



NATIONAL AGENCY FOR THE CONTROL OF AIDS

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***NATIONAL HIV/AIDS PREVENTION PLAN
2007-2009***

National Prevention Technical Working Group





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Preface

Within the last decade, the Federal Government of Nigeria in collaboration with her international partners have committed huge political capital, human and financial resources towards the multisectoral response programs aimed at preventing the spread of the virus, and mitigating its impact on Nigerians. The country and indeed international partners have committed huge political capital, human and financial resources in this regard in the past ten years. From the development a three year Interim Action Plan called HIV/AIDS Emergency Action Plan (HEAP 2001-2003) to guide the multi-sectoral response to the epidemic (extended to 2004), to the HIV/AIDS National Strategic Framework 2005-2009 which builds on the achievements of HEAP while at the same time addressing the challenges encountered and emerging issues identified.

Through the instrumentality of the NSF, supported by partners and stakeholders, the Government of Nigeria through the National Agency for the Control of AIDS developed and is putting in place the National Prevention Plan (NPP) for the next 2 years (2007-2009). This plan has taken into consideration the inputs of stakeholders groups, constituencies, states and the private sector in developing the framework for action in order to give greater attention and visibility to the issues of prevention in the National Response.

The Plan has been designed to function as a simple but robust implementation plan that will facilitate implementation and tracking of progress as well as inform programs, policies and service delivery as a part of the multi-sectoral HIV and AIDS response in Nigeria.

We are all aware that about 95% of our population is currently uninfected and it is our collective goal and therefore our responsibility to ensure that they remain so, a task which can be achieved with the determination and cooperation from all our friends, partners and stakeholders.

I appeal to all Nigerians, Civil society organizations and development agencies to adopt and use this plan as Nigeria's HIV/AIDS Prevention tool to subdue the epidemic within the next five years under the coordination of the National Agency for the Control of AIDS, (NACA).

Let me thank everyone that has been involved or contributed in one way or the other to the development of this National Prevention Plan.

Professor Babatunde Osotimehin
Director General,
NACA NOVEMBER 2007



Foreward

Since the HIV epidemic started in Nigeria 20 years ago, we as a people have committed resources to stem the tide of the infection. Initially through a mono sectoral approach, but more recently by multisectoral paradigm which seemed to have positively affected the prevalence such that, in the last 4 years we have been able to record a slight but consistent decline in the national sero prevalence.

In parallel with the effort of government, there has been a great deal of support from international partners in one way or another; thus today Nigeria plays host to over 50 organizations involved in implementing our national strategic framework to combat the epidemic.

However we have observed that there seems to be more attention given to the issues of treatment than of prevention. This is unacceptable since over 95% of our population is HIV negative, thus the justification for the prevention plan is to bring together all the critical thinkers within the national response to evolve a practical, workable framework which is robust and easy to use whilst lending itself to the issues of monitoring and evaluation.

It is our belief that this plan will be used by all on a regular basis and form the foundation for reports by the secretariat of the national response on how effective our prevention efforts have been, since the future of the epidemic lies in our ability to scale up our prevention efforts.

I wish to commend the document to all and look forward to progress that we make in providing greater information to the generality of Nigerians.

Professor Umaru Shehu
Chairman
NACA Governing Board
NOVEMBER 2007



Executive Summary

The first case of HIV/AIDS was reported in Nigeria in 1986. By 1991, prevalence rate had risen to 1.8% of the population; it progressed rapidly to 4.5% in 1996, 5.5% in 2001 and started dropping to 5% in 2003 and 4.4% of the entire population by 2005. It is expected that this reduction in the prevalence rate will be sustained. However, from the results of the 2005 Sero-prevalence Sentinel Survey, a total of 2.86 million people were estimated to be living with HIV/AIDS in the country. The report also indicated that the infection is more prevalent in the 25 – 29 age group. But the survey estimate for new infections indicated that 296,320 adults and 73,550 children less than 15 years will be infected. By 2006, the progression of new infections was projected at 346,150 in the adult population and 75,780 in children less than 15 years. It was also discovered that although the epidemic is classified as being generalized in the country, in the sense that all the states of the Federation are affected, there is a definite trend indicated by a high prevalence band running from the North Central through the South East to the South-South states. Lower prevalence areas, however, cover the North East, South West and parts of the North West states. State specific prevalence rates vary from 1.6% in Ekiti State to 10% in Benue State. But the Antenatal HIV rates are less variable by age group. It was found that young adults appear most at risk with HIV prevalence of 3.6% amongst pregnant 15 – 19 year olds and a peak of 4.9% amongst the 26 -29 year olds.

The multi-sectoral platform of the national response, the strengthening of NACA and the application of the THREE ONES principle (One national framework, One strategic plan and One monitoring and evaluation framework) have led to better coordination of the activities of various sectors, expanded both the linkages & networking amongst numerous groups as well as increased the access to available resources and interventions by those who require the services. A case in point here is the resultant improved involvement, participation and contribution of the private sector organizations, civil society organizations, bi-lateral and multi-lateral organizations, PLWHAs and the United Nations agencies. Such cooperation and collaboration have resulted in the injection of more resources into the national response by Government/public funding, the Global Fund to fight Tuberculosis, AIDS and

Malaria (GFTAM), the United States Government (PEPFAR) and the World Bank (MAP). A greater commitment to fighting the epidemic has also been demonstrated by the three tiers of Government at Federal, State and Local levels.

As soon as the first case was discovered in the country, the Nigerian Government mounted a national response principally guided by the Federal Ministry of Health. This response was expanded in 2000 with the establishment of the Presidential Council on AIDS (PCA) and the National Action Committee on AIDS (NACA). Membership of these two organizations was multi-sectoral in nature and thus began the multi-sectoral intervention on issues of HIV/AIDS in Nigeria. These provided the basis for a coordinated effort to provide comprehensive prevention, treatment, care and support services through a number of plans including the HIV/AIDS Emergency Action Plan (HEAP), the HIV Health Sector Plan and the National Strategic Framework (NSF). These plans focused on scaling up of access to and quality of HIV/AIDS services which included a wide range of interventions such as BCC, FLHE, VCT, Blood Safety, PMTCT, Palliative Care for Opportunistic Infections (OIs), ART and home based care for People Living with HIV/AIDS (PLWHA), support for orphans and vulnerable children (OVC) and People Affected by AIDS (PABA) as well as adequate treatment of sexually transmitted infections (STIs).

With specific regard to Prevention, the 2003 National Policy on HIV/AIDS and the 2005 – 2009 National Strategic Framework (NSF) for action provide a strong and comprehensive approach to prevention efforts including a balanced “ABC” approach. A national Prevention Technical Working Group was constituted to provide better coordination and harmonization of prevention programmes as well as provide technical guidance at the national & state levels towards achieving the set prevention goals within the NSF.

The Nigeria HIV prevention program over the next 2 years will adopt a new strategic thrust.

To this end, a review of current efforts at prevention shows that varied and single intervention approaches are in use by implementing agencies and these have not actualized the expected levels of behavioral change required to avert new infections. A compendium of proven best practices in Nigeria is to be developed and from within this pool, it is



recommended that partners involved in HIV prevention be required to provide a minimum package of services.

The prevention goals identified within the NSF were informed by actions/activities found to be the **drivers of the epidemic** in Nigeria. These include the following:

- Informal Transactional Sex
- Low Risk Perception of the population
- Multiple Partnerships between the sexes
- Lack of Established STI Programming for Most at Risk Persons (MARPs)
- Continuing Risky Behavior of Males in the General Population
- Gender Inequalities, and
- Trans-generational Sex.

To intensify and rapidly expand the national response, this National HIV/AIDS Prevention Plan, whilst targeting the general population also targets, within the general population, the following specific population groups:

- People Living with HIV/AIDS
- Workplace populations (Most at Risk Population), such as:
 - # Sex Workers
 - # Transport Workers
 - # Uniformed Service Men/Women
 - # Men sex Men (MSM)
 - # Intravenous Drug Users (IDUs)
 - # Youth (In & Out-of-School).
- People with Disability, and
- Children.

In addition, the plan also identified various strategic components around which it was developed. Issues were articulated for each component and recommendations made for intensifying the response in each case. The components addressed in the plan include:

- The ABC approach to the prevention of HIV/AIDS
- Prevention of Mother to Child Transmission (PMTCT)
- HCT (Voluntary Counseling and Testing)
- Blood Safety
- Injection Safety
- Condom Programming & Other Preventions (e. g. Treatment of OIs, etc)
- Management of STIs (Sexually Transmitted Infections)
- New Prevention Technologies/Male Circumcision

- Integrating Prevention to Treatment and Care
- Integrating Prevention to Reproductive Health, and
- Economic Interventions.

