is built on accountability, strong monitoring and evaluation system, evidence-based and culturally appropriate programming strategies, policy implementation and analysis, and program linkages.

In addition to the vibrant multisectoral national HIV response, the country utilizes a stakeholder-driven participatory approach. This model has led to strengthened and increased support by stakeholders (such as civil society, private sector, women, youth and religious leaders); improved national M&E system; creation of key strategic documents and guidelines for program management; and key priority setting for HIV prevention, treatment and care.

The 2010 UNGASS report shows that Nigeria has experienced progress with some indicators since 2008 UNGASS Reporting year. Such indicators include:

- Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy, which increased from 16.7% (2008) to 34.4% (2010)
- Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission from 5.3% (2008) to 21.59% (2010)
- Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV from 55.95% (2008) to 69.1% (2010)
- Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results from 8.6% (2008) to 11.7% (2010)
- Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission from 22.5% (2008) to 24.2% (2010)
- Percentage of young people aged 15–24 who are HIV infected from 4.3% (2008) to 4.2% (2010)

Although Nigeria has made some significant strategic progress in national response to HIV/AIDS and our international commitment, there are still milestones to cover in achieving Universal Access. The challenges in meeting these goals and commitments include:

- Poor domestic funding of national response; Nigeria is currently providing about 15% of the resources required for universal access
- Poor political commitment at state and local government levels
- Poor impact of prevention interventions such as Behavior Change Communication (BCC) and prevention of mother to child transmission of HIV
- Weak community participation and response to HIV/AIDS

Therefore, there is a need to strengthen the responses at the state and local government levels for a wider coverage and sustainable response. Equally important, there is a need to strengthen research, monitoring and evaluation, and increase data use to improve programming, policy and resource mobilization. Operations research needs to be an integral part of program implementation; and more funding is required to meet the needs of thematic areas especially prevention of mother-to-child transmission of HIV.

Lastly, the leadership and coordination efforts of NACA have led to significant progress in the areas of prevention, treatment, care and support, and human rights especially through the implementation of various national strategies.

1. Introduction

The United Nations General Assembly Special Session (UNGASS) 2010 report provides an opportunity to appraise progress in reducing the spread of HIV and its impact in Nigeria. A Declaration of Commitment (DoC) on HIV/AIDS at the twenty-sixth special session of the General Assembly was adopted by 189 member states including Nigeria in June 2001 as a formidable response to HIV/AIDS.[1] This was a crucial international agreement needed to motivate a coordinated and sustained response in the fight against HIV drawing from previous experiences and lessons. Furthermore, Heads of State and representatives of Governments came up with a Political Declaration on HIV/AIDS in June 2006 towards a comprehensive review of the progress achieved in realizing the targets set out in the 2001 Declaration of Commitment on HIV/AIDS.[2] The Declaration addresses political will, strong leadership, commitment and country-driven actions towards achieving the goal of universal access to comprehensive prevention, treatment, care and support programs.

HIV/AIDS is a global crisis, and a challenge to human life and dignity. The epidemic threatens social and economic development and reverses the gains that are made in life expectancy and many other development indicators. It is a major public health problem with Sub-Saharan Africa severely affected by the epidemic.[3] The continued spread of HIV has the potential of hindering the realization of many of the Millennium Development Goals and to deepen poverty in most of the world's populations where the virus is prevalent.[4]

Therefore, collective and coordinated global actions are needed to combat all aspects of the disease to avert millions of preventable deaths. This important global response requires exceptional leadership for the implementation of national and local strategies to promote effective prevention, treatment, care and support programs.

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[1] Declaration of Commitment on HIV/AIDS: United Nations General Assembly Session on HIV/AIDS 25-27 June 2001

[2] Keeping the Promise: Summary of the Declaration of Commitment on HIV/AIDS
United Nations General Assembly Special Session on HIV/AIDS 25-27 June 2001, New York

[3] Buvé A et al. The spread and effect of HIV-1 infection in sub-Saharan Africa. Lancet 2002; 359: 2011–17

[4] United Nations General Assembly Session on HIV/AIDS 25-27 June 2001: DECLARATION OF COMMITMENT ON HIV/AIDS "Global Crisis – Global Action"

Member states that are signatories to the DoC have an obligation to regularly report the progress made in the fight against HIV/AIDS to the General Assembly. The DoC includes progress on preventing new infections, prevention of mother to child transmission, provision of treatment, search for vaccine and cure, as well as care for the infected and affected people. The DoC is a crucial mandate to improve response and remind member states that there is hope in the fight against HIV with sufficient will, resources, commitment and support. The Joint United Nations Program on AIDS (UNAIDS) is charged with the responsibility of collecting and processing the report for the General Assembly. UNAIDS therefore developed core indicators for monitoring the Declaration of Commitment on HIV/AIDS in 2002. Member states were saddled with the responsibility of submitting progress report every two years to UNAIDS. This is needed to create a global alliance towards awareness, engagement and mobilization for the control of the infection.

Nigeria is committed to achieving the MDG of combating HIV/AIDS, malaria and other diseases through multisectoral collaboration for AIDS response at local, state and national levels to prevent new infections, scale-up access to treatment and care, and mitigate the impact of HIV/AIDS. The successes recorded in reducing new infections and expansion of treatment have been made possible as a result of collaboration involving various Ministries, governmental agencies/parastatals, non-governmental organizations, people living with HIV/AIDS and development partners.

Likewise, NACA has provided effective leadership, coordination, sustained commitment and conducive environment for a stakeholder-driven broad multisectoral partnership along with the development of National HIV/AIDS Plan and strategies. NACA has been involved in strengthening health systems, and policy and strategic measures to control HIV/AIDS. Within this context, national efforts have placed emphasis on the promotion of human rights, reduction of risks and vulnerabilities, reduction of stigma and discrimination, and promotion of gender equality. Furthermore, the Nigerian success model is built on accountability, decentralization, strong monitoring and evaluation system, evidence-based and culturally appropriate programming strategies, policy implementation and analysis, strengthened capacity, program linkages and sound HIV surveillance system.

In December 2005, Nigeria hosted the International Conference on HIV/AIDS and Sexually Transmitted Infections in Africa (ICASA). This was an opportunity for African countries to learn from evidence-based practices, share knowledge, strengthen existing collaboration and form new partnership in the fight against HIV. In November 2007, Nigeria hosted the forth forum of the African AIDS Vaccine Program (AAVP) to share information and knowledge in the areas of research and development of HIV vaccines, best practices and challenges, and to strengthen African involvement in HIV vaccine research. Moreover, Nigeria conducted an Integrated Biological and Behavioral Surveillance Survey (IBBSS) in 2007, a population-based survey among most at risk groups including female sex workers, men that have sex with men, injecting drug users, transport workers and uniformed service personnel. The IBBSS and other previous surveys were efforts that Nigerian government has made to provide reliable estimates of overall HIV prevalence, overview and characterization of the sexual risk behaviors among the general population and most at risk populations.[5,6] Also, there was a data triangulation study in 2009 which focused on sexual transmission of HIV and prevention efforts. The study used available multiple data sources in the country towards providing evidence capable of informing new programs, policy and research. Nigeria equally engaged in the modes of transmission (MOT) study in 2009 to evaluate the populations that are most likely to contribute to transmission of HIV or new infections in line with UNAIDS recommendation for initiating second generation HIV surveillance systems.[7] MOT results provide evidence in priority setting for resource allocation towards national prevention interventions, and strengthen policy, research and programmatic recommendations towards national prevention and strategic framework.[8]

[5] Panchaud C et al. Issues in Measuring HIV Prevalence: The Case of Nigeria. Afr Reprod Health 2002; 6(3): 11 -29

[6] Ammann A. Preventing HIV: Time to get serious about changing behaviour. ABMJ. 2003; 326(7403): 1342–1343.

[7] UNAIDS/WHO Working Group on Global HIV/AIDS/STI Surveillance. Guidelines for Second Generation HIV Surveillance (WHO/CDS/CSR/EDC/2000.5—UNAIDS/00.03E). Geneva: UNAIDS/WHO, 2000.

[8] Modes of HIV Transmission in Nigeria: Analysis of the Distribution of New HIV Infections in Nigeria and Recommendations for Prevention

NACA and Health Systems 20/20 Project conducted a sustainability analysis of HIV/AIDS response in Nigeria in 2008. Strategic information such as data on demographics, epidemiology, funding levels, service delivery and human resources collected at state and national levels was entered into an HIV program model called HIV/AIDS Program Sustainability Analysis Tool (HAPSAT). HAPSAT was therefore used to estimate the recurrent costs and non-pecuniary resources required to sustain and scale up HIV/AIDS services. This was important for cost effective response to HIV program and to identify expected resource gaps in both financing and human resources. HAPSAT was needed for evidence-based, results-oriented decision-making that is critical to sustaining and scaling up the country's HIV/AIDS response.[9]

Equally important, NACA demonstrated commitment to resource allocation and mobilization by carrying out a National AIDS Spending Assessment (NASA) in 2009. This was required to strengthen national assessments of AIDS-related spending in order to support the coordination and harmonization of HIV/AIDS resources. The assessment generated a model to track allocations and expenditures of HIV/AIDS funds and to facilitate effective decision making.

All these efforts were to further operationalize the DoC on HIV/AIDS through meaningful leadership and evidence to sustain gains in HIV prevention and achieve future successes in limiting the spread of HIV.

The production of the Nigeria 2010 UNGASS report was facilitated by NACA in partnership with UNAIDS; National Monitoring and Evaluation Technical Working Group (M&E NTWG) provided an oversight for the process while a broad-based consultation with national stakeholders was carried out for validation. The report highlights the country's progress towards achievement of UNGASS goals, in accordance with the core indicators for monitoring the DoC.

Finally, this report acknowledges that national efforts have resulted in important progress in the areas of leadership, funding, expanding access to HIV prevention, treatment, care and support, and in reducing the prevalence of HIV.

[9] HIV/AIDS Program Sustainability Analysis Tool (HAPSAT): SUSTAINABILITY ANALYSIS OF HIV/AIDS SERVICES IN NIGERIA 2009

2. Country Profile

FIGURE 1. Map of Nigeria

Nigeria is located on the West Coast of Africa with a land mass of 923,768 square kilometers between 4°16' and 13°53′ north of equator, and between 2°40′ and 14°41′ east of Greenwich. It is bordered by Niger Republic (north), Chad (north-east), Cameroon (east), Benin Republic (west) and Atlantic Ocean (south). Nigeria is the most populous country in Africa with a population of 140million in 2006. In addition, Population Reference Bureau estimated Nigerian population to be 152.6 million in mid-2009 making Nigeria the eighth most populous country in the world.[10]

[10] Population Reference Bureau 2009 Fact Sheet

TABLE 1. Facts about Nigeria

Indicators/Data Elements	**Figure**	**Year**
Landmass	923,768 Km^2	
Population	152.6million	2009*
Natural Increase	2.6%	2009*
Percentage enrolled in secondary school	32%	2005*
Births per 1,000 population	41	2009*
Deaths per 1,000 population	15	2009*
Infant Mortality Rate(per 1,000 live births	75	2009*
Total Fertility Rate	5.7	2009*
Percent of population below 15 years	45%	2009*
Percent of population above 65 years	3%	2009*
Life expectancy	47.7 years	2009**
Percentage Adult literacy (above 15 years)	72%	2009**
Human Development Index Score	0.51	2009**
GDP per capita	US$1,969	2009**

*Population Reference Bureau 2009 Data Fact Sheet

**Human Development Report 2009[11]

There are over 250 ethnic and linguistic groups in Nigeria.[12] However, there are three major languages namely: Yoruba, Hausa and Igbo with English being the official language. Nigeria is a democratic Federal Republic country comprising thirty-six states and one Federal Capital Territory with capital city in Abuja. Nigeria has three tiers of government: national, state and local government. The country is made up of 774 local government areas and the states are grouped into six geopolitical zones – North West, North East, North Central, South West, South East and South-South according to geographical proximity and ethnic homogeneity. Nigeria is endowed with human resources, and natural resources such as crude oil and gas, bitumen and agricultural products such as palm oil, rubber and cocoa. Nigeria is a secular state with Christianity and Islam as the two main religions. Political commitments,

[11] UNDP Human Development Report 2009: http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_NGA.html

[12] Geographical: The complete Atlas of the world, "Nigeria", (Random House, 2002)

economic growth, religion and culture have played various roles and impacts in HIV epidemic.

3. Overview of the Process for Development of Nigeria 2010 UNGASS Report

3.1. Participation and Inclusiveness of the Stakeholders in the Data Collection and Report Writing Process

The process of developing UNGASS 2010 report started in October 2009 with consultations involving NACA, UNAIDS, line ministries and Civil Society groups. The process was stakeholder-driven, and offered the opportunity to sustain mechanisms for monitoring and evaluating progress made in the national HIV/AIDS response. The development also involved formation of UNGASS Technical Working Group that met several times to review the collected indicators. The first meeting of the UNGASS Technical Working Group highlighted main responsibilities of the members of the group and also discussed the objectives of the reporting. The process of the development involved collection of service/program data from various ministries, departments, and agencies such as National AIDS and Sexually Transmitted Infections Control Program (NASCP), National Blood Bank, and Federal Ministry of Education.

Relevant published reports were also reviewed such as ANC 2008, NDHS 2008, NARHS 2007 and IBBSS 2007. In addition, secondary data analyses were conducted on ANC 2008, NARHS 2007 and IBBSS 2007 survey data to obtain information on relevant indicators and disaggregation. Literature review was done to strengthen the quality of the report, and additional models were run to generate some needed data from Spectrum.

Indicator values obtained for UNGASS 2010 were compared with the indicator values for UNGASS 2007 to appreciate trend and magnitude, and to assess gaps in HIV/AIDS national response.

Similarly, National Composite Policy Index (NCPI) questionnaires were administered to 18 organizations/institutions (nine government institutions and nine non-government institutions involving NGOs, UN organizations, bilateral agencies and

civil society groups). The questionnaires were administered to the HIV/AIDS focal persons in these agencies and organizations.

In addition, UNGASS consultants were responsible for the administration, collection and collation of the National Composite Policy Index (NCPI) questionnaires. The questionnaires were in two major parts A and B. Part A was administered to government institutions and consisted of the following thematic areas:

I. Strategic plan
II. Political support
III. Prevention
IV. Treatment, care and support
V. Monitoring and evaluation

Part B was administered to non-government institutions and consisted of the following thematic areas:
I. Human rights
II. Civil society involvement
III. Prevention
IV. Treatment, care and support

Before the main validation meeting, implementing partners had the opportunity of examining health sector related indicators in a meeting held in Kaduna Nigeria on March 11, 2010.

The validation meeting was held on the 24th March 2010. The meeting involved all stakeholders and an UNGASS Sub-committee meeting involving a smaller number of stakeholders was also held on the 26th March 2010 to finalize the verification of UNGASS 2010 indicators and report.

Hence, the process of development of UNGASS 2010 involved consultations of all stakeholders at the planning, data collection, data collation, data analysis, report drafting and final submission of the report. The final draft report contains inputs, feedbacks and comments from various stakeholders.

3.2. Status of the Epidemic

Nigeria HIV prevalence is estimated at 3.6% (NARHS 2007) which is a population-based survey. Antenatal sentinel survey has been used to monitor the trend of the epidemic over time. In 2008, the prevalence among pregnant women was 4.6% which could be considered a progress from 5.8% in 2001. Despite that, more interventions are needed to limit the spread of HIV in Nigeria. Current estimates by the Federal Ministry of Health (FMOH) indicate that 2.98 million people are living with HIV/AIDS in Nigeria in 2009 with a total AIDS death of 192,000. One of the most remarkable social and economic impacts of HIV/AIDS is the ever increasing number of AIDS orphans which was estimated at 2.12million in 2008 and 2.175million in 2009. Despite national prevalence of 4.6% from ANC 2008 survey, there are several variations in several states and local government areas. At the zonal level, prevalence is lowest in the South West (2.0%) and highest in the South-South (7.0%). Age-specific prevalence is highest among 25-29 years age group (5.6%) and lowest among 40-44 years age group (2.9%) according to the 2008 ANC survey.

TABLE 2. HIV/AIDS status at a glance 2009[13]

National Median HIV prevalence (ANC)	4.6%
Estimated number of people living with HIV/AIDS	Total: 2.98million
Annual HIV positive birth	Total: 56,681
Cumulative AIDS death	Total: 2.99 million (male 1.38 million; female 1.61 million)
Annual AIDS Death	Total: 192,000 (male 86,178; female 105,822)
Number requiring Antiretroviral Therapy	Total 857,455 (adult 754,375; children 103,080
New HIV infection	Total: 336,379 (males 149,095; females 187,284)
Total AIDS orphans	2,175,760

Source: FMOH (2008) ANC 2008 Report HIV estimates and projection

[13] Federal Ministry of Health Report on the 2008 National HIV/Syphilis Sero-prevalence Sentinel Survey among Pregnant Women Attending Antenatal Clinics in Nigeria. NASCP Abuja: Nigeria.

3.3. Policy and Programmatic Response

The Government of Nigeria has shown great commitment to the fight against the HIV/AIDS scourge. It is in pursuit of this purpose that the Government through the HIV/AIDS governing body, NACA has formulated policies that affect every area of the nation's multisectoral response to HIV/AIDS. The revised HIV/AIDS policy (2009) is as a result of broad consultations with the relevant stakeholders in the response. These include civil society organizations, PLWHA, line ministries and parastatals, development partners, donor agencies, faith-based organizations and community based organizations.

The HIV/AIDS policy serves as a statement of Nigeria's determination to reverse the tide of the epidemic and mitigate its impact on millions of lives of Nigerians. Furthermore, it serves as a catalyst to speed up and generate a more coordinated and effective response to the epidemic.

The first policy statement was developed in 1997 by the Federal Ministry of Health. This was at the advent of the epidemic. This policy statement was later revised in 2003 by the National Agency for the Control of AIDS in collaboration with other stakeholders with the sole aim of mitigating the impact of the HIV/AIDS. The policy focused on five thematic areas:

- Prevention of HIV/AIDS
- Law and ethics
- Care and support
- Communication
- Program management and support (National Policy on HIV/AIDS 2003)

The 2003 policy statement has been a useful tool and a guide for HIV/AIDS programs and activities till date; it recorded a lot of achievements. Nevertheless, in a bid to strengthen the national response and to incorporate emerging issues, a 2009 revised

policy has been developed. Some of the crucial issues that the revised policy addressed are the following:

- The rising HIV prevalence among women
- The increasing number of orphans and vulnerable children
- The stigmatization of people living with HIV/AIDS and violation of their rights as well as their roles and responsibilities.
- The differences in communication messages on abstinence and condom use in secondary schools and higher institutions of learning.
- The issues associated with increased access to treatment and care.[14]

These issues have been incorporated into the new revised policy. The aim of the national policy is to provide a framework for advancing the multisectoral response to HIV/AIDS in Nigeria. The main target of the policy document is to have 'halted, by 2015 and to begin to reverse the spread of the HIV/AIDS among Nigerians'.[15]

The National Strategic Framework (NSF) was developed with reference from this policy statement. The NSF has been in operation since 2005 till the end of 2009 as a skeletal structure on which HIV plans and activities are hinged on.[16] The 2005 – 2009 NSF has been reviewed and a new NSF II 2010 – 2015 is currently in place.

The thematic areas in the revised policy are as follows:

- Prevention of new infections and behavior change
- Treatment of HIV/AIDS and related health problems
- Care and support for people living with and affected by AIDS
- Institutional architecture and resourcing
- Advocacy, legal issues and human rights
- Monitoring and evaluation

[14] HERFON 2007: NIGERIAN HEALTH REVIEW
http://www.herfon.org/docs/Background_Information_on_NHR.pdf
[15] 2009 National HIV/AIDS Policy
[16] National Agency for the Control of AIDS (NACA): National Strategic Framework (NSF) 2005-2009

- Research and knowledge management

The table below shows the thematic areas with its goal and objectives.[17]

TABLE 3. HIV/AIDS Thematic Areas in Nigeria

THEMATIC AREAS	**GOALS**	**OBJECTIVES/POLICY STATEMENTS**
Prevention of HIV infection and behavior change	To reduce HIV/AIDS incidence	• Promotion of safer sexual behavior through communication related interventions • Promotion of appropriate use of male and female condoms/lubricants • Prevention of biomedical transmission of HIV. • HIV counseling and testing • Prevention of mother to child transmission • Early diagnosis and effective treatment of sexually transmitted infections
Care and support for infected and affected persons	To promote the survival and improve the quality of health of persons infected and affected by HIV/AIDS by reducing and mitigating the health, social, economic and psychological impact of the epidemic.	• Promote access to gender sensitive continuum of integrated comprehensive care, treatment, counseling, clinical and home based care, and community support. • Improve access to gender sensitive information, social and economic opportunities for PLWHA • Establish and strengthen gender sensitive referral and coordination systems that link hospital services for PLWHA to community based care in the context of an integrated, complementary and sustainable approach. • Ensure the protection, care and empowerment of orphans and vulnerable children.