Whereas a summary framework for prevention activities was developed in this document, the actual Work-plan which follows the summary is quite comprehensive. The plan articulates ten steps for each thematic area of the prevention plan. It highlights objectives, key interventions, activities and indicators for measuring the achievement of objectives. The plan goes further to identify the sector(s) responsible for each action as well as the operational level of implementation, e.g. Federal, State or Local Government. Further, time lines and budgets were established for programme implementation. Assessment of risks as well as assumptions for programme implementation was also clearly articulated.

NACA NOVEMBER 2007



Acknowledgement

Over the last few years, support for the National response from Local and International partners alike has grown, with consensus being built around ideas, and actions, truly strengthening the response and building synergies in action. Therefore, NACA wishes to acknowledge the participation of several stakeholders who supported, technically, materially and financially, the development of the National Prevention Plan and its Monitoring framework and articulated it in the presented form. These include organizations of the United Nations System (UNAIDS, UNICEF, UNFPA, WHO), DfID, GHAIN, NYNETH, TAM, the Military (AFPAC), Faith-based organizations, APYIN, JAAIDS, the Media, NEPWHAN, CISHAN, NASCP, Federal Line Ministries, USAID & its Ips; Pathfinder International, CDC, Enhance Project, MMIS, Blood Safety Services, APIN, IHVN, FHI, Aids Relief, HAAI, SFH, and various significant others. Your support in getting the National HIV/AIDS Prevention Plan (NHAPP) to this point is most invaluable.

Numerous individuals also participated in and provided assistance to the process in one way or another. We wish to express our gratitude to these people as well. It is our hope that every sector of the economy and stakeholder would find this document useful and relevant to the execution of its programmes and projects in the effort to frontally attack this epidemic and push back its frontiers from Nigeria.

Ibrahim Atta
Manager Strategic Planning
Chair:
National Prevention Technical Working Group



List of Acronyms

AAIN	ActionAid International Nigeria	GIPA	Greater Involvement of People Living With HIV/AIDS
AFPAC	Armed Forces Programme on AIDS Control	HAF	HIV/AIDS Fund
AIDS Syndrome	Acquired Immuno-deficiency Syndrome	HBC	Home-Base Care
ANC	Ante-Natal Clinics	HEAP	HIV/AIDS Emergency Action Plan
APIN Nigeria	AIDS Prevention Initiative in Nigeria	HIV	Human Immuno-deficiency Virus
ALGON	All Local Government of Nigeria	HSSP	Health Sector Strategic Plan
ARH	Adolescent Reproductive Health	IAP	Interim Action Plan
ART	Anti-Retroviral Therapy	IDPs	Internally Displaced Persons
ARV	Anti-Retroviral	IDU	Intravenous Drug User
BCC	Behavior Change Communication	IEC	Information, Education and Communication
CBOs	Community-Based Organizations	ILO	International Labour Organization
CCE	Consultative Constituent Entity	INGO	International Non-Governmental Organization
CCM	Country Coordination Mechanism	LACA	Local Government Action Committee on AIDS
CDA Association	Community Development Association	LDDs	Long Distance Drivers
CDC	Centre for Disease Control and Prevention (US)	LGA	Local Government Area
CEDAW	Convention on the Elimination of Discrimination Against Women	M&E	Monitoring and Evaluation
CHAN Nigeria	Christian Health Association of Nigeria	MAP	Multi-country AIDS Program
CHBC	Community and Home-Based Care	MARPs	Most At Risk Persons
CIDA	Canadian International Development Agency	MDGs	Millennium Development Goals
CiSHAN	Civil Society Organisations on HIV/AIDS in Nigeria	MoU	Memorandum of Understanding
CJ	Chief Judge	MSM	Men who have Sex with Men
CJN	Chief Justice of Nigeria	NACA	National Action Committee on AIDS
CRA	Child Rights Act	NDE	National Directorate of Employment
CSOs	Civil Society Organizations	NAFDAC	National Agency for Food and Drug Administration and Control
CSW	Commercial Sex Worker	NAPEP	National Poverty Eradication Programme
DFID	Department for International Development (UK)	NARHS	National Adolescent and Reproductive Health Survey
ETG	Expanded Thematic Group	NASCP	National HIV/AIDS/STI Control Programme
FBOs	Faith-Based Organizations	NASSRA	National Assembly Response to AIDS
FCT	Federal Capital Territory	NBCC	National HIV and AIDS Behavior Change Communication Strategy
FEC	Federal Executive Council	NDHS	National Demographic and Health Survey
FGN	Federal Government of Nigeria	NEEDS	National Economic Empowerment and Development Strategy
FHI	Family Health International	NEPAD	New Economic Partnership for Africa Development
FLE	Family Life Education	NEPWHAN	Network of People living With HIV and AIDS in Nigeria
FMOH	Federal Ministry of Health	NERB	National Ethical Review Board
FMOL	Federal Ministry of Labour	NGO	Non-Governmental Organization
FMOWA	Federal Ministry of Women Affairs	NHIS	National Health Insurance Scheme
FMIGA	Federal Ministry of Inter-governmental Affairs, Youth Development & Special Duties	NHVMAG	Nigeria, HIV Vaccine and Microbicide Advocacy Group
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria		



NiBUCAA	Nigerian Business Coalition Against AIDS	SPC	State Planning Commission
NIMR	Nigerian Institute of Medical Research	STIs	Sexually Transmitted Infections
NIPRD	National Institute for Pharmaceutical Research and Development	SW	Sex Worker
NISER	Nigerian Institute for Social and Economic Research	TB-DOTS	Tuberculosis Direct Observation Treatment Scheme
NNRIMS	Nigeria National Response Information Management System for HIV/AIDS	UN	United Nations
NPC	National Planning Commission	UBE	Universal Basic Education
NRCS	Nigerian Red Cross Society	UNAIDS	Joint United Nations Programme on AIDS
NRR	National Response Review	UNDP	United Nations Development Programme
NSF	National Strategic Framework	UNESCO	United Nations Educational, Scientific and Cultural Organization
NURTW	Nigerian Union of Road Transport Workers	UNFPA	United Nations Population Fund
NYNethA	Nigerian Youth Network on HIV/AIDS	UNGASS	United Nations General Assembly
OIs	Opportunistic Infections	UNICEF	United Nations Children Fund
OPS	Organized Private Sector	UNIFEM	United Nations Development Fund for Women
OVC	Orphans and Vulnerable Children	UNODC	United Nations Office on Drugs and Crimes
PABA	People Affected By AIDS	USAID	United States Agency for International Development
PAC	Presidential AIDS Council	USDOL	United States Department of Labour
PEP	Post Exposure Prophylaxis	VCT	Voluntary Counseling and Testing
PEPFAR	President's Emergency Plan For AIDS Relief	WHO	World Health Organization
PESSP	Persons Engaged in Same Sex Practice		
PLWAs	People Living With AIDS		
PMAN	Performing Musicians Association of Nigeria		
PMM	Patient Management and Monitoring		
PMTCT	Prevention of Mother-To-Child Transmission		
PSC	Partnership Steering Committee		
PSI	Population Services International		
PTC	Partnership Technical Committee		
PSRHH	Promoting Sexual and Reproductive Health for HIV/AIDS reduction		
PWG	Partnership Working Group		
R&D	Research and Development		
SACA	State Action Committee on AIDS		
SEEDS	State Economic Empowerment and Development Strategy		
SFH	Society for Family Health		
SGF	Secretary to the Government of the Federation		
SIPAA	Support to International Partnership against AIDS in Africa		
SSG	Secretary to the State Government		
SNR	Strengthening National Response		



INTRODUCTION

Background

Significant progress has been made across the world by a number of countries in reducing HIV prevalence through sound prevention efforts. However, in 2006, there were still 4.3 million new HIV infections with many young people unable to access prevention services to prevent HIV infection globally (UNAIDS Global Report, 2006: 4) According to latest estimates, HIV prevention services reach only one in ten of those most at risk. (UNAIDS Global Report, 2006: 4) At the XVI International AIDS Conference in Toronto, Canada in August 2006, the need to intensify and accelerate prevention efforts was at the centre of deliberations at most sessions. For example, UNAIDS, the International Council of AIDS Service Organizations (ICASO), the Treatment Action Campaign (TAC), the governments of India and Sweden and Merck pharmaceuticals launched the initiative of ‘uniting for HIV prevention’ which was well received by a number of countries. Emphasizing the urgent need to rapidly scale up prevention interventions, UNAIDS Director, Peter Piot called for concerted efforts to build on the good work already taking place and mobilize an alliance for HIV prevention that goes ‘beyond the converted’ involving more than ‘the usual suspects’, and with strong links to HIV treatment activism.

Central to the global commitment to universal access to HIV prevention, treatment, care and support by 2010, is an urgent need to intensify HIV prevention efforts in both size and scale to halt growing infection rates and sustain the gains that have already been made.(UNAIDS GLOBAL REPORT, 2006).

It is for this reason that the Global HIV Prevention Working Group was inaugurated in 2002 by Bill and Melinda Gates Foundation and the Henry Kaiser Family Foundation as a necessary step towards reinforcing the fact that HIV prevention still remains the most effective strategy towards addressing the global AIDS pandemic.

The International working Group seeks to inform global policymaking, program planning, and donor decisions on HIV prevention, and advocate for a

comprehensive response to HIV/AIDS that integrates prevention and care.

Following this, a number of countries across the world have instituted special committees and work groups to mainstream and rejuvenate HIV prevention efforts. UNAIDS describes this as “uniting for HIV prevention’ with others who share this goal – including civil society, treatment activists, the private sector and governments to call for the global community to mobilize an alliance for intensifying HIV prevention.

According to UNAIDS, “We need an alliance that is united by commitment to the goal of saving lives, even if we may have different tactics. We need an alliance that draws in the best and brightest minds of our generations, and that is a partnership between governments, people living with HIV, the most vulnerable groups, civil society, faith-based organizations, business and international institutions”. UNAIDS goes on to state that; “Uniting for HIV prevention” is a consolidation of existing advocacy and public mobilization efforts around HIV prevention and aims to harness the collective strengths of organizations in bringing about a sustainable response to HIV epidemic.

In summary therefore, the tasks facing countries in implementing effective and sustainable HIV prevention programs are:

- To foster leadership on HIV prevention with key stakeholders at the global, regional and national level to achieve community action
- Promote and support joint activity, activism and partnership amongst a variety of stakeholders
- Promote sound evidence and draw on the experience of communities
- Act as a convening body around scaling-up HIV prevention

Relevant National Context and Rationale for a National Prevention Plan:

Substantial progress has been made by the federal government, in facilitating the implementation of the national HIV/AIDS response’ activities in the past five years. A major achievement has been the adoption of the “3,ones” principle (one national plan, one central coordinating authority and one national strategic plan). The relevant structures are now taking shape, capacity has been substantially



built especially at the national level, political and popular support is at its peak while public private partnership is being gradually fostered.

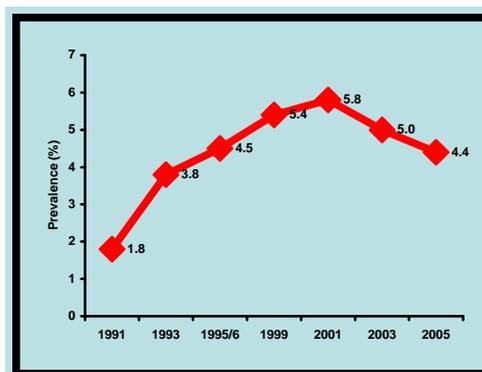
The Maiden HIV/AIDS Plan of Action: the HIV/AIDS Emergency Action Plan might have had its weaknesses but its strong point was that it was more prevention-focused and aligned with the thinking of Nigerians towards prevention as the ultimate remedy to the HIV/AIDS pandemic. However, at the eve of developing a National Strategic Framework for Nigeria two years ago, the need to scale up HIV treatment for PLWHAS became very urgent. With support from donor agencies, especially WHO and USG, the national antiretroviral program commenced and emphasis seemed to have shifted wholly to ART delivery. Soon the National Health Sector response became synonymous with ART delivery and government investments and pronouncements were skewed in favour of ART and a holistic approach to the epidemic was being neglected. In calling for a holistic approach to the response which gives equal attention to the HIV prevention, the following are worthy of note:

1. The data from the 2005 HIV sentinel survey indicated that about 4.4% of Nigerians are infected with HIV, thus implying that about 93 % of Nigerians are not infected. This fact highlights the need to embark on a well coordinated National HIV/AIDS prevention program to ensure that we keep the greater proportion of the Nigerian population free of HIV infection.(Technical Report National HIV/Syphilis Sero-Prevalence Sentinel Survey, 2005)
2. Nigeria's HIV epidemic is described as still largely within the Most-At-Risk-Populations (MARPs) and thus prevention activities should be suitably targeted within and outside the Most at Risk communities.(UNAIDS GlobalReport, 2006:AIDS In Africa,Three Scenarios)
3. A number of international documents for which Nigeria is signatory, from UNGASS to political declaration on HIV, the Abuja ATM summit resolutions and others relating to universal access to HIV/AIDS prevention, care and treatment services highlight prevention as key to success in stemming the tide of the epidemic.

4. Lessons learned from the implementation of PEPFAR, the WHO 3 by 5, and the presidential mandate on ART scale up point to the need for a very strong collaboration between prevention and treatment.
5. There is poor coordination of HIV prevention activities in the country, activities are disconnected, disjointed and episodic. There is no way of determining what works, where and what strategies should be emphasized. For instance, BCC which is just one component of prevention has a Technical Working Group (TWG). This implies that emphasis is being placed on sexual modes of transmission leaving out those related to medical transmission.
6. Thus, a National Prevention Technical Working Group (NPT-WG) was constituted to ensure synergy between the different components of prevention, as well as assure coherence with intervention on treatment, care and support.

Epidemiology of HIV/AIDS in Nigeria

AIDS was first reported in the country in 1986. The National HIV prevalence was 1.8% in 1991, 4.5% in 1996, 5.8% in 2001, 5.0% in 2003 and 4.4% in 2005. The epidemic in Nigeria has since extended beyond the high-risk groups to the general population. While some parts of the country are more affected than others, there is no state or community that is unaffected. With a median HIV prevalence of 3% or higher in 31 of the 37 states, the epidemic appears to be generalised. However, the trend shows variations across states with prevalence continuing to rise in some while declining in others.(Technical Report National HIV/Syphilis Sero-Prevalence Sentinel Survey, 2005)



National HIV Prevalence rates (1991 -2005)



Source: National Agency for Control of AIDS

From the results of the 2005 HIV Sero-Prevalence Sentinel survey, an estimated 2.6 million people were living with HIV/AIDS in the country. The report also indicated that HIV was more prevalent in the 25-29 year age group. The survey estimated for new infections in 2005 was 250,000 adults and 67,000 children <15yrs, and this will progress to 346,150 in the adult population and 75,780 in children <15yrs by 2010. (Technical Report National HIV/Syphilis Sero-Prevalence Sentinel Survey, 2005).

Prevention: The Fulcrum of HIV/AIDS Control

The Nigerian Government is a signatory to a series of global commitments (Box 1) with the ultimate objective of achieving universal access to comprehensive HIV/AIDS Prevention, treatment, care and support by 2010

Box 1

- The Millennium development Goal 6 to halt and reverse the spread of the epidemic by 2015
- The 2001 United Nations General Assembly declaration of commitment on HIV/AIDS
- The 2005 Gleneagles G8 Universal access target
- The African Union Abuja declaration of 2006 for accelerated action
- The 2006 United Nations Political declaration on HIV/AIDS

National Response

As soon as the first case of HIV/AIDS was diagnosed in the country, Nigeria mounted a National response, which was expanded in 2000 with the establishment of the Presidential Council on AIDS and the National Action Committee on AIDS. This provided the basis for a coordinated effort to provide comprehensive prevention, treatment, care and support services through policy formulation and development of plans, including the HIV/AIDS Emergency Action Plan (HEAP), the National HIV/AIDS Policy, the HIV/AIDS Health Sector Plans and the National Strategic Framework (NSF). These focused on scaling up access and quality of HIV/AIDS services and included a wide range of interventions such as BCC, FLHE, VCT, Blood

safety, PMTCT, Palliative care(OIs), ART, home based care, support for OVC and PABA and adequate treatment of STIs. Following the strategic thrust of these plans, some interventions are being widely implemented, while others are in need of scale-up while the rest are at their formative stages.

The national response under the multisectoral platform, the strengthening of National Action Committee on AIDS (NACA) and the application of the “3 Ones” principle (One National Framework, One Strategic Plan, One Monitoring and Evaluation Framework) has led to better coordination, linkages, networking as well as increased access to available resources and interventions. There has also been an improvement in the participation and the contributions of the private sector, civil society organizations, bi-lateral and multi-lateral organizations, PLWAs and the United Nations agencies. More resources have been injected through government/public funding, Global Fund to fight Tuberculosis, AIDS, and Malaria, the US government (PEPFAR) and the World Bank (MAP). Furthermore, greater commitment and engagement have been demonstrated by government, at the federal, state and local government levels in fighting the epidemic in Nigeria.