[17] 2009 National HIV/AIDS Policy

Institutional architecture and resourcing.	To assist in improved implementation of the HIV response through streamlining the roles and responsibilities of key players, enhanced resource support and strengthened coordination at all levels of the multisectoral response.	• Support improved resource mobilization, management and accountability at all levels within the national response. • Clarify roles and responsibility of key players to advance comparative advantages of stake holders and forge synergies to strengthen the national response. • Facilitate strengthened coordination at all levels and components within the multisectoral response.
Ethics, legal issues and human rights	To protect the rights of PABA and PLWHA and empower them as well as other HIV vulnerable or marginalized groups.	• Protect the rights, empower and facilitate greater participation of people living with HIV/AIDS. • Protect women, children and other socially vulnerable and marginalized groups from HIV/AIDS.
Monitoring and evaluation	To strengthen and ensure effective and robust monitoring and evaluation system to track HIV/AIDS epidemic and improve response to the epidemic.	• Strengthen the use of the national monitoring and evaluation framework for the national response. • Strengthen institutional and human capacity for monitoring and evaluation • Support evidence based approach in HIV interventions.

Source: 2009 National Policy on HIV/AIDS

Likewise, much effort has been made to incorporate gender issues especially as it affects women in Nigerian policy documents. The UNIFEM and other stakeholders met in April 2009 and discussed the streamlining of gender into HIV activities.

One of the key strategies for achieving this goal is to increase access to gender-sensitive prevention, care, treatment and support services. This involves the promotion and implementation of gender-sensitive community and home-based care services.

In addition to the National HIV/AIDS Policy, a broad multisectoral response has led to the formulation of HIV/AIDS policies in institutions, in private and public organizations to reduce new infections, mitigate the impact of the virus and to protect the rights of people living with HIV/AIDS. Consequently, there have been a number of other national policies such as National Workplace Policy, National Prevention Plan, National AIDS Priority Plan and National Monitoring & Evaluation Plan.

Policy Documents in Nigeria as at the end of 2009 used to guide the national response:

- HIV/AIDS Emergency Action Plan (HEAP)
- National Strategic Framework (NSF).
- National HIV/AIDS Policy
- NNRIMS Operational Plan
- National HIV/AIDS Prevention Plan.
- National Education sector Strategic Plan
- National Health Sector Strategic Plan for HIV/AIDS
- National Economic Empowerment and Development Strategy (NEEDS).
- National HIV/AIDS Behavior Change Communication Strategy
- National OVC Plan of Action
- NEEDS
- SEEDS

Priorities for 2010-2011:

PRIORITY A: Prevention of New Infections

- To assist 9.4 million sexually active adults access HCT services in an equitable and sustainable way.

- To assist 3.2 million pregnant women with access to quality HIV testing and counseling
- At least 60% of Nigerians have comprehensive knowledge of HIV/AIDS and 60% of sexually active males and females use condoms consistently and correctly with non-regular partners
- At least 60% of PLHIV have access to positive health, dignity and preventive programs

PRIORITY B- Treatment of HIV/AIDS and related conditions

- At least 60% of eligible adults and 60% of children are receiving ART based on national guidelines.
- To assist at least 60% of PLHIV with quality management of OIs (diagnosis, prophylaxis and treatment)
- To implement TB/HIV collaborative services in at least 50% of Nigerian States

PRORITY C- Care and Support of PLHIV, PABA and OVC

- To provide access to quality care and support services to PLHIV by at least 20% on baseline value.
- To reduce stigma and discrimination targeted at PLHIV and PABA at least 30% on baseline value.
- To build capacity of OVC households to mitigate the impact of HIV/AIDS by 10% above baseline value.

PRIORITY D- Monitoring and Evaluation

- To set up mechanisms to enhance the effectiveness of various levels of government for the delivery of one national M&E system
- To improve the coordination and cost effectiveness of data collection, analysis and use for program planning and decision making
- To develop HIV evaluation and information mechanisms to enhance national response
- To provide improved data quality and supportive supervision at all levels of government

PRIORITY E-Research

- To provide supportive environment to generate relevant HIV/AIDS knowledge
- To establish mechanisms for utilization of research products for policy, program and new research in states within the country

3.4. UNGASS Indicator Data

TABLE 4. UNGASS Indicator:

S/N	Indicator	UNGASS 2007	UNGASS 2010	Remarks
1	Domestic and international AIDS spending by categories and financing sources	US$42,275,977.57	US$ 394,963,881.00 (NASA 2008)	This is NASA figure for 2008 as there is no figure for 2009.
2	National Composite Policy Index (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)	Refer to CRIS	Refer to online UNGASS reporting template	A survey was conducted involving administration of questionnaires between October 2009-January 2010 to 18 organizations /institutions. The questionnaires were entered in online UNGASS 2010 reporting template.
3	Percentage of donated blood units screened for HIV in a quality assured manner	100% (NBTS Program Report 2007)	100% (23,935/23,935) (NBTS Program Report 2009)	The figure represents blood that passed through the NBTS facility only
4	Percentage of adults and children with advanced HIV infection receiving	16.7% (NNRIMS Data Base)	34.4% (302,973/882,139) (FMOH 2009)	

	antiretroviral therapy			
5	Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	5.3% (NNRIMS Data base)	21.6% (44,723/207,190) (FMOH 2009)	Increase in PMTCT coverage between 2007 and 2009
6	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	55.95% (NNRIMS Data base)	69.1% (18,788/27,180) (FMOH 2009)	
7	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results	8.6% (NARHS 2005)	All: 11.7% (1,247/10,695) Male: 11.9%; Female: 11.4% (NARHS 2007)	All 6.6%; Male: 6.5% female 6.6% (from NDHS 2008) NARHS 2007 was preferred for the reporting to allow for comparison with UNGASS 2007 reporting.
8	Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	FSW: 38.2; MSM:30.2: IDU 23.2 (IBBSS 2007)	All MARPS: 38.6% <25years: 32.2% ≥25 years: 40.9% Male: 37.8% Female: 41.1% FSW 38.2% (1132/2965) (Brothel 46.2% and Non-Brothel 29.6%); MSM:30.2% (265/879); Armed forces 70.5%; Transport: 20.3%; IDU 23.2% (160/690); Police: 39.1% (IBBSS 2007)	In 2007, only 6 states were covered in the IBBSS 2007)
9	Percentage of most-at-risk populations reached with HIV prevention programmes	FSW: 34.30; MSM:54.38 IDU 56.67 (IBBSS 2007)	All MARPS: 58.1% <25years: 52.6% ≥25 years: 60.1% Male: 61.1% Female: 53.2% FSW 49.4% (1,466/2,965) (brothel-based 53.6%; non-brothel 45.0%); MSM 60.3% (530/879); Armed forces 80.5%; transport workers 45.9%; IDU 59.4% (410/690); Police 62.1% (IBBSS 2007)	In 2007, only 6 states were covered in the IBBSS 2007). Although, the same database was used for UNGASS 2007 and 2010. UNGASS 2010 combined 2 questions contained in the indicator guideline for FSW and MSM, and a third question for IDU as against the previous UNGASS report where only question1 was used
10	Percentage of orphans and vulnerable children whose	9.7%	6.3% (497/7,857) (NDHS 2008)	The information sources are different

	households received free basic external support in caring for the child	(CRS 2006, Draft report on OVC Situational Analysis)		for the 2 reporting years.
11	Percentage of schools that provided life skills-based HIV education within the last academic year	33.6% (Federal Ministry of Education)	22.8% (22,980/101,000) (Federal Ministry of Education 2009)	In 2007, a survey was conducted to get this result unlike 2009 where routine data was used. Only data from secondary schools was available and none from primary schools.
12	Current school attendance among orphans and among non-orphans aged 10–14	Orphans 75%; non-orphans 87 Ratio: 0.9 (CRS 2006, Draft report on OVC Situational Analysis)	OVC: 83.9% (112/134) Non-OVC:71.7% (10,143/14,147) Ratio: 1.17:1 (NDHS 2008)	The 2 data sources are different for UNGASS 2007 and 2010.
13	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	22.5% (NARHS 2005)	All 24.2% (1,120/4,633) (NARHS 2007)	
14	Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	FSW: 32.9; MSM:44.0 IDU 34.0	FSW 32.9% (976/2,965); MSM 44.0% (387/879); IDU 34.0% (234/690) (IBBSS 2007)	
15	Percentage of young women and men who have had sexual intercourse before the age of 15	9.8 (NARHS 2005)	11.9% (549/4,632) (male 6.7% and female 17.2%) (NARHS 2007)	All 10.7%: Male 5.7% Female 15.7 % (NDHS 2008) NARHS 2007 was preferred to compare with previous reporting year
16	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	10.4 (NARHS 2005)	11.4% (1,222/10,695) (male 19.2% and female: 3.7%) (NARHS 2007)	All 5.0% Male: 14.7% Female 1.4% (NDHS 2008)
17	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last	56.1% (NARHS 2005)	52.5% (5,613/10,695) (NARHS 2007)	All (28.2%) Male: 29.3% and female 22.9%

	intercourse			(NDHS 2008)
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	91.97% (IBBSS 2007)	FSW only: <25years=98.3% ≥25years=98.1% FSW: 98% (2,727/2,784) (Brothel 98.7 Non-brothel 97.1) (IBBSS 2007)	UNGASS 2010 used condom use with the most recent client in the analysis
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	52.8% (IBBSS 2007)	52.8% (388/735) <25years=52.4% ≥25years=53.8% (IBBSS 2007)	
20	Percentage of injecting drug users who reported the use of a condom at last sexual intercourse	66.1% (IBBSS 2007)	66.2% (186/281) <25years=70.1% ≥25years=64.4% Male: 66% Female: 68% (IBBSS 2007)	
21	Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	89.2% (IBBSS 2007)	89.2% (608/682) <25years=85.5% ≥25years=89.9% Male: 89.3% Female: 86.1% (IBBSS 2007)	
22	Percentage of young people aged 15–24 who are HIV infected	4.3% (ANC 2005)	4.2% (565/13,516) (ANC 2008)	
23	Percentage of most-at-risk populations who are HIV infected	FSW: 32.7%; MSM:13.5% IDU 5.6%	All MARP=11.6% <25years=14.2% ≥25years=10.6% Male=4.8% Female: 27.5% FSW: 32.7% (700/2,140) (Brothel 36.8%; Non- brothel 28.2%); MSM 13.5% (109/810); Armed Forces 3.2% Police 3.7%; Transport workers 3.8% & IDU 5.6% (36/643) (IBBSS 2007)	

24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	94.6% (ICAP)	70% (37587/53721) (FMOH 2009 Program data)	
25	Percentage of infants born to HIV-infected mothers who are infected		29.1% (60240/207190) (Spectrum modeling)	This indicator value was 13.1% if FMOH 2009 program data was used

3.5 Comments for the Indicators:

1) Indicator 1: Domestic and international AIDS spending by categories and financing sources. This was obtained from the National AIDS Spending Assessment (NASA) document. Using an exchange rate of US$1=115 Nigerian Naira, US$394,963,881.00 is equivalent to Nigerian ₦45,420,846,315.

2) Indicator 4: There has been significant improvement in treatment coverage in Nigeria. UNGASS 2007: 16.7% (n=238,659) and UNGASS 2010: 34.4% (n=302,973) with a p-value of <0.0001. However, Nigeria needs to work harder to reduce the 65.8% treatment gap (those needing ART – those on treatment).

3) Indicators 8, 9, 14, 18, 19, 20, 21 and 23 were obtained from IBBSS 2007. The risk groups covered in this survey were female sex workers (brothel based and non-brothel based); MSM, armed forces, transport workers, IDU and police. The survey was conducted in 6 states namely Kano, Lagos, Edo, Anambra, Cross River and FCT. However, for MSM and IDU, it was conducted only in 3 states namely Lagos, Kano and Cross River. IBBSS is preferred because it is the most reliable population-based estimates among the most at risk populations in the country.

4) Indicator 9: Percentage of most-at-risk populations reached with HIV prevention programs.

The numerator was obtained by combining these 2 questions in the IBBSS database

1. Do you know where you can go if you wish to receive an HIV test?
2. In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

UNGASS 2007 used only question1 from the database but UNGASS 2009 combined these 2 questions in the database to obtain the numerator. Despite using the same survey, UNGASS 2009 figure is different from UNGASS 2007.

Among the IDU, a third question was included based on UNGASS indicator guideline. Question: 3. In the last twelve months, have you been given sterile needles and syringes (e.g. by an outreach worker, a peer educator or from a needle exchange program)?

5) Indicator 16: NDHS figure: men 14.7%; women 1.4%; and both men and women (4.98%). NARHS figure of 11.4% was preferred over NDHS to allow for comparison with the previous UNGASS report.

6) Indicator 24: Cohort analysis for survival after 12 months in Nigeria is 70%. The coverage, impact and quality of ART service delivery are important towards optimal survival of patients and Nigeria will benefit more from evidence-based HIV treatment approaches towards sustaining survival.

7) Indicator 25: Percentage of infants born to HIV-infected mothers who are infected is 29.1% from Spectrum model. Data collected from FMOH had 13.1% of infants born to HIV-infected mothers. Nigeria needs to strive towards improving the impact of PMTCT service. Operations research in the area of PMTCT is needed to improve the quality of services, and scale-up of coverage so that more HIV positive mothers could benefit from PMTCT services.

4. Overview of HIV epidemic Surveillance in the Country

4.1. Generalised Epidemic

Nigeria has the second highest number of people living with HIV in the world after South Africa. UNAIDS estimated 33.4million people living with HIV in 2008 in the world.[18] Nigeria, with about 2.98million people living with HIV, makes about 9% of the global HIV burden. However, there is gender inequality in the distribution with males accounting for 1.23million and female accounting for 1.72million in the HIV estimates and projections for 2008. Women are more affected in the defining feature of the epidemic with policy implications for prevention of mother to child transmissions.[19,20] Hence, addressing gender inequality is crucial in the control of the epidemic.[21,22] Nigeria recorded the first case of acquired immunodeficiency syndrome (AIDS) in 1986.[23] Heterosexual sex remains the primary mode of transmission for HIV and accounts for 80-95% of HIV infections in Nigeria.[24] Tracking the course of HIV epidemic in Nigeria requires good reporting and surveillance systems. Thus, Nigeria through the Federal Ministry of Health instituted regular surveillance system using clinic-based and population-based surveys to monitor the epidemic. This is needed to obtain reliable information about HIV prevalence and behavior associated with HIV transmission or acquisition. These surveys have shown the dynamic nature of HIV epidemic in relation to temporal changes, geographic distribution, magnitude, and modes of transmission. Furthermore, this surveillance system provides opportunities to monitor trend in prevalence, create awareness about early response,

[18] UNAIDS 2009 AIDS epidemic update: Global summary of the AIDS epidemic
[19] Simon V. HIV/AIDS epidemiology, pathogenesis, prevention, and treatment. Lancet 2006; 368: 489–504
[20] Quinn TC, Overbaugh J. HIV/AIDS in women: an expanding epidemic. Science 2005; 308: 1582–83
[21] Shisana O, Davids A. Correcting gender inequalities is central to controlling HIV/AIDS. Bull World Health Organ 2004; 82: 812
[22] Ezumah NE. Gender Issues in the Prevention and Control of STIs and HIV/AIDS; Lessons from Awka and Agulu, Anambra State, Nigeria. African Journal of Reproductive Health, 2003: 7:89: 99
[23] Federal Ministry of Health (2005) The National Situation Analysis of the Health Sector Response to HIV & AIDS in Nigeria. Abuja: FMH Nigeria
[24] Adeyi O, et al, editors. 2006. AIDS in Nigeria; A Nation on the Threshold (Harvard University Press, Harvard Series on Population and International Health).

inform priority setting for new interventions and measure the effectiveness of public health interventions in the control of the epidemic.[25,26]

The Federal Ministry of Health with support from NACA and other relevant stakeholders like National Population Commission, CDC, Society for Family Health and Family Health International periodically conducts four main surveys namely:

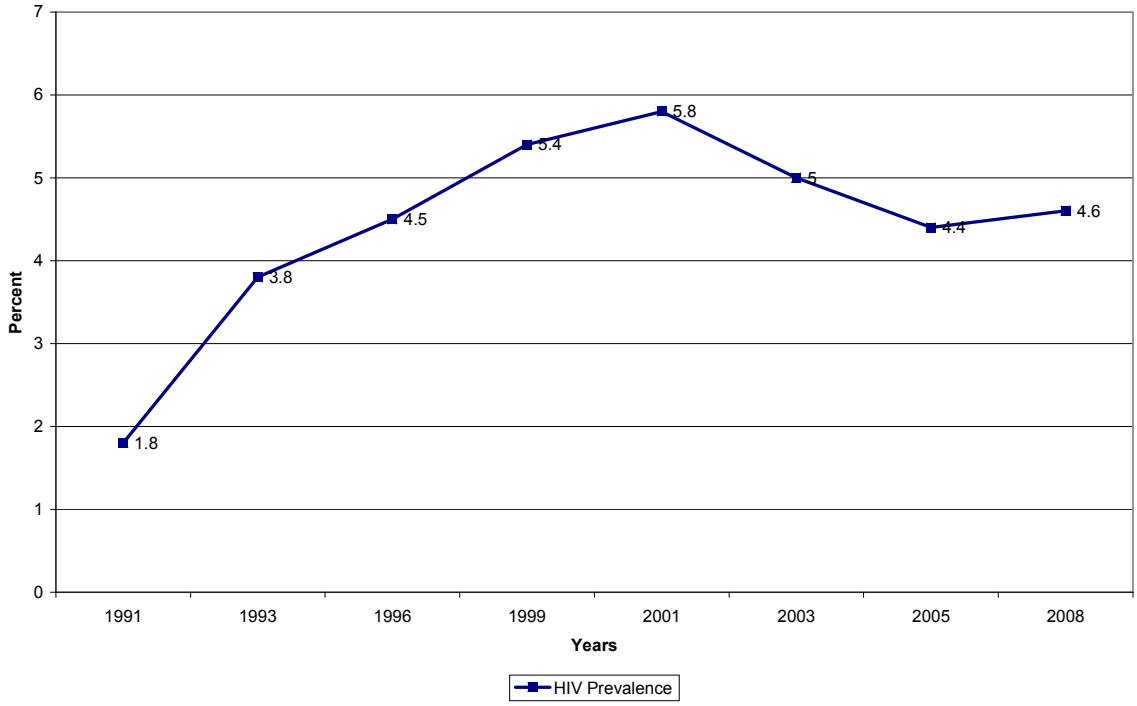
- National HIV/AIDS and Reproductive Health Survey Plus (NARHS Plus) – This is a population-based survey that estimates HIV prevalence and obtains information on the associated factors. In addition, it provides information on the behavioral, sexual and reproductive health status in the country. It is usually conducted every two years.
- HIV/STI Integrated Biological and Behavioral Surveillance Survey (IBBSS) – This survey is targeted at the most at risk populations whose behavior patterns or occupations often place them at higher risk of contracting sexually transmitted infections (STIs) including HIV. It estimates HIV prevalence among the most at risk populations and provides information on drivers of the epidemic among these groups. It is usually conducted every two years.
- Antenatal Care survey – This is a clinic based sentinel survey to estimate HIV prevalence among pregnant women attending antenatal clinic. It is conducted every two to three years.
- Nigeria Demographic and Health Survey (NDHS) – It is a nationally representative survey. Prior to 2008 survey, the last one was in 2003. It is conducted by National Population Commission with international support.