Specifically in the area of Prevention, the National HIV/AIDS Policy (2003) and the National HIV/AIDS Strategic Framework for Action (2005-2009) provides a strong and comprehensive framework for prevention efforts including a balanced “ABC” approach. A National Prevention Technical Working Group was constituted to provide better coordination and harmonization of prevention programs as well as provide technical guidance at the national and state levels towards achieving set prevention goals within the National Strategic framework.

HIV PREVALENCE IN NIGERIA



with multiple partners have a 60% increased risk, women are 10% higher than men. multiple partnering are of particular concern because of the high infectivity during recent or active infection.(NARHS, 2005)

✓ **Lack of Established STI Programming for MARPS**

At several high-risk sites supported by the National HIV programme, it has been noted that the package of services provided to MARPS was limited. Linkages to HIV counseling and testing, STI management and treatment were weak and have relied primarily on referrals.

✓ **Continuing Risky Behavior of Males in General Population**

Risky behavior in the general population is more prevalent among men than women. Twenty six percent (26%) of men report having more than one sex partner in the last 12 months as against 2% in women. Seven percent (7%) of men had more than one marital partner. (NARHS, 2005)

✓ **Gender Inequalities**

Underlying causes and consequences of HIV/AIDS infections in men and women varies reflecting differences in biology, sexual behaviors, social attitudes, economic power and vulnerability. These factors propagate inequalities between sexes with attendant limitation of women's access to care and services in Nigeria. Vulnerability for women is increased by cultural attitudes and norms that discourage safe sex negotiation, encourage cross-generational sex, lack of access to education and violation of women's human rights. Economic dependence of women and the likelihood of women engaging on menial poorly remunerated jobs further creates a setting for encouraging transactional sex, sexual violence, in addition to heightened cultural attitudes that celebrates masculinity in context of number of sexual partners and control on sexuality. These gender issues contribute to driving the epidemic in Nigeria.

✓ **Economic Drivers**

The relationship between poverty and HIV/AIDS includes the spatial and socio-economic distribution of HIV infection and consideration of poverty-related factors which

affect household and community coping capacities; While the relationship between HIV/AIDS and poverty lies in understanding the processes through which the experience of HIV and AIDS by households and communities leads to an intensification of poverty and this is greatly magnified in the female population.

HIV impoverishes individuals and communities and erodes the capacity of the socio-economic system through losses of human resources. Poverty brings about weak endowments of human and financial resources, such as low levels of education with associated low levels of literacy and few marketable skills, generally poor health status and low labor productivity. These conditions of social exclusion increase the problems of reaching the poor populations through programmes aimed at changing sexual and other behaviors. The resultant effect is that the poor adopt behaviors which expose them to HIV infection

Guiding principles for Intensifying Prevention

The National response to intensifying HIV prevention is tailored around the prevention project planning cycle recommended by UNAIDS.(UNAIDS 2007)

A. Providing Leadership for a Strong National Prevention Response

The Nigerian Government has shown strong commitment and provided leadership for HIV/AIDS control efforts as manifest in a strong national and state response and proliferation of community based prevention activities across the country.

The national agency guided by the principles of the "3 Ones" has ensured active coordination, accountability and results oriented programming across partners, agencies and all tiers of government. Coordination efforts have included the Expanded Theme Group forum that provides guidance and acts in an advisory capacity to the Federal Government of Nigeria. Complimenting this effort are various technical working groups, which have been constituted to provide program specific technical direction to actualize universal access to comprehensive prevention, treatment, care and support services in Nigeria.



B. Generating Knowledge about the AIDS Epidemic in Nigeria.

The National prevention effort has appreciated the need to be in conformity with this principle. In this regard, efforts to generate information about the epidemic have involved several planned activities, which include a sentinel HIV/Syphilis seroprevalence survey amongst ANC attendees; a National AIDS & Reproductive Health Survey with bio-markers (NARHS+); Integrated Biomedical Behavioral Surveillance Survey (IBBS); Demographic Health Survey (DHS); Mid-term Review of the National Strategic Framework (NSF); Review of the Behavioral Change Communication Strategy (BCC) and other planned Public Health Evaluations.

C. Prioritizing and Tailoring the Response to the Epidemic

The National leadership has appreciated the complexities of the epidemic and focus is currently being channeled to ensuring that HIV prevention leads the National response.

Due consideration has been given to the current geographic and population spread of the disease and in response efforts are being made to design geospecific and population specific interventions while not compromising the tenets of quality and universal access.

Specific Prevention efforts are being targeted at MARPS and other vulnerable populations while interventions for the general population are sustained.

Scale up of HCT through “moonlighting” for MARPS, mobile and community outreach services have been very effective and the healthcare provider initiated PMTCT services with opt-out option has markedly increased access. Application of the MIPA principle through training and deployment of PLHA in workplaces has given visibility and made in-roads to addressing issues of stigma.

MIPA Prevention programming is complimented with income generation activities to reduce the vulnerability predisposed by poverty and lack of economic opportunities especially with young girls, CSW, widows and other vulnerable out of school youths.

With current analysis showing little or no rural-urban variation in HIV prevalence, scale up efforts are now guided by the principles of state saturation and extension of services to rural communities.

Government and development partners have also intensified efforts at reducing medical transmission of HIV manifest through increased focus on establishment of efficient and functional centrally coordinated blood transfusion services and safer injection practices. Recent efforts in launching the National Blood Transfusion and the Injection Safety and Health Care Waste Management policies further emphasize efforts in this direction.

D. Setting Realistic and Measurable Prevention Targets

The Nigerian National Response Information Management System (NNRIMS) and the NNRIMS Operational Plan (NOP) has evolved to provide a source pool for measurable targets for the national response. Regular review of this document ensures that targets reflect current strategic thinking and scale of the national response. Several tiers of service delivery in effect derive their operational and programme targets from the NNRIMS.

E. Using Strategic Information to Steer Programming

Planning for the NSF was guided by strategic information derived from the several surveys conducted in the past. Subsequent results from future studies and other programming data will also input into the future reviews of the NSF. Outcome level indicators within the NNRIMS for the several components of Prevention serve as milestones for ensuring that scale up efforts are appropriate and focused.

Target population groups

- PLHA
- Workplace Populations
- MARPS
 - Sex workers
 - Transport workers
 - Uniformed service men
 - MSM
 - IDU's
 - Youths (In-school/Out of School)
- General population
- People with disability
- Children



Goal of the National HIV & AIDS Prevention Plan (NHAPP)

The goal of the NHAPP is to contribute to the reduction of HIV prevalence by 25% in 2009 and ensure prevention of new infection by 55% by 2010. The specific objectives is to have 95% of the general population and specific groups make appropriate behavioural changes (safe sex, abstinences etc)

Components of Prevention

ABC

Issues:

- No national guideline on ABC for the different sectors
- Exclusion of children under 14 years
- Exclusion of the workplace sector, FBOs.
- Exclusion of people with disability, incarcerated populations both male and female.
- Women are not adequately addressed in current strategies .
- Exclusion of women in programme designs with respect to violence, socio-cultural issues such as condom use and negotiation
- Inadequate knowledge on ABC
- Peer education in primary school is emerging
- Inadequate implementation of the national workplace policy on HIV/AIDS
- No national strategy on ABC for workplace sector.
- Inadequate peer education amongst the workplace sector
- Inadequate national research on ABC
- Limited programmes for married female adolescents, that addresses issue of transition from abstinence to sexual activity, safe sex negotiation and issues of risk reduction
- Inadequate implementation of the education curriculum (Baseline survey done by UNICEF/ Federal Govt / Partners shows about 22% implementation)
- Minimal service provision in the education sector
- No harmonized peer education system
- condom rejection by certain groups (religious etc)

- Poverty viz- a-viz the need for economic interventions as a prevention component
- Restriction of mass media on the promotion of male & female condom use
- Lack of visibility of marginalized children and right to be protected (House-holds e.t.c.)
- Limited programmes targeting male sex workers
- Inadequate Promotion of water based condom lubricants
- Inadequate Quality control of condoms
- Insufficient Social marketing of female condoms
- No programmes for transiting populations from Abstinence to sexual activity
- Limited engagement of Faith Based Organizations (FBOs) on ABC programmes.
- No National strategy on Prevention for Positives
- Insufficient interventions addressing Cross-generational and informal transactional sex.
- Multiple, concurrent sexual partnering.
- Absence of a robust programme addressing stigma and discrimination related to HIV/AIDS

Recommendations

- **Optimize mass media approach**
 - ❖ Media practitioners need training and retraining on appropriate HIV prevention messages responsive to identified risk factors (unprotected sex, multiple partnerships, gender and economy related vulnerabilities)
 - ❖ Targeted Abstinence campaign (for youth) to delay sexual initiation
 - ❖ Agenda Setting in the media
 - ❖ Promotion of Radio drama / jingles to reinforce HIV prevention information & skills for adolescents & youth
 - ❖ Partner reduction campaign for youth and married population
 - ❖ Media campaign targeting socio-cultural issues disaggregated by age, sex & location
 - ❖ Media campaign on Trans-generational sex
 - ❖ Harmonization of material development, distribution & use



➤ **Scale up Community mobilization efforts**

- ❖ Engagement of FBO / Civil Society Organizations, community groups, parents, and significant others on HIV/AIDS knowledge, Skills & Services
- ❖ Advocating to certain groups (e.g. gatekeepers) to promote condom use
- ❖ Community mobilization for HIV Education

➤ **Strategize resource mobilization efforts**

- ❖ Greater involvement of the Public - Private Sector
- ❖ Federal Government of Nigeria & Partner commitments to be sustained
- ❖ Undertake Resource Availability & Utilization Mapping
- ❖ Develop Resource Mobilization plan

➤ **Foster and sustain partnerships**

- ❖ Media
- ❖ Community
- ❖ FBO, CSO, NGO
- ❖ Line Ministries & Agencies
- ❖ Development Partners

➤ **Increase scope and content of capacity building efforts**

- ❖ Media training on ABC
- ❖ Teachers training on FLHE (Pre & In-SET)
- ❖ Training of partners & stakeholders on children and HIV/AIDS
- ❖ Training of peer educators
- ❖ Training of focal persons on HIV/AIDS in the Work Place
- ❖ Training of NGO on ABC
- ❖ Project management training
- ❖ Training on ABC for the most vulnerable groups including hard to reach children, physically challenged
- ❖ Skills based HIV and sexual education programs
- ❖ Addressing power imbalances, inequity and poverty
- ❖ Training centered around empowering girls and young women to address vulnerability issues

- ❖ Promoting condom use and negotiation skills
- ❖ Comprehensive male and female condom programming
- ❖ Update and implement National BCC strategy

➤ **Harmonize ABC guidelines/curricula to ensure quality**

- ❖ Adopt models of Peer education that have worked in Nigeria
- ❖ Development / Adaptation of Curriculum on ABC activities in Nigeria
- ❖ Development of Standard of Practice / Guideline on ABC Interventions to address issues of appropriate mix, duration, intensity and uptake
- ❖ Standardization of ABC intervention

➤ **Research & Documentation**

- ❖ Population based survey on high risk populations is required to identify the determinants influencing transmission in those groups and guide the design of ABC and Condom programmes
- ❖ Population based impact assessment on ABC intervention amongst the general population
- ❖ Development of system for continuous documentation of best practices on ABC

➤ **Advocacy & Policy development**

- ❖ Advocating for policy reform on socio-cultural and economic issues that promote HIV transmission, stigma and discrimination / gender inequalities
- ❖ Advocacy challenging traditional gender norms and definitions of masculinity
- ❖ Develop a National strategy on ABC for the workplace.

PMTCT Issues

- The HIV prevalence among women Nigeria has 4.4% HIV prevalence in women receiving ANC



- 10% of HIV infections are as a result of mother to child transmission
- An estimated 73,000 HIV-infected infants were born in 2005; The highest number for any country in the world (Technical Report National HIV/Syphilis Sero-Prevalence Sentinel Survey, 2005).
- 1.2m children have been orphaned in Nigeria since the beginning of the epidemic; the highest for any country globally(NARHS,2005)
- Insufficient PMTCT services; about 258 PMTCT sites currently exist in Nigeria; this is <5% coverage
- PMTCT services are urban centers
- Only about 309,000 counseled and tested under PMTCT programme (PMTCT guidelines, 2005)
- Minimal community involvement the existing PMTCT health facilities.
- Even where health facilities are available in high prevalence area, PMTCT services are not available

Recommendations

- Expansion of services to States and local government levels
- Scale up to a minimum of 2 additional facility based PMTCT sites per LGA in 2 years
- Advocacy to states and local governments on the need for PMTCT
- Institution of a policy of free maternal and child health services
- Adaptation/ development of a PMTCT training manual for PHCs
- Introduction of community based PMTCT program
- Integration of reproductive health with HIV services

HCT Issues

- Poor quality assurance
- Inadequate confidentiality and ethical service provision
- Presence of stigma and discrimination
- Most services are facility based
- Poor access to services especially at the community level

- Poor access to health services amongst women due to disempowerment as it relates to health care seeking decisions
- Current access mainly at the tertiary and secondary facility levels
- clients demand for Counseling and Testing is still low at 43%(NARHS, 2005: pg.73)

Recommendations

- Expansion of community outreach/mobile HCT services
- Expansion of Home-based/door to door HCT services
- Provision of HCT services at all Primary Health care centers
- Scaling Up HCT for MARPs
- Scaling Up Couples counseling and testing (CHCT) and male centered counseling and testing
- Involvement and full integration of Private Health Care Providers in HCT services provision
- HCT fully integrated into blood transfusion services
- Post test counselling should provide information on the correct and consistent use of male and female condoms; provide condoms and/or referrals to condom outlets as part of HCT service package
- Involvement of all stakeholders at all levels of government-Federal, State and LGAs for HCT policies, programs and service management
- Scaling up of VCT facility and community based VCT centre
- Stand alone HCT centres at the community level should be within reach of all – not more than 10 minute walk
- Promotion of available services
- Non-lab personnel should be trained to conduct rapid tests so that more people will be reached with services
- Lab scientists should be used as trainers with the National body involved in quality control –
- Increase the number of HCT centres ;stand alone centres especially in the rural communities



- Adaptation of the WHO/CDC training package for HIV rapid testing
- Promoting the use of the National HCT guideline.
- Use of PLWHA and community workers in HCT services
- HCT as entry point to prevention through Post-test counseling and referral
- Post-test counseling and referral for PLHA with high CD4 count for Positive prevention
- Full integration of Provider Initiated Counselling and Testing in all health-care facilities

Blood Safety

Issues

- Highly fragmented Hospital Based and unregulated Blood Transfusion Services
- Use of Paid Donors and Family Replacement instead of voluntary non remunerated donor
- Confusion of HIV diagnostic testing algorithms with screening of donated blood
- Poor blood banking expertise
- Inappropriate use of blood and blood products, (haemovigilance)
- Insufficient Blood supply and distribution logistics including commodities
- Incomplete and improper screening of blood for TTI's
- Weak capacity at facilities for blood safety (personnel & institutional)
- Lack of skills in recruitment of Voluntary Non remunerated blood Donors among Health Care Workers
- Poor Understanding of Voluntary Blood Donation
- Lack of health care waste management programs at facilities
-

Recommendation

- National Coordination and Regulation of all Blood Transfusion Service with Legislative Backing of the National Policy
- Band of Commercial Blood Transfusion Services

- Implement standards by NBTS/national policy on screening i.e all transfused to be fully screened with an antigen testing method for all TTI; including 'emergency screening targets of less than 20% of blood transfused'
- Samples of blood transfused with emergency screening should be retested at the nearest NBTS center
- Increase efforts to actualize 100% voluntary non remunerated blood donor system
- GON through NBTS and donor agencies should build capacity of hospital and care /treatment staff on phlebotomy, donor recruitment, lab screening, blood banking and blood haemovigilance
- Proper data, blood supply/distribution and logistics management should be coordinated by the NBTS
- Appropriate designation, recognition and public enlightenment on 'Blood safety service units'
- Establishment of blood transfusion committee at state and health facility level
- Linkage of blood safety programs to other program-malaria, maternal health, HCT, Lab services etc
- Increase access to PEP

Injection Safety

Issues

- Lack of PEP Protocol
- Lack of functional Infection prevention and control committees at all levels
- Lack of adequate facilities for collection and disposal of injection and other health care wastes
- Improper treatment and disposal of injection materials and other health care waste.
- Over-prescription of injections
- Limited availability of guidelines for health workers on injection safety practices including the care of needle stick injuries at all health care levels
- Inadequate supply of injection materials leading to reuse of injection supplies without sterilization

Recommendation

- Implement effective behavioral change approaches to injection safety, targeting both



health workers and communities through effective advocacy, community mobilization, communication, and creating an enabling environment.