HIV epidemic rose from 1.8% in 1991 and peaked at 5.8% in 2001. It is currently at 4.6% in 2008 antenatal survey. Figure 1 below shows a rapid rise in HIV prevalence in the sentinel surveys carried out from 1991 to 2001 (1.8% in 1991 to 4.5% in 1996 and then to 5.8% in 2001). Subsequently, the trend reversed and took a downward turn from 5.8% in 2001 to 5% in 2003 and then to 4.4% in 2005.[27,28]

[25] Ainsworth M, Teokul W. Breaking the silence: setting realistic priorities for AIDS control in less-developed countries. Lancet 2000; 356:55-60.
[26] Jha P, Nagelkerke NJD, Ngugi EN, Prasada Rao JVR, Willbond B, Moses S, et al. Reducing HIV transmission in developing countries. Science 2001; 292:224-5
[27] Federal Ministry of Health (2001) A Technical Report on 2001 National HIV/Syphilis Sero-Prevalence Sentinel Survey among Pregnant Women Attending Antenatal Clinics in Nigeria. Abuja: NASCP, Nigeria.

Although a slight increase was observed in HIV prevalence from 4.4% in 2005 to 4.6% in 2008.[29,30] However, in each of the sentinel survey, there were state level variations.

FIGURE 2. Trend in HIV Prevalence in Nigeria (1991-2008)



In addition, the National HIV prevalence was 3.6% from the National HIV/AIDS and Reproductive Health Survey (NARHS) 2007.[31] NARHS has the advantage of being a population-based survey. NARHS 2007 report shows 78.6% of males and 78.5% of females accepted to be tested among the survey participants. Likewise, among the male participants, HIV testing coverage was higher in the rural areas (81%) than the

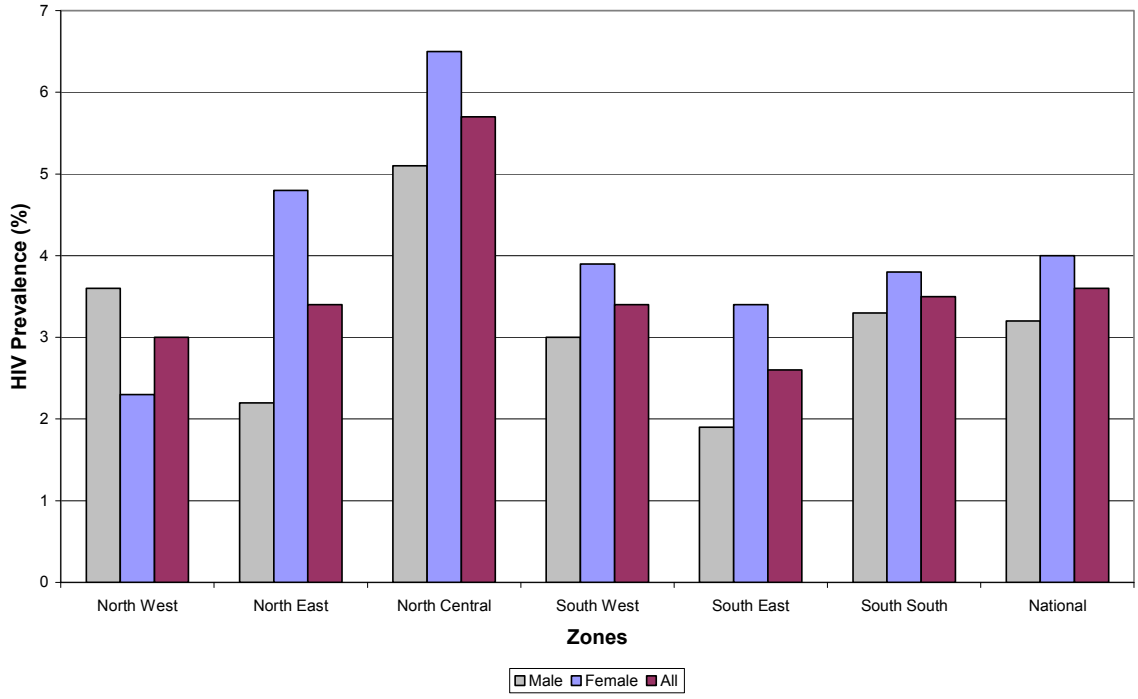
[28] Federal Ministry of Health (2004) A Technical Report on 2003 National HIV/Syphilis Sero-Prevalence Sentinel Survey among Pregnant Women Attending Antenatal clinics in Nigeria. Abuja: National AIDS/STIs Control Program, Nigeria.
[29] Federal Ministry of Health (2005) Technical Report on the 2005 National HIV/Syphilis Sero-prevalence Sentinel Survey Among Pregnant Women Attending Antenatal Clinics in Nigeria. Department of Public Health National AIDS/STI Control Programme. Abuja: Nigeria.
[30] Federal Ministry of Health (2010) Technical Report on the 2008 National HIV/Syphilis Sero-prevalence Sentinel Survey Among Pregnant Women Attending Antenatal Clinics in Nigeria. Department of Public Health National AIDS/STI Control Programme. Abuja: Nigeria.
[31] Federal Ministry of Health (2009) National HIV/AIDS and Reproductive Health Survey. Abuja (NARHS 2007), Nigeria.

urban areas (75%). While among the female participants, HIV testing coverage in the rural areas was 79% compared to the urban areas (78%). Similarly, North East zone had the highest testing coverage (85%) and age group 15-24years (80%). The report further shows that more females (4.0%) were infected than males (3.2%) in the country. Prevalence was slightly higher in urban areas (3.8%) compared to rural areas (3.5%). North Central Nigeria has the highest prevalence of 5.7% with South East having the least 2.6%. Youths (ages 15 – 24 years) had a prevalence of 2.4% which was about 67% of the national HIV prevalence of 3.6% in the survey which buttresses the fact that youths are important risk group in HIV epidemic.[32]

The NARHS report further shows that HIV prevalence in the general population was higher among those with tertiary education (4.0%) compared to those without education (2.7%). HIV prevalence among those who had sex in the last 12 months: male (3.9%) and female (4.4%). In addition, among males that ever had sex HIV prevalence was 3.8% unlike in males (1.7%) that never had sex, while in females (4.7%) that ever had sex and those that never had sex 1.7%. Males that exchanged sex for gifts had prevalence of 5% and those that did not had HIV prevalence of 3.9%. Females that exchanged sex for gifts had prevalence of 5.2% and those that did not exchange sex for gifts had HIV prevalence of 3.9%. Females with two or more non-marital sexual partners had prevalence of 14.5% while males with two or more non-marital partners had a prevalence of 1.5%.

[32] Pettifor AE, Rees HV, Kleinschmidt I, et al. Young people's sexual health in South Africa: HIV prevalence and sexual behaviors from a nationally representative household survey. AIDS 2005; 19: 1525–34.

FIGURE 3. HIV Prevalence by Zones and Sex in Nigeria, 2007



Source: FMOH NARHS 2007

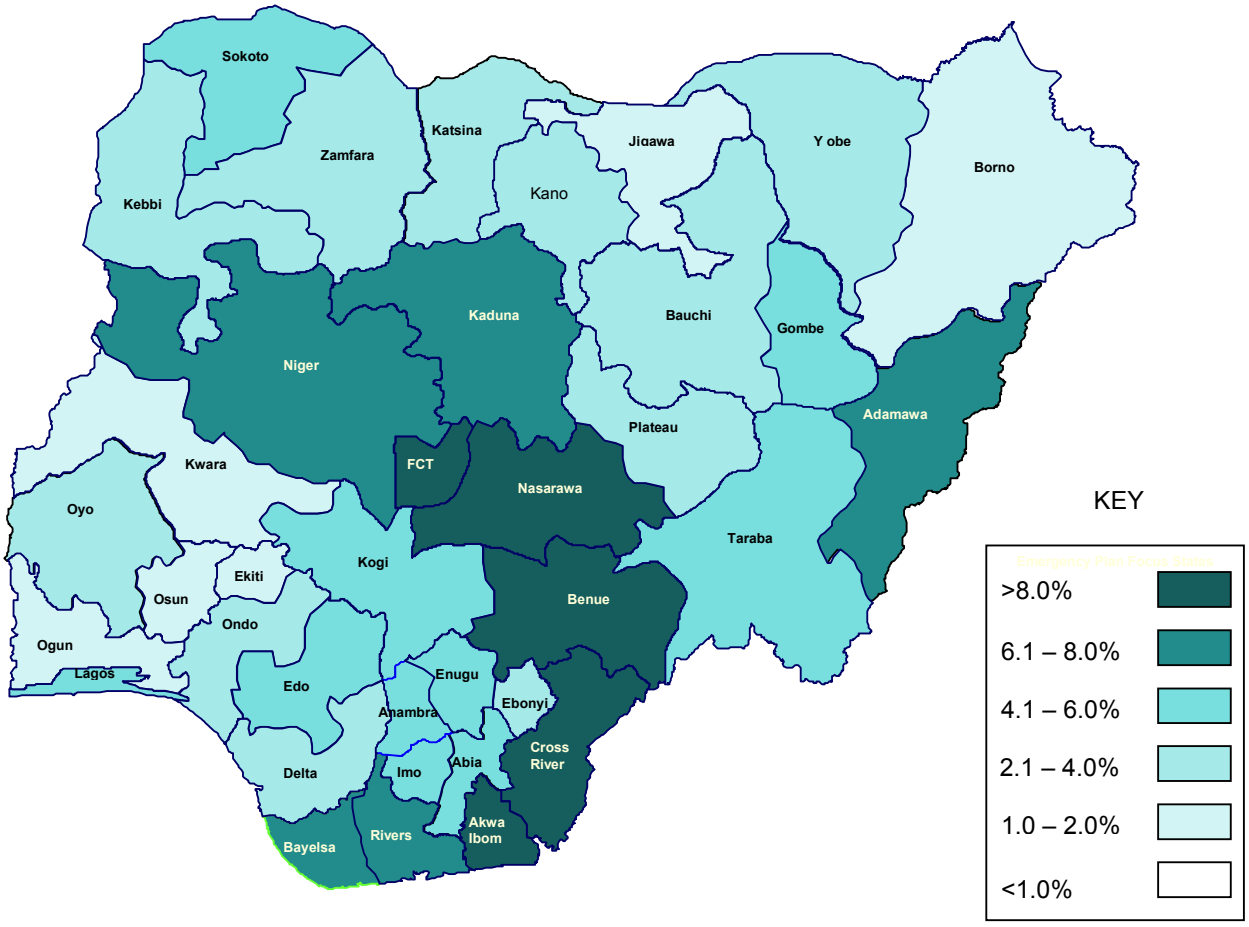
In the most recent 2008 sentinel survey, national HIV prevalence for women attending ANC was 4.6%. Nigeria has a generalized epidemic with a prevalence above 1% as defined by UNAIDS/WHO Working Group in 2000. This sentinel survey was carried out in the 36 states of Nigeria and the Federal Capital Territory (FCT). The results of the survey indicate that Ekiti state in the South West zone of Nigeria had the lowest prevalence of 1.0%, while Benue state in North Central zone had the highest prevalence of 10.6%. Additionally, Bwari local government area in the Federal capital territory had the highest site prevalence of 22%.[34]

The ANC survey report shows women with primary, secondary and tertiary education had HIV prevalence of 5.1%, 5.8% and 4% respectively. Single women had higher HIV prevalence than married women (5.9% versus 4.7%). HIV prevalence was 5.4% in North Central zone with rural prevalence of 4.7% and urban prevalence of 6.2%. North East had prevalence of 4% with rural prevalence 3.1% and urban prevalence 4%. North West had prevalence of 2.4% with rural prevalence 2% and urban prevalence 2.6%. South East had prevalence of 3.7% with rural prevalence 3.4% and urban prevalence 5.4%. South West had prevalence of 2.0% with rural prevalence

1.7% and urban prevalence 2%. South-South had prevalence of 7% with rural prevalence 4% and urban prevalence 7.1%.

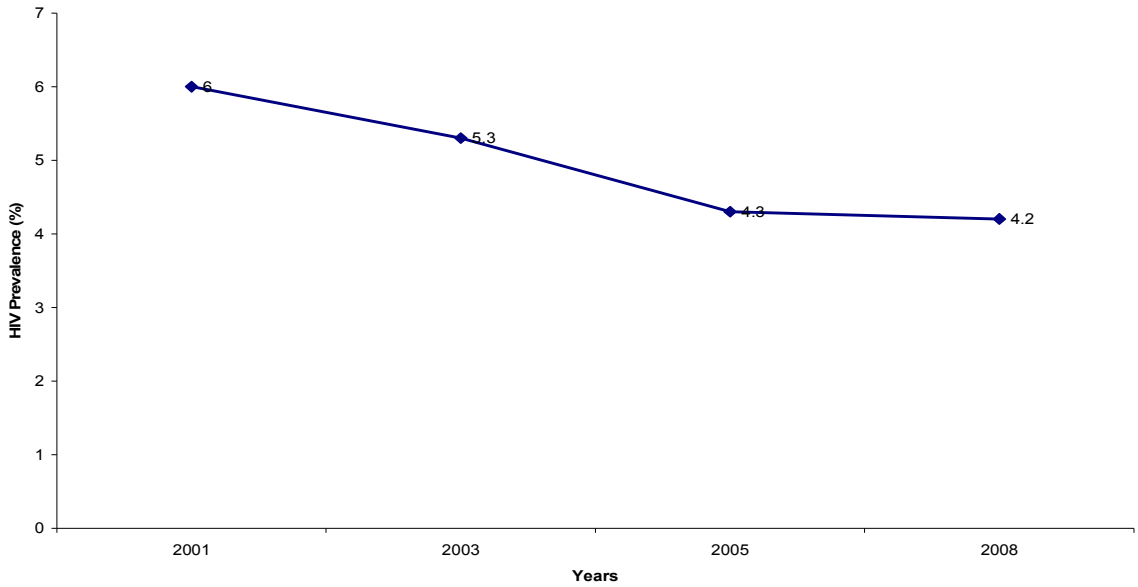
Furthermore, five states namely; Plateau, Gombe, Zamfara, Bauchi and Ekiti showed a consistently decreasing HIV prevalence from 2001 to 2008 in antenatal sentinel survey.

FIGURE 4. Geographic Distribution of HIV Prevalence by States: Federal Ministry of Health ANC 2008 Report



In figure 5, there was a noticeably declining trend among women aged 15-24years from 2001-2008.

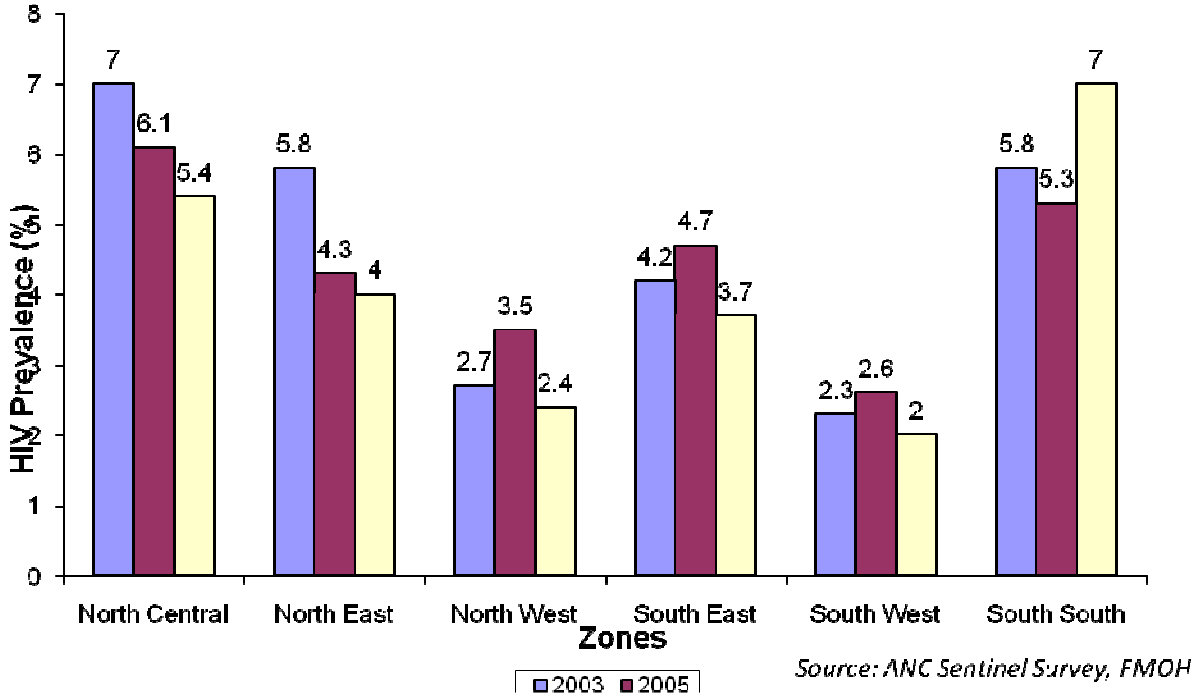
FIGURE 5. Trend in Prevalence among Young Women aged 15-24 in Nigeria (2001- 2008)



Source: ANC Sentinel Surveys, FMOH

The graph below (figure 6) shows zonal trend in ANC surveys from 2003 to 2008 to appreciate the magnitude and trend of the epidemic in Nigeria.

FIGURE 6. Zonal Trend in HIV Prevalence in ANC Surveys from 2003 – 2008



Similarly, urban and rural zonal trends in HIV epidemic are shown in figures 7 and 8.

FIGURE 7. Zonal Urban Trend in HIV Prevalence in ANC Surveys from 2003 - 2008

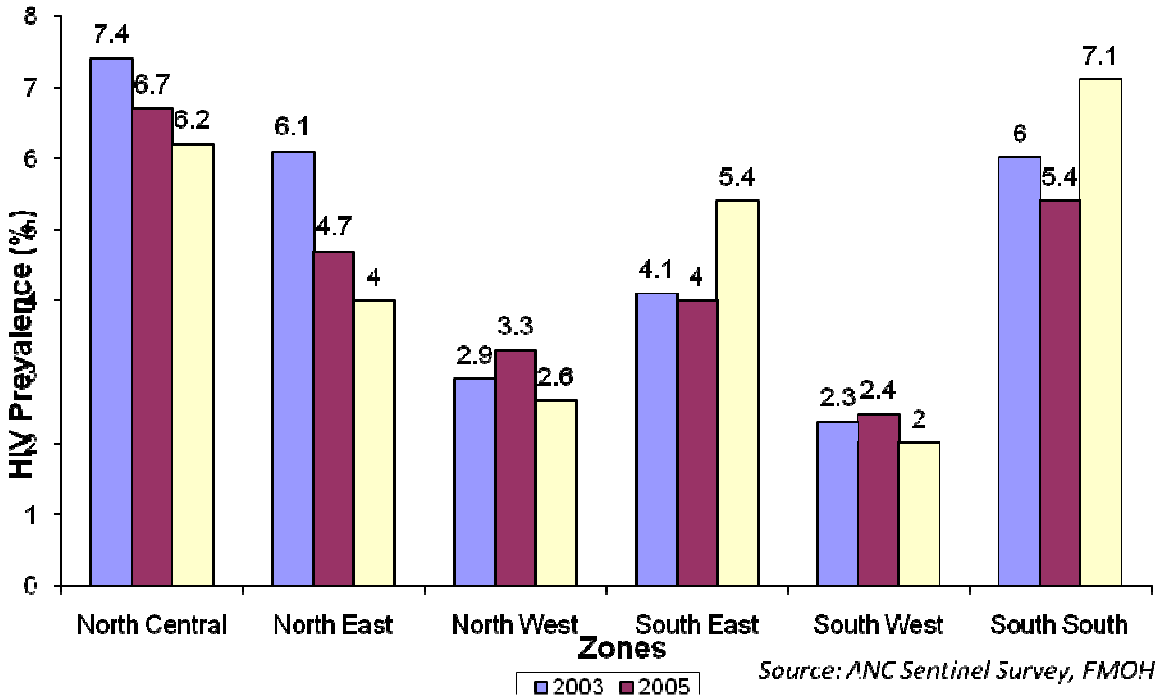
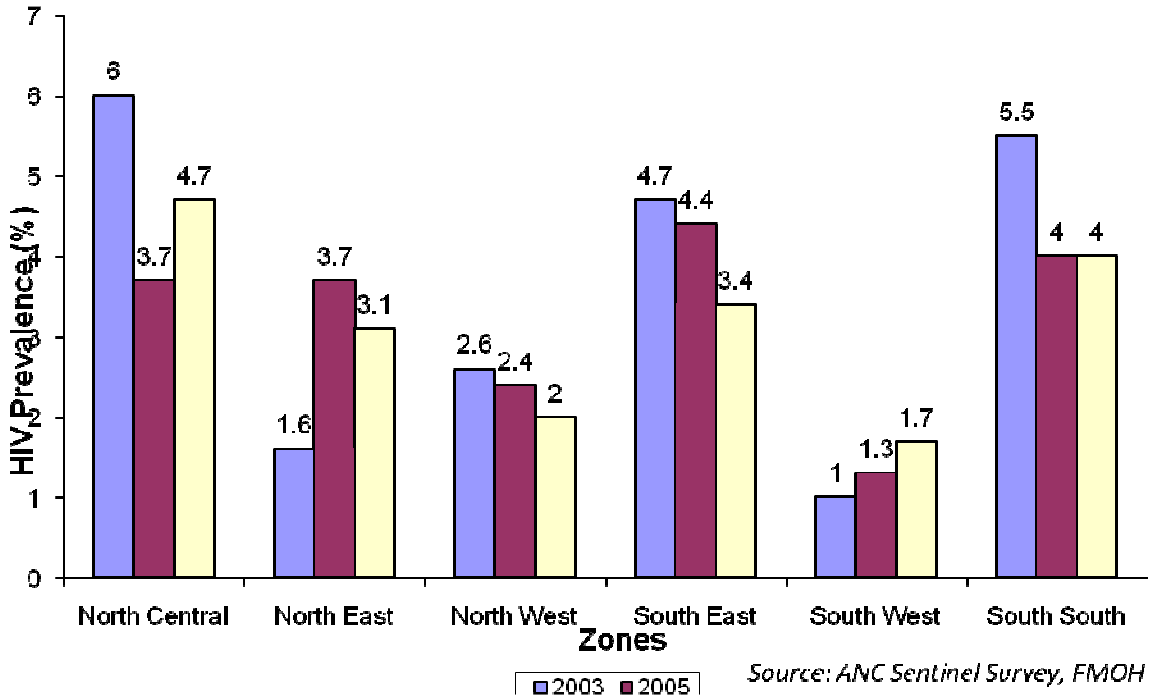


FIGURE 8. Zonal Rural Trend in HIV Prevalence in ANC Surveys from 2003 - 2008



Tables 4 and 5 below show states with high HIV prevalence and states with low prevalence:

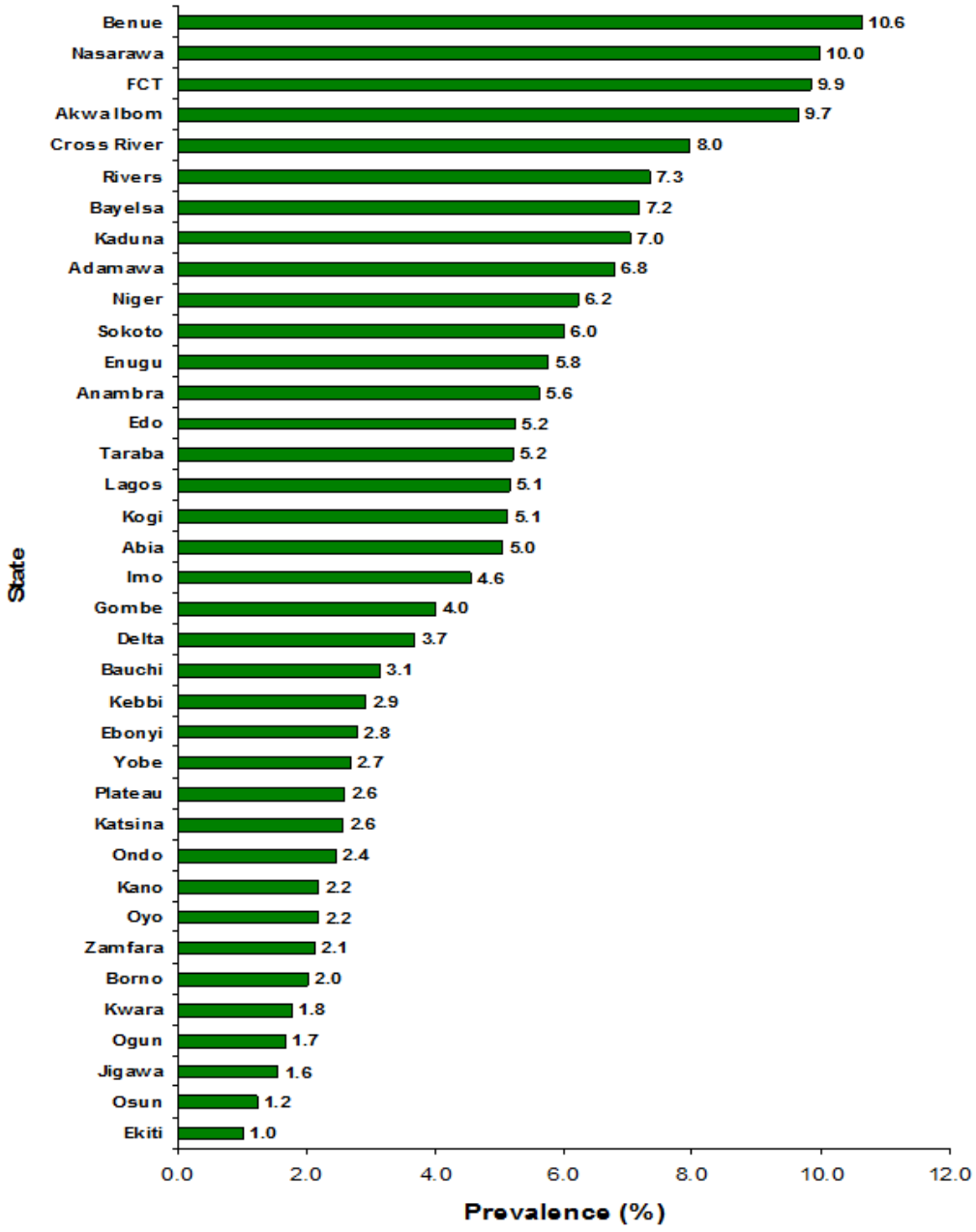
TABLE 5. States with High Prevalence (ANC 2008)

States	**Prevalence rates (%)**
Benue	10.6
Nassarawa	10.0
F.C.T	9.9
Akwa –Ibom	9.7
Cross-rivers	8.0
Rivers	7.3

TABLE 6. States with Low Prevalence (ANC 2008)

States	**Prevalence rates (%)**
Ekiti	1.0
Osun	1.2
Jigawa	1.6
Ogun	1.7
Kwara	1.8
Borno	2.0
Zamfara	2.1

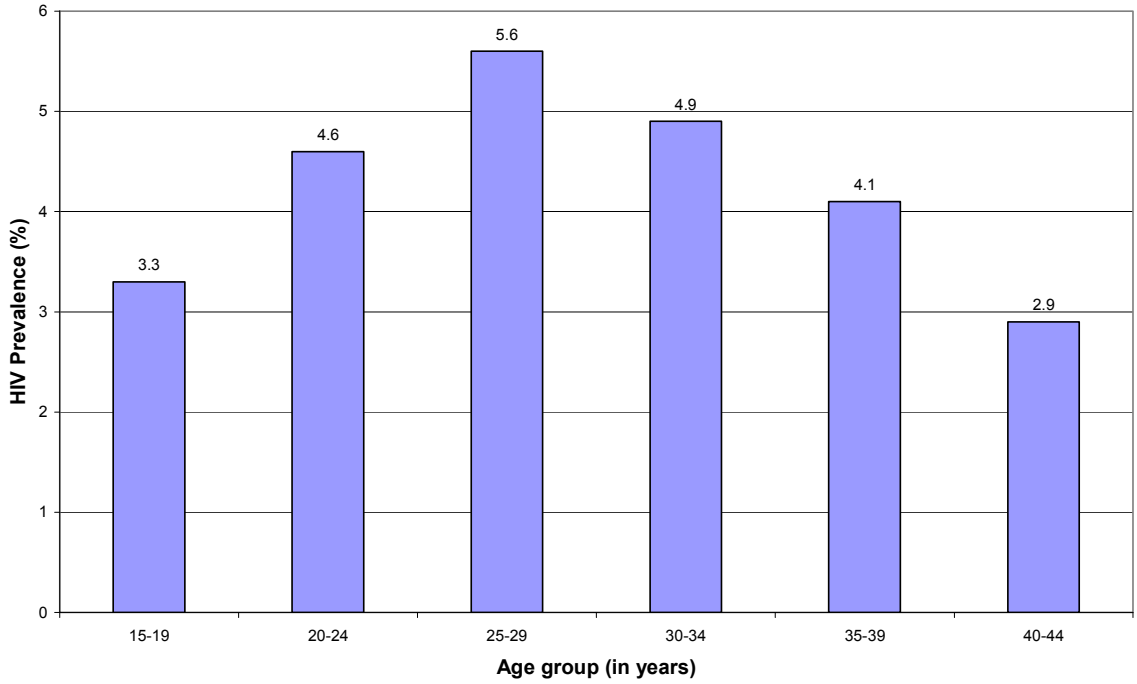
FIGURE 9. HIV Prevalence among Pregnant Women attending ANC by State in Nigeria, 2008



4.2. Prevalence among Different Age Groups

The ANC 2008 survey report shows that age group 25 – 29 years had the highest HIV prevalence with age group 40- 44 years having the lowest prevalence.

FIGURE 10. Prevalence by Age Groups (ANC 2008)



With the current HIV prevalence of 4.6%, it was estimated that the number of people living with HIV at the end of 2010 will be 3.11 million using projections from Estimation and Projection Package (EPP) and Spectrum models.[29] The number of new infections will be 339,016 (males 150,351 and females 186,665); total number that will require antiretroviral therapy will be 910,850 (adults 807,166 and children 103,684). Estimated annual AIDS deaths in 2010 will be 181,774 (males 81,728 and females 100,046). Furthermore, the number of children orphaned by HIV will be about 2.2 million and the number of HIV positive pregnant women will be 243,730.

It is important to note that the national response targets from the Nigerian National Response Information Management System (NNRIMS) Operation Plan 2007 – 2010 are 25% reduction of HIV prevalence; prevention of 55% of new HIV infections and treatment of 550,000 HIV positive people by 2010. Hence, Nigeria is committed to intensifying programs aimed at increasing HIV prevention and treatment efforts.

4.3. Mode of HIV Transmission in Nigeria

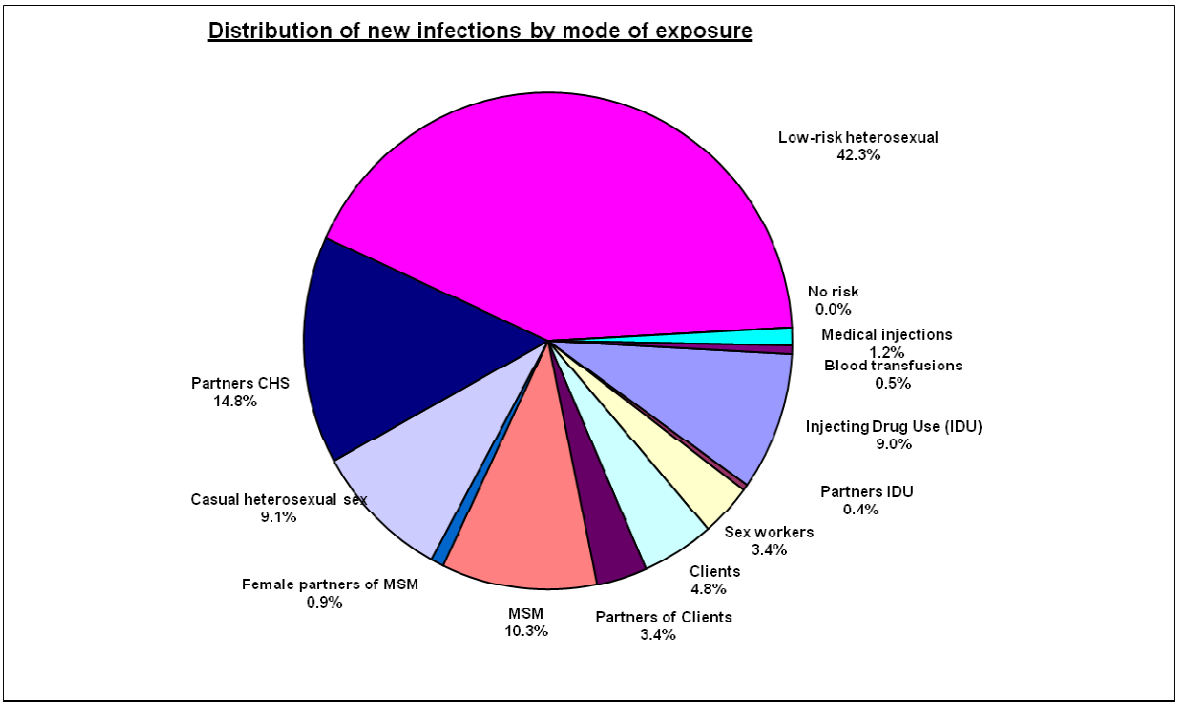
Nigeria undertook modes of transmission (MOT) modeling in 2009. The UNAIDS MOT model was undertaken by the National Country Team, with support from UNAIDS and the World Bank, and was built on the World Bank epidemiology and response synthesis project in Nigeria. The model estimates the distribution of new infections and identifies populations at highest risk for HIV infection.

Moreover, the MOT model has the potential of contributing to the understanding new infections, drivers of the epidemic and ongoing efforts in HIV prevention response in Nigeria among general populations and various target groups. The MOT model can also assist in priority setting for resource allocation towards national prevention interventions, and to strengthen policy, programmatic and research recommendations for national prevention and strategic framework.

The findings from the country MOT model study shows that high-risk groups will significantly contribute to new HIV infections. The high risk groups are about 1% of the general population, and are men that have sex with men, female sex workers and injecting drug users. They will contribute almost 23% of new infections. Also, the high risk groups and their partners will contribute 40% of new infections. However, people practicing low-risk sex in the general population will contribute 42% of the infections due to low condom use and high sexual networking.[33]

[33] UNAIDS 2009 Report: Modes of HIV Transmission in Nigeria: Analysis of the Distribution of New HIV Infections in Nigeria and Recommendations for Prevention

FIGURE 11. Modes of Transmission 2009 Result[37]



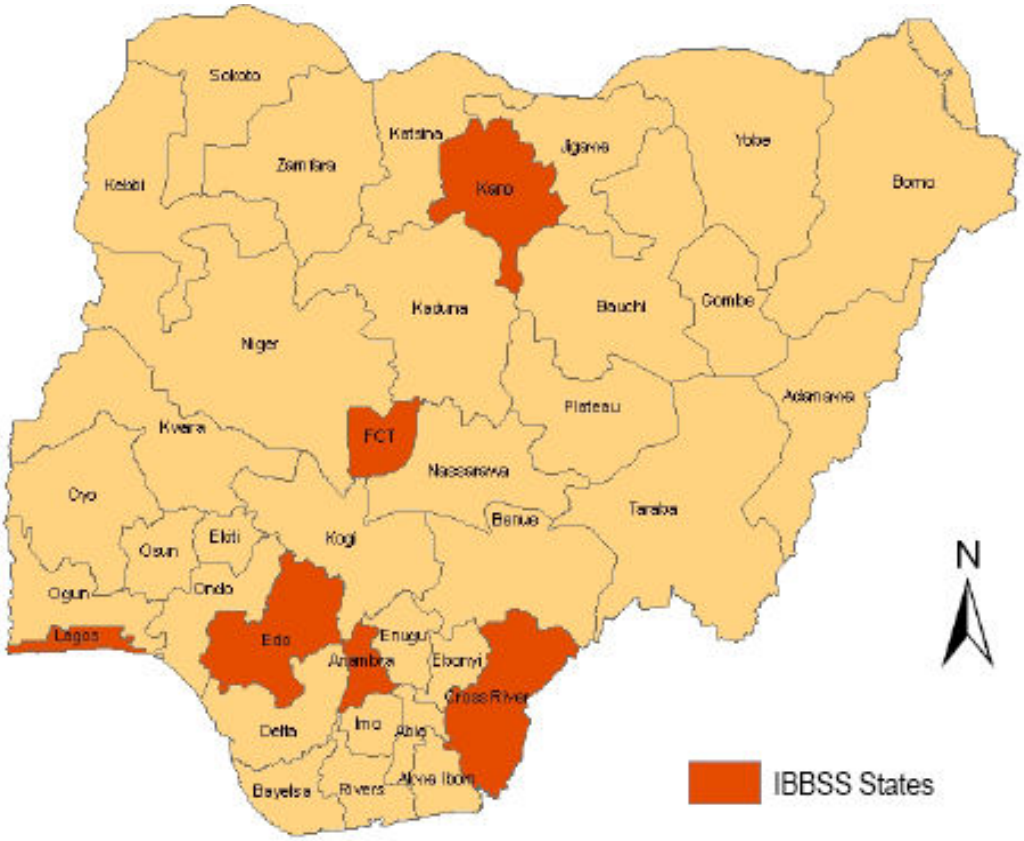
4.4. HIV Prevalence among Most at Risk Population (MARP)

HIV/AIDS Integrated Biological and Behavioral Surveillance Survey (IBBSS) was conducted in 2007 among sub-populations whose behaviors or occupations expose them to higher risk of acquiring or contracting sexually transmitted infections (STI). These sub-groups include MSM, FSW, IDU, transport workers and uniformed service personnel. They are often neglected in prevention programs. The survey was conducted in five states namely: Anambra, Cross River, Edo, Kano, Lagos and the Federal Capital Territory (FCT) with the objectives of obtaining baseline data on risk behavior; determining the prevalence of HIV infection and syphilis; and assessing their knowledge and beliefs about STI.[34]

[34]Federal Ministry of Health (2007) Integrated Bio-Behavioural Surveillance Survey Among Most at Risk Populations in Nigeria. Abuja: National AIDS/STIs Control Programme (NASCP), Nigeria (IBBSS 2007)

Despite decreases in HIV prevalence in Nigeria, new epidemic foci arose among sub-groups often neglected in HIV prevention and control programs.