- Training of health care workers on injection safety issues and appropriate waste disposal practices.
- Establish standardized PEP protocols in all facilities
- Educate and encourage patients to seek treatment only from qualified providers.
- Support supervision of health care workers involved in administration of injections and the process of disposal and destruction of health care waste.
- Use of behavioral trials to model effective behavior change approaches for clients and health workers; to discourage unnecessary injections, reduce re-use of injection materials, discourage sharing injection materials among family members, and safely dispose waste immediately and destroy it within the week.
- Appropriate procurement, distribution and monitoring of injection equipment and related supplies such as safety boxes, auto disable syringes and needles .
- Establish and implement a system for ensuring that injections and other health care waste are properly managed by persons and facilities generating them both in the health sector and in the communities.
- Develop and disseminate guidelines for injection Safety and health care waste management
- Construction and installation of health care waste treatment/disposal facilities.
- Safe collection and transportation of sharps ,other Health Care Waste and their disposal using incinerators or other environmentally approved means.
- Establish and strengthen infection prevention and control committees in facilities

Condom programming & Other preventions, (e.g. treatment of OIs e.t.c.)

Issues

- Resistance to condom promotion by FBOs, Govt & Other Stakeholders

- Inadequate skills on condom use and negotiation:– Mis-conception about condom, low acceptance of condom
- Availability, accessibility, and affordability of female condoms

Recommendations

- **Redesign of Mass media approach and content**
 - ❖ Awareness creation on where condom vending/outlets are.
 - ❖ Condom promotion to break barriers
 - ❖ Demand creation
 - ❖ Repositioning of condom use for dual protection
- **Encourage community involvement**
 - ❖ Community mobilization for condom programming
 - ❖ Create social support for condom use
- **Build capacity on appropriate condom use**
 - ❖ Media Training on condom promotion
 - ❖ Training of health workers
 - ❖ Condom negotiation skill training for vulnerable groups especially women
 - ❖ Training of CBO / NGO on condom logistic management
- **Increase product availability**
 - ❖ Increase Access, Coverage and Availability of male & female condoms

STI management

Issues

- STI control overshadowed by HIV control at the level of implementation
- Since over a decade of introduction, Syndromic management has not been fully adopted at many health facilities
- Limited research activities on STI including drug resistance monitoring
- Inadequate funding and coordination of activities

Recommendations

- **Effective use of the mass media**



- ❖ Develop, print and disseminate general and audience-segmented IEC materials on STI
- ❖ Design/update resource/press kits for media practitioners STI and HIV
- ❖ Commission and air weekly drama programs on major radio stations to sensitise on STI/HIV issues
- ❖ Commission and air jingles on STI prevention & STI/HIV issues
- ❖ Promote bulk text messages on STI/HIV sensitization
- ❖ Commission and air jingles on STI/HIV symptoms, management and management facilities
- ❖ BCC campaign

➤ **Greater involvement of the community**

- ❖ Commission community participatory dramas
- ❖ Conduct Inter-personal communication with community groups
- ❖ Implement Peer Education program among general population as well as different segments of the population
- ❖ Sensitisation of community leaders against stigmatising MARPs
- ❖ Build effective linkage/referral systems for STI management in communities

➤ **Provide more capacity building opportunities**

- ❖ Training/retraining of media practitioners on relationship b/w STI and HIV and its communication
- ❖ Proposal development workshops for community groups
- ❖ IEC material development workshops
- ❖ Project/grant management trainings for CBOs
- ❖ M&E training for program managers and community groups implementing STI activities
- ❖ National sensitization workshop for lecturers /tutors of health training institutions
- ❖ Zonal TOT (Pre-service and in-service training) for Health Care Providers(HCPs)

- ❖ Step down training at States and LGAs for HCPs
- ❖ Logistics management training for staff at different levels of the different distribution chain
- ❖ Training of MARPs on correct of use of condom

• **Ensure accessibility of services**

- ❖ *Establish designated youth-friendly centres*
- ❖ Establish STI outreach centres among MARP communities
- ❖ Print and disseminate clinic aids (Wall charts, management manual, IEC, etc)
- ❖ Create access to new information on STI issues in State STI/HIV Units

➤ **Standardize curriculum & Guidelines**

- ❖ Review of National guidelines and training instruments informed by research findings
- ❖ Adopt/adapt LSM guidelines and protocols

➤ **Guide STI programming through research**

- ❖ Biennial validation of Vaginal Discharge algorithm
- ❖ Conduct bi-annual Measuring Access and Performance (MAP) surveys
- ❖ Biennial drug resistance monitoring

➤ **Advocacy and Policy development**

- ❖ Advocate and develop National Policy on STI
- ❖ Advocacy meetings with donors to support STI-related activities
- ❖ Advocacy/ sensitization of medical/health regulatory bodies on comprehensive Syndromic management of STIs
- ❖ Integration of comprehensive Syndromic management of STIs into curriculum of training institutions in Nigeria
- ❖ Advocate for speedy integration of RH and STI services
- ❖ Advocacy meetings to community groups (women, okada riders,



- drivers, etc) to sensitise their members on STI/HIV issues
- ❖ Advocacy meetings with major GSM networks to support bulk text messages on STI/HIV sensitization

New Prevention technologies/Male circumcision

Existing technologies (condoms, sterile injection equipment, STIs treatment and PMTCT) though highly effective in reducing HIV transmission, additional HIV prevention technologies are required to increase the range of prevention options available to individuals. This involves research and development of new prevention technology tools

Issues

- Poor access to information on New HIV Prevention Technology
- Poor research literacy by community members
- Poor support and funding for research on New HIV Prevention Technology
- Poor commodity distribution mechanisms that could facilitate future access of NPT products
- Poor local capacity (human and infrastructural) to support new HIV prevention technology clinical trials
- Lack of national data on male circumcision practices
- Lack of supply of new prevention technology tools
- Lack of access to information on new technologies including microbicides and vaccines

Recommendation

- Prioritization public sector funding for research on vaccines, microbicides and other new prevention tools
- Encourage public and private sector support (by way of incentives) for research into other new prevention technologies such as female control barrier methods
- Provide incentives for private sector investment in research for new prevention and facilitate local, regional and international collaboration in this respect

- Conduct nationwide assessment on practice of male circumcision and mapping of areas it is not practiced
- Identify possible system gaps that could impede future access to NPT when developed and facilitate processes to address them.
- Integrate NPT information into HIV prevention communication such information should facilitate research literacy efforts within IEC efforts

Integrating Prevention to treatment & Care

Issues

- Stigma and discrimination
- Greater information on the prevention of opportunistic infections
- Prevention for Positives (re-infection with different strains of the virus).
- Belief that treatment with ARV prevents transmission of the virus from infected persons

Recommendation

- Adequate emphasis on the incorporation of prevention messages i.e. Adherence counseling and other health worker-client contact.
- Increased treatment literacy and education
- Increased community education/ public awareness

Integrating Prevention to Reproductive health

Issues

- Inadequate offer of HCT as part of reproductive health package.
- Inadequate pre and post test counseling done especially for negatives.

Recommendation

- Improved integration of HCT into reproductive health strategies.
- Adequate pre and post test counseling for both negatives and positives.

Economic Interventions

Issues

- Social and political exclusion of the poor and most at risk population from economically viable options in terms of skills acquisition and sustainable livelihood programs



- Lack of information/data on number of female headed households and their economic status
- Propagation of economic policies and programs that marginalize women, discourage girl child education and propagate exclusion of women from highly paid jobs

Recommendation

- HIV-specific programmes that are related to the needs of the poor with the possibilities of changing the socio-economic conditions of the poor.
- Mix of non-HIV related programme activities with livelihoods strategies to promote economic power through programs such as micro-credit, vocational training and placement, and linkages to sustainable and non-traditional market opportunities.
- Social change prevention program strategies that stimulate community dialogue regarding social norms that address gender inequalities.

Achieving behavior change through appropriate use of best practices and reinforcement of prevention interventions

The Nigeria HIV prevention program over the next 2 years will adopt a new strategic thrust. To avert new infections in this time period, behavioral change needs to occur within the general population and populations currently involved in risky behavior.

To this end, a review of current efforts at prevention shows that varied and single intervention approaches are in use by implementing agencies and these have not actualized the expected behavioral change required to avert new infections.

To forestall the effect of this, the *reinforcement* approach is to be promoted for services offered to clients. A compendium of proven best practices in Nigeria is to be developed and from within this pool, it is recommended that partners involved in HIV prevention be required to provide a minimum package of services from this pool to reach clients.