FIGURE 12. States Covered in IBBSS 2007



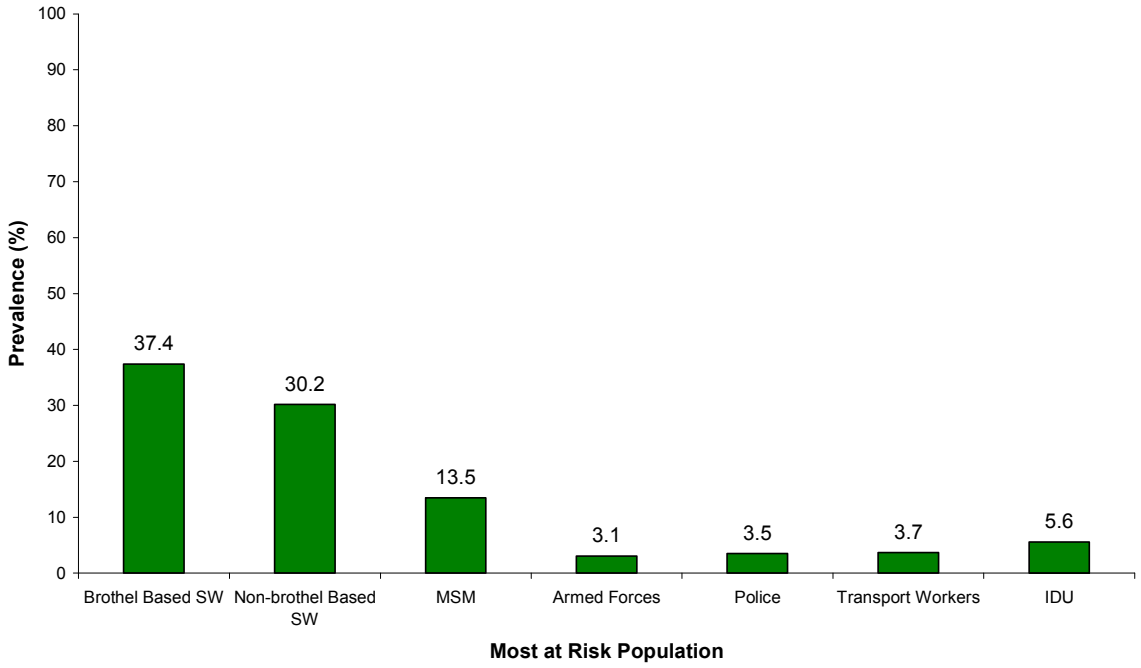
Source: IBBSS Report 2007

HIV prevalence was highest among female brothel-based sex workers (37.4%); followed by non-brothel-based sex workers (30.2%); MSM (13.5%); IDU (5.6%); transport workers (3.7%); police (3.5%) and armed forces (3.1%). Individual-level risks for HIV acquisition and transmission within the sub-populations are critical in the diverse ongoing epidemics and are impacted by social, structural, and sub-population-level risks and protections.[35,36]

[35] Rhodes T, Simic M. Transition and the HIV risk environment. BMJ 2005; 331:220–3

[36] Beyrer C. HIV Epidemiology Update and Transmission Factors: Risks and Risk Contexts—16th International AIDS Conference Epidemiology Plenary. Clinical Infectious Diseases 2007; 44:981–7

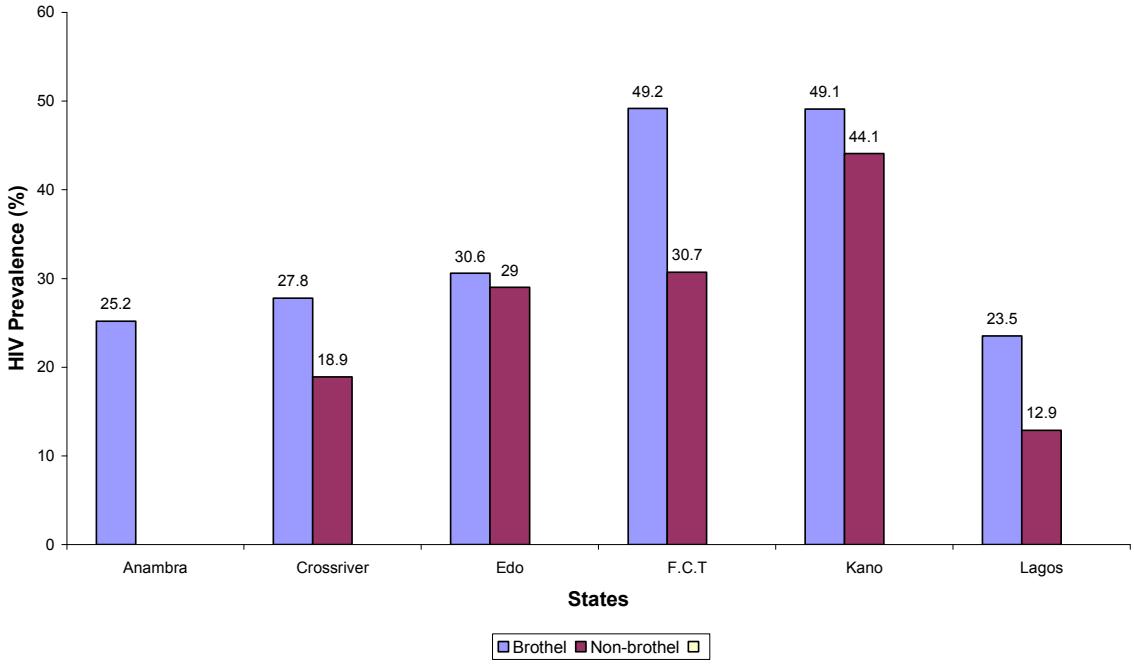
FIGURE 13. HIV Prevalence among High Risk Groups



Female sex workers (FSW) Brothel based and non brothel based.

Female sex workers were the sub-group most affected by HIV/AIDS in Nigeria. The IBBSS 2007 shows different HIV prevalence among FSW in different states. Federal Capital Territory (FCT) and Kano recorded the highest prevalence. In FCT, HIV prevalence was 49.2% and Kano state was 49.1% among brothel-based FSW. Lagos had the lowest prevalence of 23.5% (brothel-based) and 12.9% (non-brothel based), which may be due to the high condom use (98.2% in brothel based and 98.6% among non-brothel based). Alcohol abuse was common among FSW with a quarter or more consuming alcohol daily. However, the survey shows condom use was lower in sexual relationships with boyfriends (38.1% in brothel-based and 46.1% in non-brothel based) and higher among casual partners (83.2% in brothel based and 84.8% in non brothel based) as this is a potential bridge in the spread of HIV to the general population.

FIGURE 14. HIV Prevalence among Brothel & Non-brothel based Female Sex Workers



Source: IBBSS 2007, FMOH

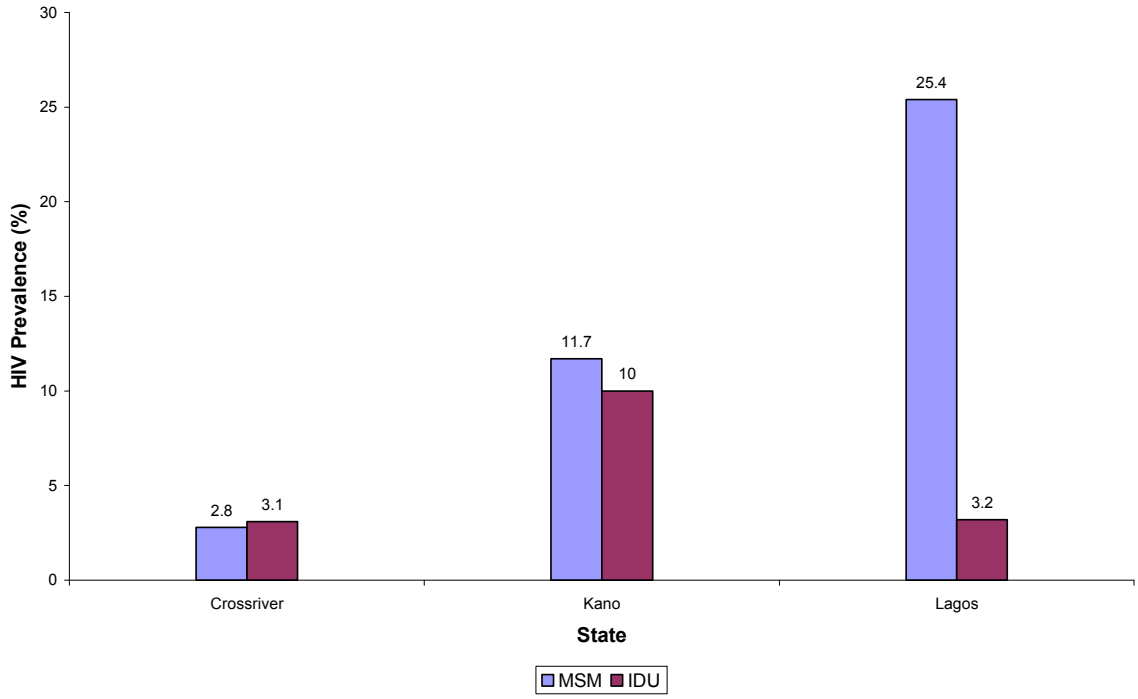
Men that have sex with men (MSM)

Men that have sex with men were surveyed in three states namely: Lagos, Kano and Cross River states. The overall prevalence among MSM was 13.5%. However, there was considerable variation in the three states with Lagos having a prevalence of 25.4%, Kano 11.7% and Cross Rivers 2.8%. The MSM were a younger group compared to other risk groups with about 75% less than 25 years. MSM had high knowledge of HIV prevention. None of the MSM had syphilis. Consistent condom use was lower among MSM than FSW. Similarly, there was a low level of exposure to interventions among MSM with about one quarter receiving safe sex education from peer/outreach workers. Due to low consistent condom use in anal sex and high biological risk of HIV acquisition associated with unprotected anal sex, HIV prevalence may worsen among this group, and spread to the general population since there is MSM sexual networking with their female partners.

Injecting drug users (IDU)

Three states (Kano, Lagos and Cross River) surveyed in the IBBSS 2007 showed that injecting drug users had the third highest HIV prevalence after FSW and MSM. Kano had a prevalence of 10%, Lagos 3% and Cross River 3%. IDUs are mostly younger than members of other sub-groups. About 60% were sexually active in Kano and Lagos. However, IDUs based in Kano showed greater risks of infection as they were injecting drugs more than once a day and less than 40% of them consistently used sterilized injecting needles. About 20% of the IDUs reported sex with FSW and with low condom use. There was a low prevalence of syphilis (1.2%); over five percent of IDUs reported STI symptoms; and about 60% had received HIV education in the past 12 months of the survey.

FIGURE 15. HIV Prevalence by States among IDU and MSM



Source: IBBSS 2007, FMOH

Armed forces/Police/Transport workers

The bio-behavioral survey done among uniformed service personnel and transport workers in certain states in the country showed that there were considerable variations in HIV prevalence.

Table 7 shows HIV prevalence among transport workers and uniformed service personnel for Anambra, Cross River, Edo, F.C.T, Kano and Lagos.

TABLE 7. Prevalence among Armed forces/Police/Transport workers

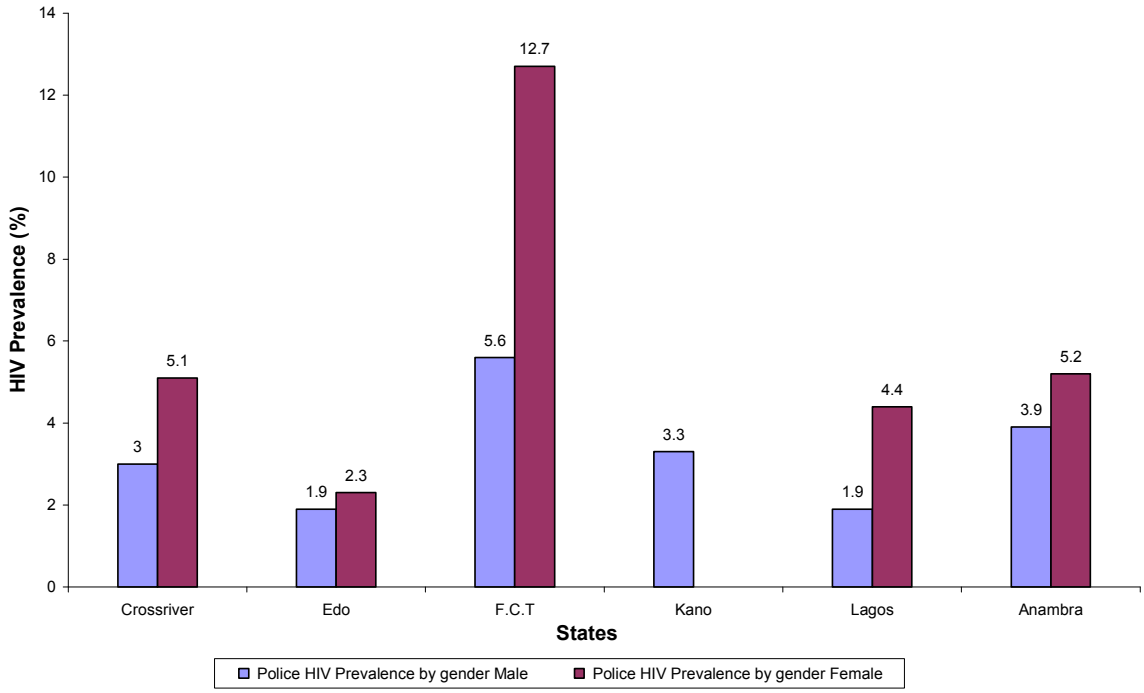
States	Transport workers	Police	Armed forces
Anambra	5.8%	4.3%	7.6%
Cross river	6%	3.9%	3.5%
Edo	2.3%	2%	3.9%
F.C.T	7.2%	7.3%	1.1%
Kano	1.4%	4.4%	3.7%
Lagos	2.8%	2.5%	2.1%

Source: IBBSS 2007, FMOH

Transport workers, armed forces and police had the lowest prevalence of HIV ranging from 3.1 - 3.7% in the IBBSS 2007. These sub-populations engaged in multiple partnerships in the past 12months of the survey with armed forces, police and transport workers having 37.3%, 29.4% and 37.9% respectively.

A sub-analysis by gender among the police force indicated a higher HIV prevalence among women especially in FCT. A more consistent condom use by their male counterparts may be responsible for their lower HIV prevalence.[34]

FIGURE 16. HIV Prevalence by Gender among the Police

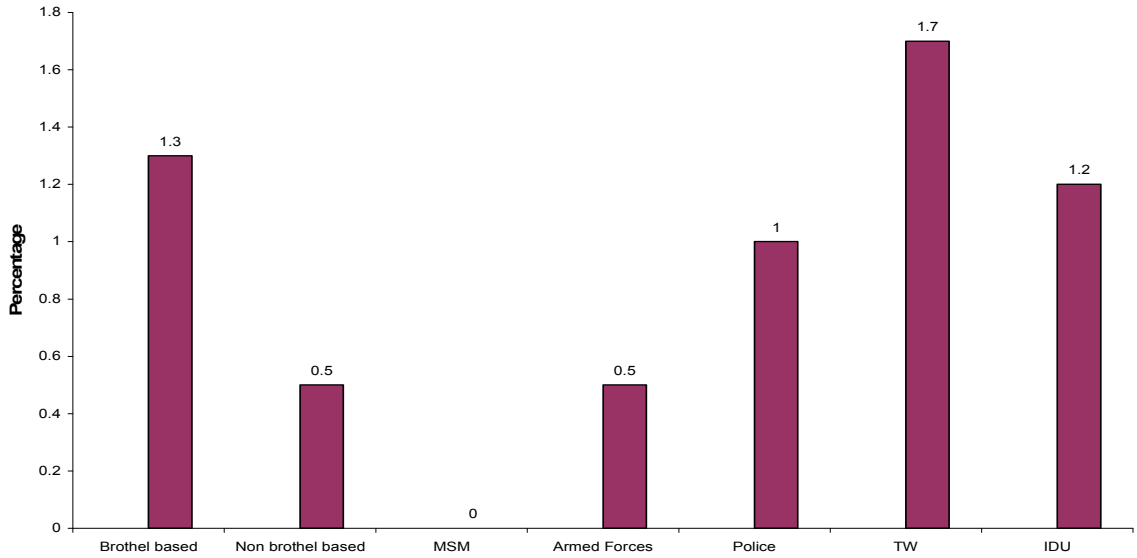


Source: IBBSS 2007, FMOH

Syphilis prevalence

The IBBSS survey indicated a low prevalence of Syphilis. No syphilis was detected among MSM. The prevalence of syphilis was one percent or less among police, non-brothel based FSW and the armed forces.

FIGURE 17. Syphilis Prevalence among MARPs



Source: IBBSS 2007, FMOH

Generally, there is a need to target most at risk populations (MSM, FSW, Transport Workers and Uniformed Service Personnel) with more prevention interventions based on IBBSS and MOT analyses of their contributions to HIV prevalence and where new infections are likely to occur among them and partners/clients.[37]

[37] Pisani E, Garnett G, Grassly N, Brown T, Stover J, Hankins C. Back to basics in HIV prevention: focus on exposure. BMJ. 2003 June 21; 326(7403): 1384–1387.

5. National Response to the HIV/AIDS Epidemic

5.1. Background

Initially, there was a national health sector response to limit the spread of HIV after the first case of AIDS was reported in Nigeria in 1986. However, the advent of democratic rule in 1999 brought the first signs of a strengthened national response, led to the initiation of drastic measures to curb the already increasing spread of the epidemic and move the response from a health centered response to a development-oriented multi-sectoral response.

The adoption of a national multi-sectoral response led to the creation of the Presidential Council on AIDS (PCA) and the National Action Committee on AIDS (NACA) in 2001 to coordinate the activities at the federal level. At the state and local government levels, the coordination was done by the State Action Committee on AIDS (SACA) and by the Local Government Action Committee on AIDS (LACA) respectively to spearhead the state and local multisectoral responses to HIV/AIDS. PCA membership included ministers from all sectors, with the President serving as Chairperson. NACA emphasizes a multisectoral approach to national HIV/AIDS response. Membership includes representatives from Ministries, the private sector, nongovernmental organizations (NGOs) and networks of people living with HIV/AIDS.

NACA with the collaboration of the relevant stakeholders developed the HIV/AIDS Emergency Action Plan (HEAP) in 2001. This served as an interim action plan and it focused on three major areas: creation of an enabling environment through the removal of socio-cultural, informational and systematic barriers to community-based responses; prevention; and care and support. Similarly, NACA developed a National HIV/AIDS Policy to create the enabling policy environment to drive the response against HIV/AIDS and developed guidelines for ART, PMTCT and HCT. The demand for a more comprehensive response which included treatment led to the development of the National Strategic Framework (NSF) in 2005. The development of the NSF was done in collaboration with different stakeholders.

The goal of the National Strategic Framework (NSF) is to reduce HIV incidence and prevalence by at least 25%, and to provide equitable prevention, care, treatment, and support while mitigating its impact among women, children and other vulnerable groups and the general population by 2009.[38]

The NSF goal and objectives have served as a guide towards national response strategic plan and action till date. The NSF has been reviewed and a new six year National Strategic Framework for the period 2010-2015 has been developed to further strengthen the national response.

The NSF strategic plan strictly followed multi-sectoral principle. This involves stakeholder participation such as civil society organizations, network of people living with AIDS (NEPWAN), faith based organizations, line ministries, non-governmental organizations, development partners and the private sector. Also, there has been improved participation of the private sector, civil societies and international partners in the national response.

The multi-sectoral response has led to better resource mobilization and coordination among stakeholders (public, private and the civil societies) in a "*Three Ones Model"* (one national structure, one strategic plan, and one monitoring and evaluation framework).

5.2. Coordinating Structures

The national response is coordinated through a three-tier system of administration led by NACA, SACA and LACA. At the federal level, the National Action Committee on AIDS (NACA) was legally transformed into National Agency for the Control of AIDS through an Act of Parliament in 2007 to give it more autonomy, improve efficiency and accountability. NACA is headed by a board and the responsibility of the board is to provide the following:

[38] National Agency for the Control of AIDS (NACA): National Strategic Framework (NSF) 2005-2009

- Leadership and advocacy for the prevention and control of the HIV and AIDS scourge in the federation; and provide intergovernmental and multisectoral coordination;
- Facilitate the formation and development of national and international partnerships and collaboration for the purpose of enhancing Nigeria's control initiatives on the HIV/AIDS pandemic;
- Facilitate funding for effective dissemination of information and counseling against HIV infection, and care and support for people living with HIV and AIDS throughout the federation;
- Review from time to time the extent of the implementation of the National Strategic Framework on the prevention and control of HIV/AIDS by the Agency (NACA Act 2007).

The chairman and the other members of the board are appointed by the President of the Federal Republic of Nigeria. The members include a representative of relevant ministries, non-governmental organizations and civil society organizations. The National Agency for the Control of AIDS is headed by a Director-General.

5.3. The Public Sector Response

Public Sector Response involves participation of all sectors to limit the spread of HIV by bringing in their competencies and capacities in an effectively coordinated response model.

The Health sector response is led by the Federal Ministry of Health through a sub-body; National AIDS and STI Control Program (NASCP). The core components of its response are in the following;

- Prevention and health promotion
- Treatment and care
- Influencing positive changes in health systems and health standards
- Informed policy and strategic development
- Strengthened health information systems

Prevention and health promotion involves supporting programs that serve to educate the general population and increase awareness about HIV/AIDS. It also promotes safer sex practices among youths, high risk groups and the entire population. This includes community mobilization, HIV sensitization programs, advocacy, promotion of healthy lifestyle, printing and distribution of Information, Education & Communication (IEC) materials. The ministry engages in effective partnership and coordination with implementing partners towards HIV prevention and health promotion in various states.

Treatment and care: Adequate system has been put in place to manage HIV/AIDS, opportunistic infections and sexually transmitted infections. This involves over 300,000 patients on antiretroviral therapy.