These best practices are as indicated in Table below

- A. Mass media approach (Radio/TV)
 - TV/Radio jingles
 - Discussion slots
 - Adverts
 - Punch lines
- B. Community awareness campaigns
 - Rallies
 - Focus group discussions
 - IPC
 - Community dialogues
 - Promotion of counselling and testing
 - Condom messaging and distribution
 - Balanced ABC messaging
- C. Specific population awareness campaigns
 - Focus group discussions
 - IPC
- D. Peer education models
 - Age peers
 - Social peers (IDU, MSM,)
 - Job peers
 - PLWA
- E. Peer Education Plus model
 - Folklore
 - Dance
 - Drama
 - Sports activities
 - Use of role models
- F. Workplace Programme
 - GIPA
 - Condom service outlets
 - Development and implementation of workplace policies
- G. Infection control measures in clinical settings
 - Universal precautions
 - Post exposure prophylaxis
- H. Provision of STI management
 - Training on STI syndromic management
 - STI counselling for affected individuals



- STI treatment services (Diagnosis & drugs)

I. School based approach for youths

- Age appropriate messaging
- Curricula based approach
- Non-Curricula based approach (Dramas, HIV Clubs)

J. Vulnerability issues

- Income generating activities
- microfinance,
- alternative livelihood source, (skills acquisition)
- Essential life skills training
- Addressing gender issue
- Improving male support

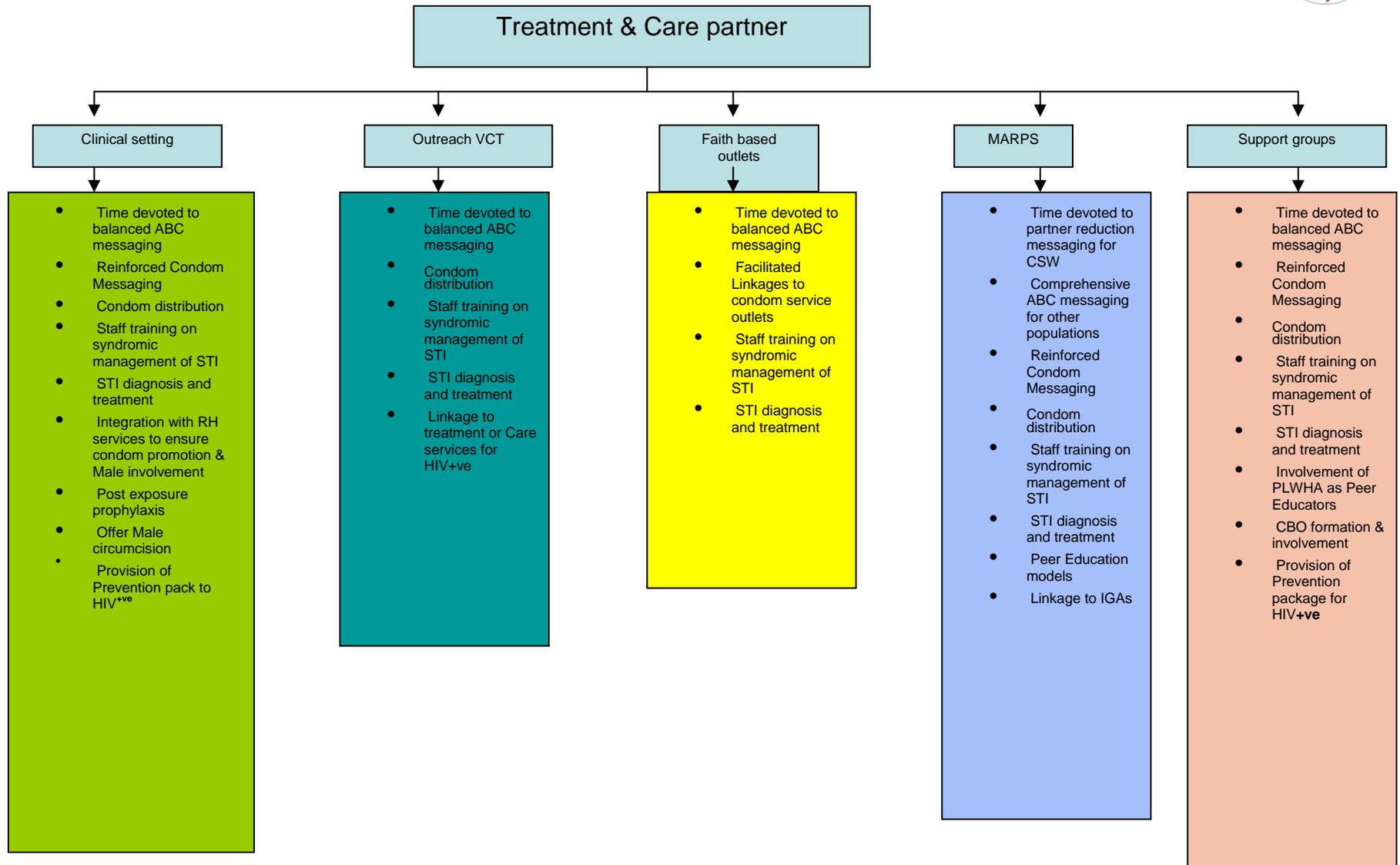
Partners will be expected to utilize a minimum of three of these interventions to reach a target and these will be reinforced with National mass media activities which will be championed by the GoN. The minimum package of services will ensure that the intended behaviour change outcomes are achieved and will provide a proxy tool for measuring targets reached with prevention services. Although this review will result in an increase in cost of delivering prevention services in the country, it will ensure a higher quality program package with emphasis on intensity and appropriate dosage of messages and services. The reinforcement in messaging by this approach will hopefully result in behaviour change limiting risky behaviour and obtaining essential life saving skills.

To ensure comprehensiveness of HIV/AIDS services, steps will be taken to ensure integration of ABC with care and treatment services. Treatment partners should be encouraged to jumpstart this integration. HIV clinics/hospitals will be supported in the integration of prevention counseling and services for people living with HIV and for other clients through a VCT linkage. Specifically, healthcare providers and lay counselors in care and treatment settings will be trained to deliver prevention messages during routine clinic visits using tools and job aids. These prevention messages will be delivered during risk-reduction counseling, family planning counseling, and sexually transmitted infection management and counseling. Partner reduction messages will be given, emphasizing faithfulness to one partner, mutual fidelity while

discouraging intergenerational and multiple sex partnerships. In line with this also is the need to provide condom service outlets at every treatment facility and provide similar linkages with all VCT centres be it fixed or mobile.



Standards for Treatment & Care Partners in HIV Prevention





SUMMARY FRAMEWORK FOR PREVENTION ACTIVITIES

	ABC	PMTCT	Blood Safety / Injection Safety	HCT	Male Circumcision /New prevention technologies	Research	Condom programming and other prevention (OI Rx, etc)	STI Management	Economic Intervention
Mass Media	<p>Targeted Abstinence campaign (for youth) to delay sexual initiation</p> <p>Agenda Setting in the media</p> <p>Promotion of Radio drama / jingles to reinforce HIV prevention info & skills for adolescent & youth</p> <p>Partner reduction campaign for youth and married population</p> <p>Media campaign targeting socio-cultural issues disaggregated by age, sex & location</p> <p>Media campaign on inter-generational sex</p> <p>Harmonization of material development, distribution & use</p>	<p>Communication strategies to generate demand</p> <p>Incorporate PMTCT into HCT communication and mobilization strategies</p> <p>Incorporate HCT and PMTCT education into the curriculum for training journalists in HIV/AIDS reporting</p> <p>Incorporate HCT and PMTCT access information in media messages at state and LGA levels</p>	<p>Roll out mass media campaign to promote voluntary and non-remunerated blood donation</p>	<p>Communication strategies to generate demand</p> <p>Incorporate into HCT communication and mobilization strategies</p> <p>Incorporate HCT and education into the curriculum for training journalists in HIV/AIDS reporting</p> <p>Incorporate HCT and access information in media messages at state and LGA levels</p>	<p>Develop a strategy to communicate importance of male circumcision to identified/ stratified audience (uncircumcised men, media, HCP.</p> <p>Produce jingles, IEC materials on male circumcision</p> <p>Develop mechanism for periodic media engagement on male circumcision in each zone including Lagos and Abuja (roundtables, workshops, seminars.</p>	<p>Evaluate media strategy for HIV prevention through STI management</p> <p>Establish a corps of media professionals to support advocacy for microbicides/HIV vaccine research and development</p>	<p>Awareness creation on the sites for condom</p> <p>Condom promotion to break barriers</p> <p>Demand creation</p> <p>Repositioning of condom use for dual protection</p>	<ul style="list-style-type: none"> • Design/update resource/press kits for media practitioners STI and HIV • Commission and air weekly drama programs on major radio stations to sensitise on STI/HIV issues • Commission and air jingles on STI/HIV issues • Promote bulk text messages on STI/HIV sensitization • Develop, print and disseminate general and audience-segmented IEC materials on STI • Commission and air jingles on STI/HIV symptoms, management and management facilities • Commission and air jingles on STI prevention • BCC campaign 	<p>Media campaign against stigma and discrimination in the work place</p> <p>Dissemination of policy</p> <p>Raise Awareness on HCT, care & support in the work force especially the informal sector</p>