Health Sector Strategic Information

The Nigerian government has taken steps by initiating and strengthening the HIV seroprevalence sentinel and bio-behavioral surveys among the general population and most at risk populations. Additionally, monitoring systems have been put in place to monitor the use of financial and human resources. Policies have been made to reduce discrimination and stigmatization of people living with HIV/AIDS. Similarly, there is increasing mobilization of non-governmental organizations, the business sector, the PLWHA and vulnerable groups.

Among the early achievements of the Federal Ministry of Health are the promotion of safer sex behavior, blood safety measures, management and treatment of STI, reduction of HIV transmission through piercing objects like injections and razor blades and establishment of HCT centers. Importantly, its priority intervention was in the following areas:

Preventive interventions for the general population and most at risk populations (MARPS)

These interventions include blood safety procedures, family life and sex education in schools and the training of peer educators, increased availability of condoms and increased services for STI treatment.

Treatment, care and support for people living with HIV/AIDS and people affected by HIV/AIDS.

This has been achieved largely through public sector hospitals and community networks. Public sector hospitals are mainly responsible for the provision of antiretroviral therapy as well as prevention of mother to child transmission (PMTCT) services through counseling and treatment; and the management of tuberculosis and other opportunistic infections.

Line Ministries Response:

There has been establishment of HIV/AIDS responses in all the line ministries for a robust public sector response. This involves support to line ministries to design and implement long term sustainable programs in their respective sectors among their staff in a workplace HIV/AIDS programs and activities targeting their clientele based on the sector's competences.

Critical Mass teams and Project Teams have been established in the line ministries and their parastatals. Line Ministries develop annual workplans in line with national priorities. They have been involved in capacity building, development of workplace policy, peer education by National Youth Service Corps, and development of sectoral strategic plans. Additionally, prison management conducted a situational analysis of HIV in Nigerian prisons in 2009. As a matter of fact, NACA provides technical assistance for the design, planning, implementation and monitoring of Line Ministries' programs.

5.4. The Private Sector Response

Public-Private Partnership Forum was established to leverage the vast pools of private sector resources and competencies as a bridge towards sustainability for the national response. For example, through Nigeria Business Coalition Against HIV/AIDS (NIBUCCA), 39 multi-national companies, such as MTN, Coca- Cola, Julius Berger, Nigerian Breweries, Cadbury, Guinness and Chevron supported workplace programs including prevention, treatment, care and support. In addition, companies supported outreach programs to the public using their Corporate Social Responsibility portfolios either directly or through partnerships with local organizations.

Examples of achievements in this regard include:

- NACA's partnership with ECOBANK to establish seven youth friendly reproductive health centers in eight universities to provide AIDS information and counseling services, training of youths peer educators, and HCT.

- MTN Foundation is an emerging creative model of comprehensive corporate contribution to HIV/AIDS prevention. This partnership involves economic empowerment for women, skills acquisition and capacity building of peer educators.

- Zain, a telecommunication service provider supports 20 toll free phone lines for HIV/AIDS information services provided by an NGO which has served over 100,000 callers.

- Partnership between NACA and LNG, SHELL and Exxon-Mobil provides comprehensive prevention, treatment, and care and support worth over N500million in Niger Delta communities through the IBANISE ART program.

- Technical assistance provided to 29 companies to develop workplace policies and HIV/AIDS interventions by AED/SMART WORK program.

- NIBUCCA provided technical assistance to trade/workers unions to develop HIV/AIDS programs.

Challenges to Private Sector Response:

- The scope and engagement of companies in the private sector response remains limited to multinationals. Small and Medium Enterprises remain largely unengaged in HIV/AIDS activities particularly in the states.

- Limited or insignificant private sector response in many states. Evidently, HIV/AIDS is not recognized as priority issue by some companies.

- Workplace stigma and employment discrimination against PLWHA remains a major challenge in private sector settings

5.5. Civil Society Participation in the National HIV Response

Civil Society Organizations (CSOs), Faith Based Organizations (FBOs) and community leaders have valuable roles in preventing new infections and mitigating the impact of HIV in Nigeria. Civil society encompasses such organizations as local and international nongovernmental organizations, community-based organizations, community development associations, Faith-Based Organizations, support groups for people living with HIV/AIDS (PLWHAs), professional associations and trade unions.

Civil Society Organizations have taken a center stage in the prevention and control of HIV/AIDS in Nigeria, and have made their marks during the last two decades. The unique strength of CSOs is their ability to provide platform to evaluate, challenge and strengthen government policies so that the policies could be culturally appropriate to the people and communities. Their use of participatory approaches and integration with communities place them at a vantage point to be able to tackle the social and cultural determinants driving the epidemic. Consequently, CSOs have been involved in community engagement to limit the impact of HIV/AIDS. CSOs are adept at uniting the underprivileged and marginalized people in the society, building their capacity and promoting their social inclusion. Nigeria has a flourishing CSOs participation in HIV/AIDS prevention. They have served as a source of social capital and network across many Nigerian communities. The emergence of the Civil Society Consultative Group on HIV/AIDS in Nigeria (CISCGHAN) in 2000 provided the first opportunity for local CSOs to provide coherent input to Nigeria's HIV/AIDS policy formulation and implementation. CISCGHAN coordinates, facilitates, advocates and ensures the needs and issues of CSOs working on HIV/AIDS are addressed. CISCGHAN also provides a coordinated input into the national response to HIV/AIDS epidemic.[24]

Additionally, CISCGHAN is engaged in the consultation process of the World Bank Multi-Country AIDS program (MAP) to ensure that the program implementation

manual for the World Bank HIV/AIDS Fund (HAF) reflected the needs of CSOs. Thus, CSOs are important players in HIV/AIDS program implementation in Nigeria. CSO are involved in various programs such as prevention, treatment, care and support, and institutional capacity building. Similarly, international NGOs working with and through local CSOs manage more than 70% of the program interventions in the country.[24] CSOs have contributed immensely in the areas of research and surveillance among the general populations and most at risk populations such as National HIV/AIDS and Reproductive Health Survey and Integrated Biological and Behavioral Surveillance Survey.

TABLE 8. Major Programs and Implementing Agencies in Nigeria

Program	**Description**	**Agencies**	**Total Amount**
World Bank Multi-Country AIDS program	Resources to both public sector and CSO for the national HIV responses	Funded by the World Bank; implemented by the National Program Team (NPT)	US$90.3 million for 2002-2006
Promoting Sexual and Reproductive Health and HIV/AIDS Reduction (PSRHH)	Major prevention program targeting most at risk populations and young people; provides research capacity for the national HIV response	Funded by DFID and USAID; implemented by Population Services International, Action Aid and the Society for Family Health	Approximately US$ 90 million
Nigeria AIDS Response Fund	Funds CSOs response to HIV/AIDS, with a special focus on gender	Funded by CIDA; implemented by Pathfinder International	Can$4.8 million for 2004-2008
Policy Project	Public sector policies in	Funded by USAID and implemented	US$6.155 million for 2000-2004

	reproductive health and HIV/AIDS in Nigeria	by the Futures Group's Policy Project	
AIDS Prevention Initiative in Nigeria (APIN	Provides sero-surveillance for HIV and other STIs, scale-up prevention interventions among high-risk groups, conducts research, builds laboratory capacities, funds CSO interventions and supports government policy responses	Funded by the Bill & Melinda Gate Foundation and implemented by the Harvard School of Public Health	US$25 million for 2001- 2005
DFID Nigeria HIV/AIDS Reproductive Health programs	Over seven years of DFID commitment to HIV/AIDS	Multiple implementing organizations such as PSRHH, Strengthening Nigeria Response (SNR), and Partnership for the Transformation of Health Systems (PATHS)	£81.5 million (US$123 million) for 2001-2008
USAID program	Handles proposals and selection of implementing	Implementing partners are selected after a bid	More than US$82 million for 2004-2009 (US$99

	partners for funding	process	million in related sectors, reproductive health, maternal and child health, and enabling environment)
Global Fund for AIDS, Tuberculosis and Malaria	PMTCT program; promotion of CSO participation in the HIV/AIDS response; the national antiretroviral program	National Action Committee on AIDS and Yakubu Gowon Centre	US$28 million for 2004-2005

Source: *AIDS in Nigeria: A nation on the Threshold Edited by Adeyi O, Kanki P et al*[24]

Achievements of CSOs[24]

CSOs have made outstanding contributions to Nigeria's HIV/AIDS prevention efforts such as:

1. **Enhanced Program Capacity:** HIV program interventions by the CSOs have resulted in an increase capacity for program implementation, and have greatly increased the CSO capacity for influencing policy and networking.
2. **Involvement in Policy Development:** The outcome of civil society mapping exercise by ActionAid in 2001 indicated that most CSOs were observed to be program implementers only. However, the emergence of CISCGHAN and the development of the HEAP strategy gave the CSOs opportunity to be formally involved in influencing policy in Nigeria.
3. **Collaboration and Networking:** There has been increased collaboration by the CSOs in sourcing for funding and implementing programs.
4. **HIV Information flow:** HIV information flow has greatly improved as a result of involvement of CSOs in reaching several Nigerians using internet-

based information sharing portals such as the Nigerian e-forum coordinated by Journalists against AIDS.

5. **Partnership with Government Agencies and the Private Sector:** Partnership of CSOs with government agencies and the private sector has increased over the years. The government and private sectors have recognized the competence of CSOs and value their contribution to the national response.
6. **Program Implementation and Research:** CSOs have shown leadership in program implementation and research. Quite a number of HIV program interventions in Nigeria are being managed by international NGOs working with local counterparts. Such programs include the Nigeria AIDS Responsive Fund project funded by Canadian International Development Agency and implemented by Pathfinder International; UNICEF programs; and USAID funded POLICY project of the Futures Group.

CHALLENGES

Despite the achievements of CSOs in Nigeria, there are a number of challenges militating against their successes. Some of these challenges are:

1. **Limited Institutional Capacity:** There is a need to build not only technical capacities of CSOs but also institutional capacities so as to improve greatly in effective program delivery, monitoring and evaluation.
2. **Poor Documentation:** Dearth of proper documentation of programs implemented by CSOs is another challenge in Nigeria. Skills for documentation are weak with lack of an effective project monitoring system. CSOs need to improve in the areas of documenting programming lessons, best practices, experiences and successes.
3. **Donor Driven Agenda:** Funding for HIV/AIDS in Nigeria is mainly from international donors. CSOs have no choice but to conform to donor driven agendas which may not necessarily solve immediate community needs.
4. **Poor Resource Mobilization:** Ability of CSOs to source and mobilize resources has been a challenge. There is a need for improved in-country resource mobilization from government and private sector.

Finally, without doubt CSOs have played a significant role in Nigeria's national response to the HIV/AIDS epidemic since 2000. Their contributions have improved

the quality of programming and capacities to effectively manage HIV/AIDS with good results. The multi-sectoral approach adopted by the Nigerian government in its HIV/AIDS program has provided conducive and reasonable environment for CSOs interventions to be implemented in all the states.

Progress Report:

Nigeria had gone through various stages over the years in the control of HIV epidemic. The stages include the period of denial of the existence of HIV, followed by accepting the existence of HIV infection and employing effective measures to reduce new infections in the country. The efforts have over time recorded a progressive reduction in HIV prevalence. HIV prevalence was 1.8% in 1991, 3.8% in 1994, 4.5% in 1996, 5.4% in 1999 and 5.8% in 2001. Thereafter, a decline was noticed as the prevalence dropped through 5.0% in 2003 to 4.4% in 2005 and currently stabilized at 4.6%. HIV epidemic in Nigeria is characterized by one of the most rapidly increasing rates of new HIV cases in West Africa.[39] This infection rate, although lower than that of neighboring African countries, should be considered in the context of Nigeria's relatively large population. It was estimated that 3.11 million Nigerian adults and children will be living with HIV/AIDS by the end of 2010 from the HIV estimates and projection models.[40]

Besides, educational attainment of young women in Nigeria has increased in all parts of the country since 1990, but levels and trends vary widely across regions or geopolitical zones. Although use of modern contraceptives among sexually active female adolescents has increased in most parts of the country but remains extremely low. Nationally, the proportion of people aged 15-49years using modern contraceptive methods increased from 4% in 1990 to 9% in 2009.[10] Even so, it is far higher in the South-South and South West (26–39%) than in other zones. About 30% of sexually active women aged 15–24years had an unmet need for modern contraceptives.[41]

[39]HIV/AIDS in Nigeria: A USAID Brief
http://pdf.usaid.gov/pdf_docs/Pnacq945.pdf (Accessed January 30, 2010)
[40] Federal Ministry of Health (2010) Technical Report on the 2008 National HIV/Syphilis Sero-prevalence Sentinel Survey Among Pregnant Women Attending Antenatal Clinics in Nigeria. Department of Public Health National AIDS/STI Control Programme. Abuja: Nigeria.
[41] Sedgh G et al. Meeting Young Women's Reproductive and Sexual Health Needs in Nigeria. New York: Guttmacher Institute, 2009.

Government policies and strategies promoting the sexual and reproductive health of young people in Nigeria have not been successfully carried out. Hence, international, national and local nongovernmental organizations are implementing programs to promote the reproductive health of Nigerian youth. Improving the sexual and reproductive health of young people will require effective leadership, coordination of efforts; consultations with relevant stakeholders; financial commitment on the part of the federal and state governments; and understanding various religious, socio-cultural, familial and educational issues associated with youth adolescent health in Nigeria.

Similarly, NACA has made great progress in strategic areas over the years. These areas include the following:

- Securing an increased ownership of the HIV program at all levels and sectors
- Raising awareness about HIV/AIDS in the country, and discouraging against stigma and discrimination
- Developing a formidable multisectoral national response
- Engaging relevant stakeholders and development partners in meaningful partnership towards reduction of new infections and providing adequate support for treatment, care and support.
- Institutional strengthening/capacity building at the national and state levels
- Strengthening collaborations across Nigeria among civil society organizations including private sector, women coalition, religious bodies and youths
- Developing agenda for prevention, treatment and care interventions
- Strengthening of the monitoring and evaluation systems using databases such as NNRIMS, LHPMIP and DHIS at national and state levels

- Strengthening resource mobilization and allocation of resources

- Strengthening analytic work to support evidence generation for policy and program decision making

6. Best Practices

The Nigerian leadership has shown commitment to reducing the impact of HIV epidemic. In this regard, the government has worked carefully to formulate new policies; create enabling environment and provide effective leadership to combat HIV epidemic while ensuring a healthier Nigeria. Although HIV/AIDS was first discovered in 1986, sentinel survey results showed that HIV prevalence increased from 1.8% in 1991 to 5.8% in 2001, and in 2005 when the first downward estimate was recorded at 4.4%.

The political environment in Nigeria has progressively been favorable towards the AIDS response. The emergence of democratic rule in 1999 brought increased political commitment at national, state and local government levels. There has also been significant increase in government budgeting and disbursements to AIDS expenditures at the national level and in line with this, the National Economic Council in March 2007 directed all states to ensure that a minimum of 1% of their annual budgetary provision is dedicated to HIV and AIDS programming in their respective Ministries.

Due to religious and socio-cultural peculiarities of the drivers of HIV infection in the country, the strategy of advocacy has been utilized to increase the commitment of political and religious leaders towards strengthening the established State and Local Agencies for the Control of AIDS (SACA and LACA). This effort is being led by NACA, and has the sustainable structure to be relied upon at each state and local government of the federation.

Similarly, Nigeria has followed suit in the formation of the Global Coalition of Women and AIDS by establishing and inaugurating National Action for Women Coalition and AIDS (NAWOCA) with state chapters already inaugurated in some states of the federation. NAWOCA addresses the vulnerability of girls, women and children through increased access to information and education on prevention, treatment, care and support for HIV and reproductive health services.

Following the trend of event the National Economic Empowerment and Development Strategy (NEEDS) was established in 2003. One of the goals of NEEDS is to control the spread of HIV/AIDS in Nigeria, provide equitable care and support for those infected with HIV/AIDS and mitigate its impact to the point – where it is no longer of public health, social, or economic concern. The policy aims to create an environment in which all Nigerians will be able to live socially and economically – productive lives free of the disease and its effects.[42]

The following are Government policies under the NEEDS program:

- Reduce the disease burden attributable to HIV/AIDS and other opportunistic infections.
- Ensure the mainstreaming of HIV/AIDS issues into every sector (HIV/AIDS epidemic is more of a development issue than a health issue).
- Improve physical and financial access to good quality HIV/AIDS treatment, care and related health services.
- Improve its stewardship over policy formulation on HIV/AIDS, related Legislations, regulations, resources, mobilization, coordination, monitoring and evaluation.
- Foster effective collaboration and partnership necessary for mitigating the impact of HIV/AIDS.[43]

NEEDS projected that HIV prevalence would drop annually by 0.2% in 2003/2005. But the sentinel surveys in 2003 and 2005 show a decline of prevalence by 0.3 per cent. HIV/AIDS epidemic requires a developmental, holistic, coordinated and multisectoral approach of which NACA has provided. The strong political commitment of Nigerian leadership to fight HIV/AIDS served as a powerful catalyst and motivator for establishing a supraministerial and multisectoral body, the National Agency for the Control of AIDS (NACA). A national policy on HIV/AIDS was launched in August 2002 to give policy direction and to make a policy statement on the transformation of NACA from a Committee to a full-fledged agency that is well

[42] National Economic Empowerment and Development Strategy (NEEDS)

[43] 2006 HIV/AIDS in Nigeria National Planning Commission

positioned and poised to scale-up the fight against the epidemic. Hence, NACA is committed to the following:

- To limit the spread of HIV/AIDS through advocacy, information and education campaigns.
- To focus on the treatment and care for people living with HIV/AIDS, which is a top national priority.
- To break down barriers to HIV prevention and support community based responses.
- To promote the development of HIV/AIDS workplace policy in public and private sectors

PREVENTION

The National HIV/AIDS Prevention Plan (2007-2009) has been developed to ensure the scale-up of implementation of prevention activities at all levels in the country.

In order to reduce the spread of new infections especially among the youths in school, NACA in collaboration with Federal Ministry of Education facilitated the development and implementation of Family life HIV/AIDS education program in the country. Reports collected from schools in Nigeria in 2009 showed that 23% of all public secondary schools are teaching family life HIV/AIDS curriculum.

Most at risk populations (MARPs) such as female sex workers and their clients, men that have sex with men, uniformed service personnel and transport workers have continued to receive increased attention from the national response in a bid to reduce the spread of HIV/AIDS among these sub-groups, and between the groups and the general population.

Prevention efforts among the MARPs are yielding encouraging results. In 2007, 30% of these most at risk groups took HIV test and received their results,[38] which is higher than the general population of about 10%.[35] Also, 50% of these groups were provided with a minimum package of prevention program while 92% of sex workers reported using condom with their clients. Intensified behavior change activities, community

mobilization and advocacy at all levels have continued to produce significant impact on the epidemic.

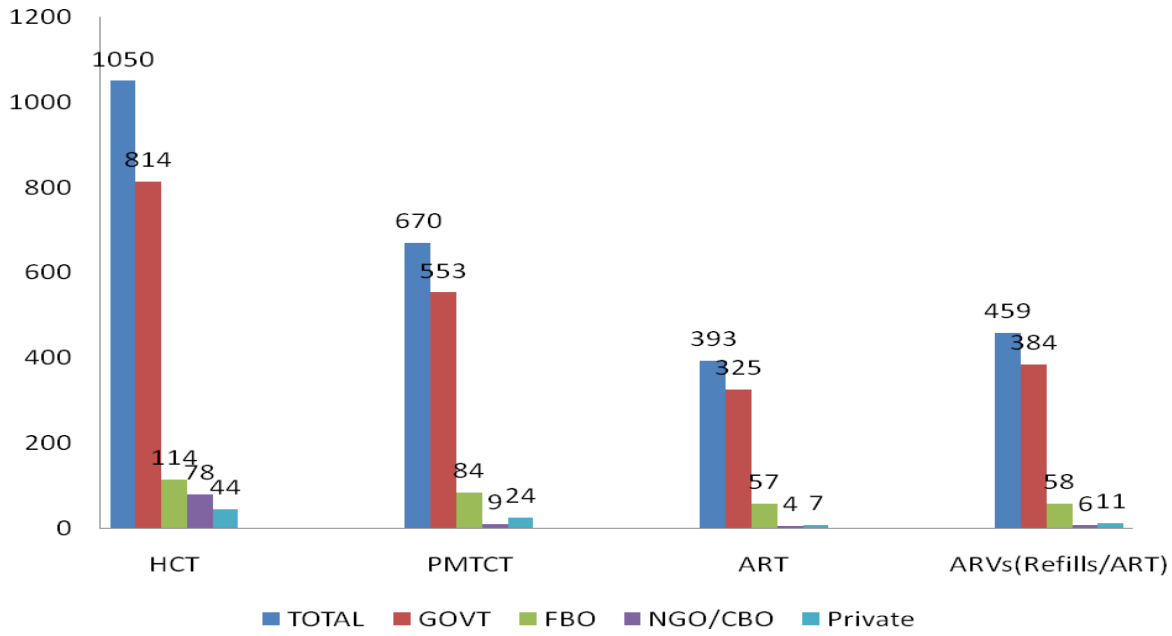
The model of public-private partnership is one of the best practices to show corporate contributions to the HIV/AIDS response. For example, NACA-MTN FOUNDATION collaboration addresses:

- Economic empowerment through skills acquisition and provision of telephones as micro enterprise credit to PLWHA in rural areas.
- Establishment of youth friendly centers in three universities in collaboration with NGO, Hope Worldwide.
- Touch Screen Program—12 machines located at strategic locations providing HIV information services in three main language and Pidgin English.
- Peer Education training for over 3,000 youths and 60 teachers.

SCALE UP OF TREATMENT PROGRAMS

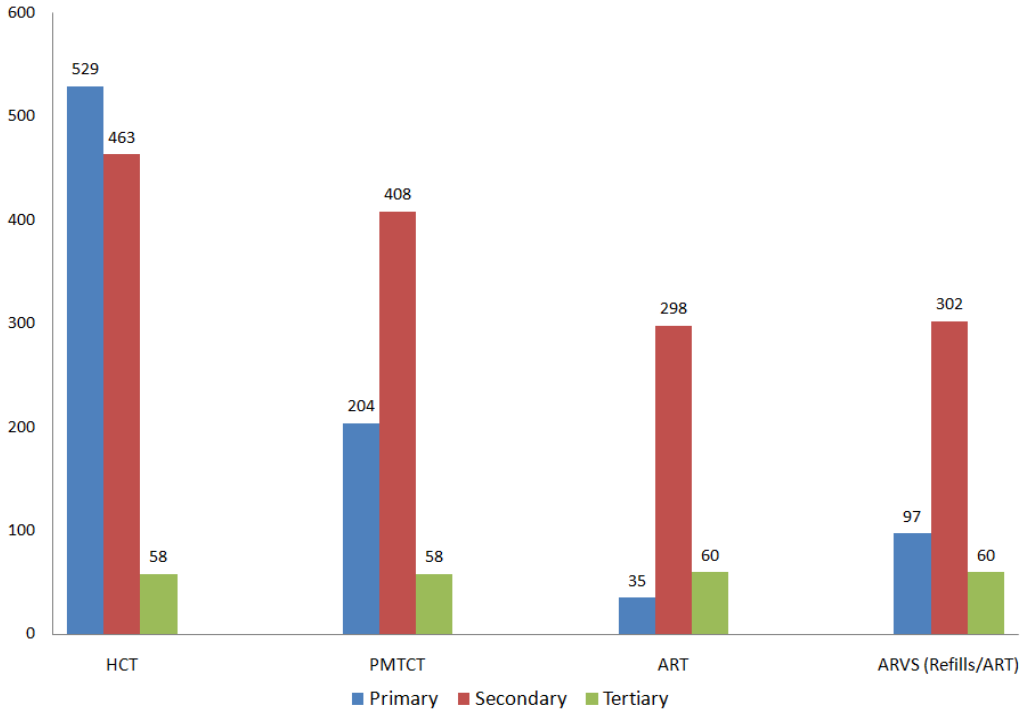
There is an ongoing scale up of ART, PMTCT and HCT services in public, private and faith-based institutions across the country. As at March 2009, there has been scale-up of ART, PMTCT and HCT to 393, 670 and 1050 sites respectively in Nigeria, from an initial 20 sites in 2002.

FIGURE 18. Site Distribution by Ownership



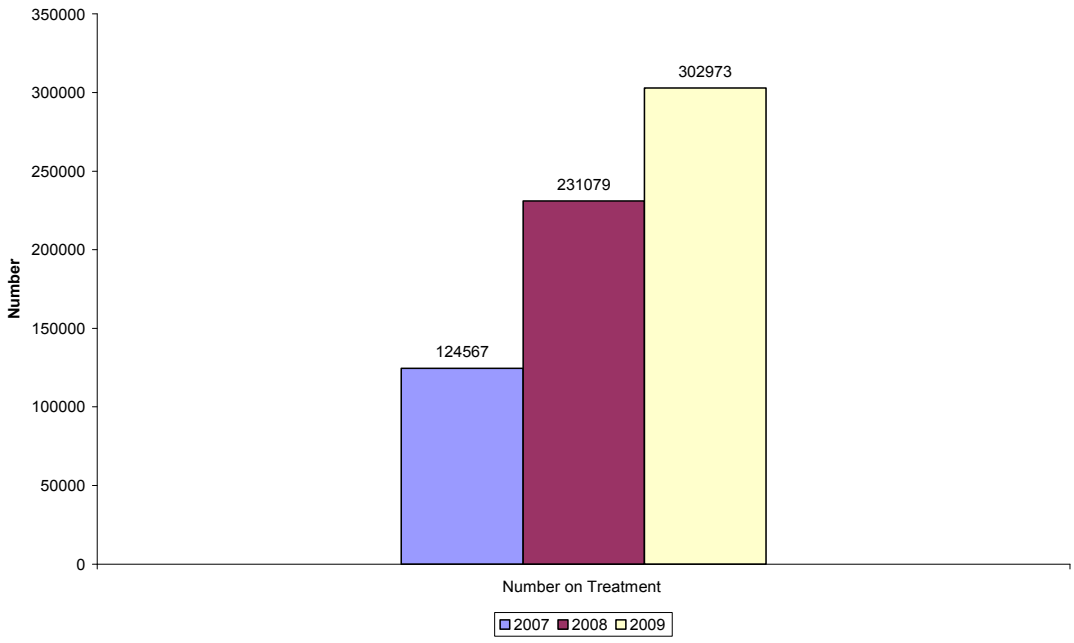
Source: FMOH 2009 (HIV/AIDS Division)

FIGURE 19. Site Distribution by Level of Care



Source: FMOH 2009 (HIV/AIDS Division)

FIGURE 20. Number of PLWHA on ART from 2007-2009



Free antiretroviral (ARV) provision policy in 2006 has led to increased access and uptake. Annual number of clients on ART has increased from 50,581 at inception of

ARV provision in Nigeria in 2005 to 302973 in 2009. The contributions of the PEPFAR program within the country and the Global Fund Round 5 support have also played a significant role in the scale up of ART services in Nigeria.

Moreover, increased uptake of ARV drugs in Nigeria is prolonging and improving the quality of life of HIV/AIDS patients in the country. For instance, the survival data of 2009 shows that about 70% of adults and children that were on treatment are still alive and healthy after 12 months.

STRATEGIC PLANNING AND POLICY FORMULATION

Nigeria developed a National Strategic Framework, which was put in place as her first multi-sectoral strategic plan. Given the federal nature of Nigeria, the states have also developed states' strategic plans, which derive from the principles of the national strategy. The different sectors including the Health, Education, Youth, and Women Affairs have also established strategic plans which are providing templates for implementing their various responses. The life span of the strategic framework is five years and, it was reviewed at its midterm in 2007. The outcome of the review has provided information for a two-year evidence-based national priority plan for implementation. Three outstanding features of note in the priority plan are the need to deepen interventions in the prevention arena, re-strategize behavior change communication (BCC) systems and provide greater care for orphans and vulnerable children.

Thus, NACA has evolved a national prevention plan and is currently reviewing the BCC strategy in order to address the emerging challenges. The OVC strategy and plans are also being strengthened. In addition to these policy initiatives and given the dynamics of the global response to the epidemic, HCT, PMTCT and treatment guidelines have been reviewed. The activities have all been achieved through a deliberate inclusion and active participation of all stakeholder groups at national, state and local government levels.

7. Accomplishments, Challenges and Remedial Actions

Despite the fact that Nigeria has made good progress in the response to HIV/AIDS over the years, there still exist gaps that challenge the national response. The country has risen to the HIV/AIDS challenge with a determination to overcome the fight.

It is important to note some of the achievements recorded by the country in response to HIV/AIDS[44]:

- Increased awareness about HIV/AIDS in the general population and significant efforts in reducing stigma and discrimination. The legislation on anti-stigma and discrimination is at an advanced stage.
- Nigeria has established a vibrant multisectoral response to the epidemic.
- At the end of 2009, over 300,000 persons have received ARV treatment therapy in over 400 centers spread across the country
- The increased availability of antiretroviral therapy through the Federal Government free ARV policy has led to better quality of life for people living with HIV/AIDS
- NACA and SACA (in 21 states) have become autonomous legal entities (agencies) and are strongly committed to mitigating the impacts of HIV at federal and state levels
- There is implementation of HIV/AIDS programs in 28 Federal Ministries Departments and Agencies (MDAs)
- State responses have been established and it is functional in 36 states and FCT
- Nigeria has established a vibrant multisectoral response to the epidemic.
- Involvement of major development partners and relevant stakeholders has expanded response and funding to all states
- Grants are given to key institutions to strengthen HIV/AIDS responses at federal and state levels.
- Approval by the National Economic Council that all states establish an AIDS agency with appropriate budgetary allocation for HIV/AIDS.

[44] NACA: Status of the HIV National Response in Nigeria

- Strengthening and increasing support for stakeholders (civil society, private sector, women, youth & religious leaders) in effectively implementing multisectorial national response
- Setting agenda in terms of key priorities (e.g. Prevention, Treatment, and OVC).
- Creating key strategic document and guidelines for program management (NSF, NNRIMS, Prevention strategy).
- Developing and strengthening national M&E systems (NNRIMS, LHPMIP & DHIS)
- Increased funding for HIV/AIDS programs at all levels and sectors
- Involvement of CSOs in the national response through increased support for their networks
- Scale-up of treatment, prevention, care and support programs with increasing number of ART, HCT and PMTCT sites
- Establishment of Women Coalition on HIV/AIDS (NAWOCA) at national and in all states of the federation.
- Drop in HIV prevalence among youths from 4.3% in 2005 to 4.2% in 2008.[28]
- NACA in collaboration with FMOE facilitated the development and implementation of Family life HIV/AIDS education in the country. Reports collected from schools in Nigeria in 2007 showed that 34% of all public secondary schools are teaching family life HIV/AIDS curriculum in Nigeria. This has served to increase awareness among school children and youths and subsequently contributed to reducing the spread of new infection especially among the youths in school.
- Increased attention has been given to most at risk populations in Nigeria, especially among commercial sex workers and their clients, men having sex with men, uniformed men and migrant workers.
- At the end of 2009, more than 63,457 orphans and vulnerable children received free external support in form of school fees and materials, health care and foods. These activities were implemented to reduce the impact of HIV/AIDS among children.
- Active involvement of CSOs in the national response through increased support for CiSHAN, NEPWHAN, NYNETHA and NFACA (National Faith-Based Advisory Council on AIDS).

Despite these achievements, the country needs to work hard to overcome the following challenges such as:

- Inadequate funding and coordination of HIV prevention, treatment, care and support which is not commensurate with the scale and complexity of HIV epidemic in Nigeria
- Over-dependence on donor support
- Weak political and financial commitment at state and LGA levels
- Poor coordination of research efforts
- Coverage and quality of PMTCT in Nigeria is poor (UNGASS indicator 25: percentage of infants born to HIV-infected mothers who are infected in 2009 was 13.1%)
- Limited knowledge of the drivers of the epidemic
- Low risk perception among policymakers and general population
- Limited use of HIV/AIDS evidence-based information to support government policies
- Inadequate supportive legislation for national and state level HIV/AIDS response
- Institutionalization of AIDS Spending Assessment for data on evidence based funding, resources, needs, gaps and sustainability
- Inadequate implementation of national M&E system and limited data use
- Focus has been mainly on intervention monitoring rather than impact evaluation
- Inadequate human capacity to effectively implement national response
- Poverty and gender inequality have continued to drive the epidemic

Remedial Actions:

NACA is working actively on strengthening political commitment towards increasing financial resources to HIV/AIDS programs. More advocacies are needed at national and state levels to improve political commitments and financial resources for HIV/AIDS response. Secondly, NACA is working on making research a vital component in the national response. This is needed to implement impact evaluation, assess program sustainability and improve surveillance systems for HIV and STI.

NACA is working on scaling-up PMTCT services in terms of coverage and quality in the country.

There is a need to empower women and address gender inequalities towards mitigating the impact of HIV. Lastly, national data triangulation study is on the way to inform priority setting for new programs, policy and research. It will also provide opportunity to evaluate thematic areas of national HIV/AIDS responses in order to assess reach, coverage, impacts and gaps.

8. Support from the Country's Development Partners

Nigeria has received support from a number of development partners to achieve the national multisectoral HIV/AIDS response. These partners have been responsible for financing various programs in the areas of capacity building, institutional strengthening, prevention, treatment, care and support. Development partners are largely responsible for financial resources for HIV/AIDS management. These development partners include US President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank. PEPFAR provided about US$448 million for HIV/AIDS prevention, treatment, care and support; and World Bank loaned US$90.3 million to support a five-year HIV/AIDS Program Development Project in 2002 with an additional loan of US$50 million in 2007. Similarly, as at 2008, Global Fund gave US$95 million to expand prevention, antiretroviral treatment program and prevention of mother-to-child transmission programs.[45] Additionally, United Nations International Children's Emergency Fund (UNICEF) has provided technical assistance to the Federal and State Governments in areas of development and implementation of proposals like the Global Fund. UNICEF participated with UNAIDS in developing an inter-agency strategy to address HIV, women and girls.[46] UNICEF equally gave substantive guidance to support the Global Fund in the development of gender strategies. UNICEF, UNAIDS, the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC) are committed to collaborating with national and international stakeholders, for technical support in accelerating the scale-up of programs and tracking progress in prevention of mother-to-child transmission (PMTCT) of HIV, including the provision of care and support to the most vulnerable populations, such as women, orphans, children and their families.

UNICEF and other international partners have been instrumental in the development and pilot testing of an innovative packaging of PMTCT-related commodities to sustain and scale-up coverage and quality in the areas of PMTCT and pediatric care,

[45] AVERT HIV/AIDS Nigeria 2010: http://www.avert.org/aids-nigeria.htm
[46] UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV. August 2009

support and treatment. Likewise, in the prevention efforts, UNICEF promoted HIV-prevention life skills education to girls 15-17 years.

The institutions below have earmarked resources for HIV/AIDS activities in Nigeria from 2005 to 2009.

FEDERAL GOVERNMENT OF NIGERIA

STATE GOVERNMENT

CIDA

JICA

USAID

USDOL

DFID/SNR

DFID/SIPAA

AAIN

UNAIDS

WORLD BANK

UNICEF

UNFPA

UNDP

DFID

UNESCO

UNIFEM

APIN

VMOBILE

MTN

MTN FOUNDATION

ECOBANK

JULIUS BERGER

CHEVRON/ELF

Undoubtedly, several national and international institutions including those that were previously mentioned are committed to making resources available in the fight against HIV. Despite that the resources are still limited. It is believed that with more support, commitment, effective leadership, sound coordination and conducive environment in Nigeria, huge success will be recorded in the fight against the epidemic.

9. Monitoring and Evaluation Environment

9.1. Overview

Monitoring and evaluation (M&E) is a vital aspect of the multisectoral response to HIV/AIDS in Nigeria**.** Monitoring of the HIV/AIDS epidemic was done initially using HIV sentinel surveys among pregnant women accessing antenatal services in hospitals and clinics in line with global health standards from the World Health Organization. M&E system in Nigeria has also experienced progress at all levels.

In order to monitor and evaluate multisectoral response to HIV epidemic, the country launched Nigeria National Response Information Management System (NNRIMS) in 2004. This currently provides a robust, standardized and unified monitoring and evaluation framework.[47] NNRIMS has the functions of tracking progress in the implementation of the national HIV/AIDS response and using feedback information to improve policies, programs and service delivery.

Nigeria operates on the principle of 'three ones' which is one HIV/AIDS governing body, one strategic framework, and one monitoring and evaluation system. NACA has a well coordinated and suitably staffed Strategic Knowledge Management Department which has monitoring and evaluation as one of its key functions. The Department is also supported by a functional national technical working group which ensures that the M&E plan is precisely adhered to.

In 2004, NACA initiated the formation of National M & E Technical Working Group to backstop the gap in technical capacities in monitoring & evaluation in the areas of prevention, treatment, care and support, research, surveillance, and capacity building. An HIV/AIDS NNRIMS Operational plan (NOP) was developed in 2007 as a guide or algorithm to data collection, management, analysis and reporting, decision making, program planning and implementation. Similarly, the presence of NNRIMS Operational plan has led to the harmonization of M & E tools by partners. The long term vision is not only to reduce the incidence of HIV to the barest minimum but also

[47] National Agency for the Control of AIDS: HIV/AIDS NNRIMS Operational Plan 2007 – 2010.

to create a conductive environment in which all Nigerians will be able to live socially and economically – productive lives free of diseases and its devastating effects.

9.2. Achievements

One of the key achievements of the NACA is the development of NNRIMS. NNRIMS monitors the national response through an activity report system, a generation of comprehensive data of essential output indicators from a list of service delivery points using standard and harmonized tools. It has served as a guide in the monitoring and evaluation of interventions.

Other achievements include:

- NNRIMS operational plan (NOP) 2007 – 2010 which was developed after wide consultation with different stakeholders, with representatives from civil society including people living with HIV/AIDS. The goal is to provide a simple and robust monitoring and evaluation system as a part of the multisectoral HIV/AIDS response in Nigeria. The plan was designed for 2007 to 2010, after which it will be reviewed.

- Harmonization of indicators and data collection systems, and standardized data collection tools

- Equally important, stakeholders in all 36 states and the Federal Capital Territory have been trained in the use of NNRIMS. This training has been stepped down at state level, and service delivery points are using the harmonized M&E tools.

- NACA with the support of partners embarked on a wide scale capacity building of M & E officers at the national and state levels through training on various aspects of M & E particularly on the NNRIMS which is the fulcrum of M & E activities in Nigeria. Since 2007, over 846 state-level M & E officers and those from LGAs, and NGOs/CBOs have been trained to increase their capacities towards efficient M & E system in the country.

- Well defined organizational structure for M&E including HIV M&E unit, Zonal M&E focal persons and State M&E focal persons

- 28 Federal Ministries, Departments and Agencies (MDAs) implementing HIV/AIDS programs have also developed supporting M&E systems aligned to National M&E system.

- Major development partners and other relevant public/private sectors' stakeholders are contributing in varying degrees to strengthening the National M&E system.

- Conduct of regular Data Quality Audit exercise led and coordinated by NACA with the involvement of relevant stakeholders.

- National M&E Capacity assessment: In 2009, NACA led other relevant stakeholders to conduct a detailed assessment of the status of the national HIV M&E system using the 12 components of a functional M&E system as a framework. A standard tool was administered at a multi-stakeholder assessment workshop with distinct groups of stakeholders representing different institutions and levels of the M & E system which included NACA, SACA, NASCP, SASCP, CISHAN, NEPWHAN, public sector ministries, health facilities, donors and implementing partners in attendance. Findings and recommendations will be used to strengthen the country's HIV M&E system to track progress in the national response more effectively and efficiently.

In addition, 29 states in Nigeria have installed the DHIS Electronic database for program monitoring and evaluation. The LHPMIP database, which complements DHIS, has also been rolled out to about 200 service delivery points and 20 states.

9.3. Key Aspects of the NNRIMS Operational Plan (NOP)

The NOP 2007-2010 clearly indicates the following:

- Data collection strategy which addresses routine monitoring of programs, research, behavioral surveys and HIV surveillance.

- Standard and harmonized set of indicators
- Guidelines for data collection to aid M&E officers in the different service delivery points.
- Strategy to determine data quality: accuracy, completeness, reliability and validity.
- Data analysis and subsequent dissemination strategy.

The NOP led to the development of harmonized and standardized data tools and collection systems. Data collected by NNRIMS are for global indicators as well as for local indicators that are collected by specific organizations according to their goals and objectives. NACA ensures the use of a standardized reporting tool for uniformity.

9.4. Data Flow

The national HIV/AIDS M&E system's goal is to track the progress being made in the national response. There is also a programmatic level of the M&E system which collects data for the use of implementers of HIV/AIDS program and for feedback to the national M&E system.

NACA receives monthly reports on ART, PMTCT, HCT and laboratory services from its development partners as well as quarterly program reports.

In addition, there are three levels of reporting, the lowest level of reporting is at the facility level or at the implementing level. Each organization has indicators that guide their program activities.

The indicators required at the national level are recorded and put together at the facility/service delivery point, and then sent to the Local Government Action Committee on AIDS (LACA) representing the first level. The LACA then aggregate all the data from the different facilities and send to the State Agency for the Control of AIDS (SACA), which is the second level, while the third level of reporting is to the national level from the states. At each of these levels, there are feedback mechanisms in place. The National Agency for the Control of AIDS is responsible for dissemination of information to national and international bodies. Similarly, the

Ministries of Health, Defense, Internal affairs and their relevant agencies feed data on their HIV response activities to the national response.

9.5. Coordination of M&E Activities

The coordination of M&E activities at the National level is done by NACA. M&E priorities are determined through an M&E system assessment, which is carried out biennially. The assessment is done simply by sending an M&E system assessment tool to different organizations.

National M&E meetings are held twice a year to bring together different stakeholders to brief them on the progress as well as the challenges being made in the national M&E plan. SACAs also hold quarterly coordination meetings with all the implementing partners to harmonize and analyze the data collected, and address challenges.

The NACA M&E officers work with other M&E officers in other organizations towards broad involvement and sense of ownership.

9.6. Training of M&E Officers

In order to build the capacity of M&E officers, training workshops are conducted regularly with participants from federal and state parastatals/agencies, line ministries as well as civil society. Training is focused on the relevance of monitoring and evaluation, the importance of timely and complete reporting of data, and the need for consistency.

9.7. Research activities

At the national level, M&E research activities have been carried out in form of sentinel surveillance surveys. Examples include the 2008 Sentinel Seroprevalence Survey (ANC), the 2007 Integrated Behavioral and Biological Sentinel Survey (IBBSS) and 2007 National AIDS and Reproductive Health Survey NARHS. They were coordinated by the Federal Ministry of Health with support from the National Agency for the Control of AIDS. All these surveys have measured successfully

impact, output and outcome indicators as indicated in the National M&E plan. Other surveys conducted are the MARC survey by the Society for Family Health on high risk populations.

9.8. Evaluation

NACA has carried out evaluation activities to date among which are: Joint Review of MAP 1, Joint Mid-term review of NSF, Public Sector Impact Assessment, HAF CSO Assessment, National HIV/AIDS Policy review and National Strategic Framework review.

Also, NACA has facilitated and supported the conduct of evaluation studies commissioned by some key partners, and these include OVC Situational Assessment and a National Survey on HIV/AIDS.

9.9. Analytic Work

NACA in the last two years has commissioned a number of analytic work on the epidemic and response to provide tools and evidence for policy and program decision making. These analytic works include the following:

1. Epidemic Response and Policy Synthesis at National and State levels.
2. Modes of Transmission Analysis.
3. HIV Program Sustainability Analysis.
4. Human Resource needs for Health.
5. HIV/AIDS Service Provision Assessment.
6. Data Triangulation.
7. National AIDS Spending Assessment.

9.10. Publications of M&E Reports

The National Agency for the Control of AIDS publishes several M&E reports through the M&E unit as required annually. Additionally, quarterly reports are available that focus on ART, PMTCT and HCT services. Other reports produced include the World Bank project monitoring reports, HAF monitoring reports and the UNGASS country report. These and others are made available on the NACA website once published.

9.11. Challenges

Despite the achievements and giant strides attained, there are still challenges. The major challenges encountered are as follows:

Structure

- The need for a new M&E plan that clearly indicates the responsibilities and roles of the Federal Ministry of Health, Federal Line Ministries and NGOs.
- Lack of strong M&E leadership in federal line ministries and NGOs.
- The need for the development of M&E plan under the national strategic framework for states to give a sense of direction in their M&E activities. A new M&E plan that will be responsible for monitoring the revised National Strategic Plan.
- At the state level are challenges of insufficient funding for activities as well as inadequate M&E personnel.
- The need to improve the level of research in the evaluation systems. Researches should not be limited to surveys only but other methodologies capable of effectively evaluating prevention, treatment, care and support programs.
- There is a need to harmonize multiple data systems for prompt decision making

Human Capacity

- Capacity building programs are needed at all levels since this is vital to the overall productivity of M&E staff

Multisectoral M&E plan

- The need to link state and sector M&E plan to the national plan in all the key aspects for example data flow and reporting channel
- Lack of cost-related work plan to ensure effective resource allocation.

HIV Program Monitoring

- Presently, home-based care activities are not being tracked and this is mainly due to the absence of data collection tools and lack of indicator definition

- Under reporting: This is mainly observed in submission of incomplete forms.
- Late reporting: Forms are submitted later than the stipulated dates and this hinders update of the database.
- Transfer of trained M&E officers from the facility/service delivery points
- Poor filing and record keeping in some facilities

9.12. Remedial Actions:

NACA is committed to investing in building capacity of personnel from different stakeholder groups as well as strengthening the research efforts in the evaluation systems by constituting a research team who work in partnership with different stakeholders especially Nigerian AIDS Research Network. Equally important, there is the revision of NNRIMS framework to align with issues articulated in new NSF. This will provide the opportunity to address the weakness, costing for operational plan and basis for resource mobilization towards efficient and effective monitoring and evaluation system. The country is committed to harmonizing multiple data systems and facilitates timely collection of data from the field with analysis to enhance good feedback system.

10. Conclusion

This report shows the progress in the national response to the HIV epidemic in Nigeria. It was developed in collaboration with different stakeholders such as civil society groups and line ministries. Nigeria as a nation has shown great commitment to achieving the goals and targets that were made in the Declaration of Commitment.
This has been reflected in giant strides that have been made in the following key areas:

- Increased HIV/AIDS awareness among the general population and most at risk populations.
- Increased coverage in PMTCT services.
- Many States Action committees out of the 36 states have been transformed to agencies leading to increased ownership and participation.
- Provision of more centers for HCT
- Increased access to antiretroviral drugs
- Gender mainstreaming into the HIV national response.
- Development of policy documents such as the National Strategic Framework and Plan for 2010-2015.
- Scale-up of ongoing national programs.

Despite all these achievements, there are still challenges that are being tackled, and they include:

- The country's national response is still largely donor driven.
- Political commitment is not strong enough at the state and local government levels.
- There is still much stigmatization and discrimination against people living with HIV/AIDS.
- Inadequate community directed interventions.

Nigeria appreciates the efforts of the international organizations, development partners and NGOs at reducing the prevalence of HIV. However, more assistance is still needed in the areas of capacity building, program implementation and technical assistance.

The leadership of NACA is committed to innovative strategic thinking in prevention, treatment, care and support with advocacy. Finally, NACA strives to sustain robust partnerships with both local and international organizations towards attaining its objective of effectively controlling the epidemic and achieving the targets of Universal Access.

11. References

[1]Declaration of Commitment on HIV/AIDS: United Nations General Assembly Session on HIV/AIDS 25-27 June 2001

[2]Keeping the Promise: Summary of the Declaration of Commitment on HIV/AIDS United Nations General Assembly Special Session on HIV/AIDS 25-27 June 2001, New York

[3]Buvé A et al. The spread and effect of HIV-1 infection in sub-Saharan Africa. Lancet 2002; 359: 2011–17

[4]United Nations General Assembly Session on HIV/AIDS 25-27 June 2001: DECLARATION OF COMMITMENT ON HIV/AIDS "Global Crisis – Global Action"

[5]Panchaud C et al. Issues in Measuring HIV Prevalence: The Case of Nigeria. Afr Reprod Health 2002; 6(3): 11 -29

[6]Ammann A. Preventing HIV: Time to get serious about changing behaviour. ABMJ. 2003; 326(7403): 1342–1343.

[7]UNAIDS/WHO Working Group on Global HIV/AIDS/STI Surveillance. Guidelines for Second Generation HIV Surveillance (WHO/CDS/CSR/EDC/2000.5—UNAIDS/00.03E). Geneva: UNAIDS/WHO, 2000.

[8]Modes of HIV Transmission in Nigeria: Analysis of the Distribution of New HIV Infections in Nigeria and Recommendations for Prevention

[9]HIV/AIDS Program Sustainability Analysis Tool (HAPSAT): SUSTAINABILITY ANALYSIS OF HIV/AIDS SERVICES IN NIGERIA 2009

[10]Population Reference Bureau 2009 Data Fact Sheet

[11]UNDP Human Development Report 2009: http://hdrstats.undp.org/en/countries/country_fact_sheets/cty_fs_NGA.html

[12]Geographical: The complete Atlas of the world, "Nigeria", (Random House, 2002)

[13]Federal Ministry of Health Report on the 2008 National HIV/Syphilis Sero-prevalence Sentinel Survey among Pregnant Women Attending Antenatal Clinics in Nigeria. NASCP Abuja: Nigeria.

[14]HERFON 2007: NIGERIAN HEALTH REVIEW
http://www.herfon.org/docs/Background_Information_on_NHR.pdf
[15]2009 National HIV/AIDS Policy Draft
[16]National Agency for the Control of AIDS (NACA): National Strategic Framework (NSF) 2005-2009
[17]2009 National HIV/AIDS Policy
[18]UNAIDS 2009 AIDS epidemic update: Global summary of the AIDS epidemic
[19]Simon V. HIV/AIDS epidemiology, pathogenesis, prevention, and treatment. Lancet 2006; 368: 489–504
[20]Quinn TC, Overbaugh J. HIV/AIDS in women: an expanding epidemic. Science 2005; 308: 1582–83
[21]Shisana O, Davids A. Correcting gender inequalities is central to controlling HIV/AIDS. Bull World Health Organ 2004; 82: 812
[22]Ezumah NE. Gender Issues in the Prevention and Control of STIs and HIV/AIDS; Lessons from Awka and Agulu, Anambra State, Nigeria. African Journal of Reproductive Health, 2003: 7:89: 99
[23]Federal Ministry of Health (2005) The National Situation Analysis of the Health Sector Response to HIV & AIDS in Nigeria. Abuja: FMH Nigeria
[24]Adeyi O, et al, editors. 2006. AIDS in Nigeria; A Nation on the Threshold (Harvard University Press, Harvard Series on Population and International Health).
[25]Ainsworth M, Teokul W. Breaking the silence: setting realistic priorities for AIDS control in less-developed countries. Lancet 2000; 356:55-60.
[26]Jha P, Nagelkerke NJD, Ngugi EN, Prasada Rao JVR, Willbond B, Moses S, et al. Reducing HIV transmission in developing countries. Science 2001; 292:224-5
[27]Federal Ministry of Health (2001) A Technical Report on 2001 National HIV/Syphilis Sero-Prevalence Sentinel Survey among Pregnant Women Attending Antenatal Clinics in Nigeria. Abuja: NASCP, Nigeria.
[28]Federal Ministry of Health (2004) A Technical Report on 2003 National HIV/Syphilis Sero-Prevalence Sentinel Survey among Pregnant Women Attending Antenatal clinics in Nigeria. Abuja: National AIDS/STIs Control Program, Nigeria.

[29]Federal Ministry of Health (2005) Technical Report on the 2005 National HIV/Syphilis Sero-prevalence Sentinel Survey Among Pregnant Women Attending Antenatal Clinics in Nigeria. Department of Public Health National AIDS/STI Control Programme. Abuja: Nigeria.

[30]Federal Ministry of Health (2010) Technical Report on the 2008 National HIV/Syphilis Sero-prevalence Sentinel Survey Among Pregnant Women Attending Antenatal Clinics in Nigeria. Department of Public Health National AIDS/STI Control Programme. Abuja: Nigeria.

[31]Federal Ministry of Health (2009) National HIV/AIDS and Reproductive Health Survey. Abuja (NARHS 2007), Nigeria.

[32]Pettifor AE, Rees HV, Kleinschmidt I, et al. Young people's sexual health in South Africa: HIV prevalence and sexual behaviors from a nationally representative household survey. AIDS 2005; 19: 1525–34.

[33]UNAIDS 2009 Report: Modes of HIV Transmission in Nigeria: Analysis of the Distribution of New HIV Infections in Nigeria and Recommendations for Prevention

[34]Federal Ministry of Health (2007) Integrated Bio-Behavioural Surveillance Survey Among Most at Risk Populations in Nigeria. Abuja: National AIDS/STIs Control Programme (NASCP), Nigeria (IBBSS 2007)

[35]Rhodes T, Simic M. Transition and the HIV risk environment. BMJ2005;331:220–3

[36]Beyrer C. HIV Epidemiology Update and Transmission Factors: Risks and Risk Contexts—16th International AIDS Conference Epidemiology Plenary. Clinical Infectious Diseases 2007; 44:981–7

[37]Pisani E, Garnett G, Grassly N, Brown T, Stover J, Hankins C. Back to basics in HIV prevention: focus on exposure. BMJ. 2003 June 21; 326(7403): 1384–1387.

[38]National Agency for the Control of AIDS (NACA): National Strategic Framework (NSF) 2005-2009

[39]HIV/AIDS in Nigeria: A USAID Brief
http://pdf.usaid.gov/pdf_docs/Pnacq945.pdf (Accessed January 30, 2010)

[40]Federal Ministry of Health (2010) Technical Report on the 2008 National HIV/Syphilis Sero-prevalence Sentinel Survey Among Pregnant Women Attending Antenatal Clinics in Nigeria. Department of Public Health National AIDS/STI Control Programme. Abuja: Nigeria.

[41]Sedgh G et al. Meeting Young Women's Reproductive and Sexual Health Needs in Nigeria. New York: Guttmacher Institute, 2009.

[42]National Economic Empowerment and Development Strategy (NEEDS)

[43]2006 HIV/AIDS in Nigeria National Planning Commission

[44]NACA: Status of the HIV National Response in Nigeria

[45]AVERT HIV/AIDS Nigeria 2010: http://www.avert.org/aids-nigeria.htm

[46]UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV. August 2009

[47]National Agency for the Control of AIDS: HIV/AIDS NNRIMS Operational Plan 2007 – 2010

12. Annexes

12.1. Consultation/Preparation Process for the Country Progress Report

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

a) NAC or equivalent Yes
No

b) NAP Yes
No

c) Others Yes
No
(Please specify)

2) With inputs from Ministries:

Education Yes
No

Health Yes
No

Labor Yes
No

Foreign Affairs Yes
No

Others Yes
No
(Please specify): Women Affairs

Civil society organizations Yes
No

People living with HIV Yes
No

Private sector Yes
No

United Nations organizations Yes
No

Bilaterals Yes
No

International NGOs Yes
No

Others Yes
No
(Please specify)

3) Was the report discussed in a large forum? Yes
No

4) Are the survey results stored centrally? Yes
No

5) Are data available for public consultation? Yes
No

6) Who is the person responsible for submission of the report and for follow-up if there are question on the Country Progress Report?

Name/title:

Dr. Micheal Kayode Ogungbemi, Director of Strategic Knowledge Management Department

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Date: 31 March, 2010

Signature:

Address: National Agency for the Control of AIDS (NACA), Plot 823 Ralph Shodeinde Street, Central Area, Abuja Nigeria

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Email: o_kayodem@yahoo.com

Telephone: +234-9-4613715

12.2. National Composite Policy Index (NCPI) 2010

COUNTRY: Nigeria

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions:

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Date of submission: 31 March, 2010

NCPI- Part A: Government Official Respondents' Results

Organization	Name/Positions	Respondents to Part A				
		A.I: Strategic Plan	**A.II: Political Support**	**A.III: Prevention**	**A.IV: Treatment, Care & Support**	**A.V: Monitoring and Evaluation**
Oyo SACA	Siji Ganiyu	Yes	Yes	Yes	Yes	Yes
NACA	Dr .Kayode Ogungbemi	Yes	Yes	Yes	Yes	Yes
Nigerian Prisons	Dr. Bello	Yes	Yes	Yes	Yes	Yes
AFPAC	Col. Simeon Ekanem	Yes	Yes	Yes	Yes	Yes
Federal Ministry of Labor	Godson Ogbiyi	Yes	Yes	Yes	Yes	Yes
Federal Ministry of Education	Mrs. Offiah	Yes	Yes	Yes	Yes	Yes
Ministry of Women Affairs	Dr. McJohn	Yes	Yes	Yes	Yes	Yes
Federal Ministry of Health	Dr. Balami	Yes	Yes	Yes	Yes	Yes
Abia State Agency for the Control of AIDS	P.C. Nwabuko	Yes	Yes	Yes	Yes	Yes

NCPI- Part B: Representatives of NGOs, Bilateral Agencies and UN Organizations

Organization	Name/Position	Respondents to Part B			
		B.I: Human Rights	B.II: Civil Society Participation	B.III: Prevention	B.IV: Treatment, Care and Support
NEPHWAN	Peter Nweke	Yes	Yes	Yes	Yes
Society for Family Health	Samson Adebayo	Yes	Yes	Yes	Yes
ICAP	Frank Orosanye	Yes	Yes	Yes	Yes
World Bank	Dr. Okesola	Yes	Yes	Yes	Yes
APIN	Dr. Prosper Okonkwo	Yes	Yes	Yes	Yes
FHI/GHAIN	Brigid O'Connor	Yes	Yes	Yes	Yes
CISHAN	Bukky	Yes	Yes	Yes	Yes
NYNETHA	Moses Okpara	Yes	Yes	Yes	Yes
UNAIDS	Dr Warren Naamara	Yes	Yes	Yes	Yes

12.3. Attendance: Nigeria UNGASS 2010 Stakeholders' Validation Meeting

Wednesday March 24, 2010 @ 10am
Main Hall, 1st Floor, UN House Abuja

CONVENER	Mr. Francis Agbo		
SECRETARY	Nkem Iku/Lucy Okosun		
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	Are-Shodede A	UNAIDS	

	P.C. Nwabuho	ABSACA	
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Committee to Review and Finalize the Nigeria UNGASS 2010 Report

The Committee met at UN House RM 1A03 @ 10am Friday March 26, 2010

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9	Dr Job Sagbohan	UNAIDS	sagbohanj@unaids.org

12.4. Schedule of Activities for the Completion of UN Joint Reporting Form 2010

DATE	ACTIVITY	COMMENTS
Jan 2010	MEMO from Regional offices to Heads of Agencies received	
	Distribution to focal points of UN agencies	
Feb 5 2010	WHO/UNICEF/UNAIDS Meeting of Focal Points	
Feb 7-12, 2010	Meeting with FMOH and submission of forms to NASCP.	
Feb 2010	Filling of forms designated by NASCP	One week
February 19-20, 2010	Review of the preliminary data and filling of the report template by NASCP and UN focal points	A total of three meetings between NASCAP and UN focal persons
March 9-13, 2010	Kaduna Workshop with Implementing partners and attendance of WHO HQ and IST Agenda • Presentation by WHO Presentations by IPs Presentation of the UNGASS preliminary report • Group work • Elaboration of a list of facilities, IPs, and services provided • Extraction of data from Published documents reports and programme records • Data quality check • Aggregation of Reports from IPs records • Next steps	Attendance include FHI, IHVN, USG, FMOH, NACA Consultant/UN FMOH/UN
March 24 2010	Validation meeting for both UNGASS and universal Access reports	FMoH/UN
March 27 2010	Meeting with IPs, consultants, NACA, FMoH and UN focal persons to incorporate comments and inputs of the validation meeting to both UNGASS and universal access reports.	FMoH/UN
March 29 2010	Finalizing both Universal access and UNGASS report forms	WHO/FMOH
March 29 2010	Dissemination of Fist final draft of Completed Joint Form and approval of national authority	FMOH
March 30 2010	Memo from Government to UN submitting the completed forms	
March 30 2010	Memo from UNAIDS to WHO, UNICEF and UNAIDS	UNAIDS as secretariat and WHO as Theme Group Chair.
March 31 2010	Submission of the reports to WHO,UNICEF and UNAIDS	Final report uploaded by National authority
June 2010	Wide Dissemination of Report	Government and UN