Community Mobilization	Engagement of FBO / CSO & community groups, parents on HIV/AIDS knowledge, Skills & Services Community mobilization for HIV Education	<ul style="list-style-type: none"> Scaling up of PMTCT through establishing community based PMTCT sites Promotion of PMTCT services through community mobilization to generate demand <p>Train TBAs/retired health care workers to provide community based PMTCT services and promote male involvement</p>	<p>Mass mobilization for non remunerated blood donation</p> <p>Engagement of CSO and CBOs on</p>	<ul style="list-style-type: none"> Scaling up of HCT facility and community based HCT centre (Stand alone HCT centres – not more than 10 minute walk Absence of services during weekends – community sites advised to provide services during weekends and off hours 	<p>Mapping exercise to delineate communities not practicing male circumcision or circumcision of male adults</p> <p>Outreach to communities not practicing male circumcision</p>	Commission research/studies on factors perpetuating STI and HIV spread in communities and locally-relevant means of addressing them	Community mobilization for condom programming Community mobilization on condom use	<ul style="list-style-type: none"> Commission community participatory dramas Conduct Inter-personal communication with community groups Implement Peer Education program among general population as well different segments of the population Build effective linkage/referral systems for STI management in communities Sensitisation of community leaders against stigmatising MARPs 	Mobilize association of workers and employers including professional organization etc on work place policies on HIV/AIDS
Resource Mobilization	Public - Private Sector FGN & Partner Undertake Resource Availability & Utilization Mapping Develop Resource Mobilization plan	Public - Private Sector FGN & Partner Undertake Resource Availability & Utilization Mapping Develop Resource Mobilization plan Advocate for the development and implementation of a government policy for free PMTCT services (including CD4 counts)	Public - Private Sector Partnership on Production of Retractable Syringes and safety boxes	Public - Private Sector FGN & Partner Undertake Resource Availability & Utilization Mapping Develop Resource Mobilization plan	Public - Private Sector FGN & Partner Undertake Resource Availability & Utilization Mapping Develop Resource Mobilization plan	Public - Private Sector FGN & Partner	Public - Private Sector FGN & Partner Undertake Resource Availability & Utilization Mapping Develop Resource Mobilization plan	<ul style="list-style-type: none"> Community involvement in planning and funding of activities 	Government Dev Partners Employers of labour



Partnership	Media Community FBO, CSO, NGO Line Ministries & Agencies Dev Partners	Media Community FBO, CSO, NGO Agencies Dev Partners Advocate to the community leaders, LGA, CBOs, FBOs, TBAs to promote community PMTCT services and male involvement	Media Community FBO, CSO, NGO Line Ministries & Agencies Dev Partners	Media Community FBO, CSO, NGO Agencies Dev Partners Advocate to the community leaders, LGA, CBOs, FBOs, to promote mobile services	Media Community FBO, CSO, NGO Agencies Dev Partners	Media Community FBO, CSO, NGO Agencies Dev Partners	Media Community FBO, NGO, CSO Line Ministries & Agencies Dev Partners	<ul style="list-style-type: none"> • Develop/strengthen media-based NGOs • Develop/strengthen collaboration with GSM networks • Develop partnership with ART centres to provide STI management services • Collaborate with and support private health facilities to provide STI management services • Collaborate with established and efficient distribution systems (eg TB and ARV drugs) • Collaborate with NAFDAC to ascertain quality of drugs 	Employers and workers Organization NIBUCA Media CSO, NGO Fed Ministry of Labour Line Ministries & Agencies Dev Partners
Capacity Building	Media training on ABC Teachers training on FLHE (Pre & In-SET) Training of partners & stakeholders on children and HIV/AIDS Training of peer educators Training of focal persons on HIV/AIDS in the Work Place Training of NGO on ABC Project management training Training on ABC for the most vulnerable groups including hard to reach children, physically challenged	Revise training manual for personnel at the primary health care level Conduct TOT for Master Trainers on PMTCT Train HCW on PMTCT Train TBAs/retired health care workers to provide community based PMTCT	<ul style="list-style-type: none"> • Infrastructural development for health facilities for effective blood screening, storage and distribution ❖ Develop a training manual on Blood safety 	<ul style="list-style-type: none"> • Non-lab personnel should be trained to conduct rapid tests so that more people will be reached with services • Lab scientists could be used as trainers and in the area of quality control – National body to be involved 	Develop or review existing (and adopt) training modules		Media Training on condom promotion Training of health workers Condom negotiation skill training for vulnerable groups especially women Training of CBO / NGO on condom logistic management	<ul style="list-style-type: none"> • Training/retraining of media practitioners on relationship b/w STI and HIV and its communication • Proposal development workshops for community groups • IEC material development workshops • Project/grant management trainings for CBOs • M&E training for program managers and community groups implementing STI activities • National sensitization workshop for lecturers /tutors of health training institutions • Zonal TOT (Pre-service and in-service training) for HCPs • Step down training at States and LGAs for HCPs • Training of MARPs on correct of use of condoms • Logistics management training for staff at different levels of the 	Entrepreneurial & Vocational skills training for MARPS, youth, PLHA & Women Project management skill



								different distribution chain	
Product Accessibility/ Service Provision	Availability of friendly service centers for reinforcing ABC in the school, workplace & communities	<ul style="list-style-type: none"> • Get all existing hospitals (Secondary, Primary and Private facilities) to offer PMTCT services • Evidence based siting of PMTCT sites (Population, prevalence and PHC) • All ANC sites should offer PMTCT services 	<ul style="list-style-type: none"> • Need for massive scale up blood screening services to the secondary and tertiary facilities and private facilities • --- • Scaling up the MMIS in Tertiary, Secondary, Primary and Private facilities • Promote and implement the injection waste management Tertiary, Secondary, Primary and Private facilities 	<ul style="list-style-type: none"> • Use of PLWHA and community workers in HCT services • HCT as entry point to prevention be linked to prevention and Continuum of Care through Post-test counseling and referral (Negative or Positive Prevention) 	•		Increase Access, Coverage and Availability of male & female condoms	<ul style="list-style-type: none"> • Create access to new information on STI issues in State STI/HIV Units • Ref condom programming workplan • Ref logistic workplan • Establish designated youth-friendly centres • Establish STI outreach centres among MARP communities • Print and disseminate clinic aids (Wall charts, management manual, IEC, etc) 	
Guideline / Curriculum development	Adopt models of Peer education that have worked in Nigeria Development / Adaptation of Curriculum on ABC activities in Nigeria	<ul style="list-style-type: none"> • Revision of guideline to facilitate scaling up through decentralization • Revision of training manual to make it user friendly to address the need of the lower level health workers/service providers 	<ul style="list-style-type: none"> • Dissemination of policy and guidelines to secondary and primary levels, including the private facilities 	<ul style="list-style-type: none"> • Adaptation of the WHO/CDC training package for HIV rapid testing 			Adapt FC manual and services Protocol for CBOs Develop/adapt MC protocol/guidelines	<ul style="list-style-type: none"> • Design training curriculum for media practitioners • Design and update press kit • Review of National guidelines and training instruments informed by research findings • Adopt/adapt LSM guidelines and protocols 	



Quality Assurance	Dev of Standard of Practice / Guideline on ABC Interventions to address issues of appropriate mix, duration, intensity and uptake Standardization of ABC intervention			<ul style="list-style-type: none"> • Lab scientists could be used as trainers and in the area of quality control - National body to be involved 				<ul style="list-style-type: none"> • Development of discussion guides for IPCs • Establish audience listenership groups to provide feedback on media outputs • Establish/strengthen zonal STI reference laboratories • Conduct semi-annually Measuring Access to Products (MAP) surveys 	
Research	Population based survey on ABC intervention and Condom Programming in specific pop is required		Population based survey is needed to determine barriers to voluntary blood donation so that BCC activities are specific and strategic				Population based survey on ABC intervention and Condom Programming in specific pop is required	<ul style="list-style-type: none"> • Biennial validation of Vaginal Discharge algorithm • Biennial drug resistance monitoring • Conduct bi-annual Measuring Access to Products (MAP) surveys 	Population based survey on ABC intervention and Condom Programming in specific pop is required
M&E/ S.I/ Best practices	Development of system for continuous documentation of best practices on ABC							<ul style="list-style-type: none"> • M&E tools development workshop • Produce and disseminate M&E tools • Establish effective STI M&E system within the context of NNRIMS • Media monitoring for content and frequency of STI messages • M&E tools development workshop • M&E training for program managers and community groups implementing STI activities • Assessment of level of implementation of curriculum • Evaluation of impact of syndromic management of STIs at service delivery levels 	
Advocacy/ Policy	Advocating for policy reform on socio-cultural and economic issues that promote HIV transmission, stigma and		Conduct at least one advocacy visit to State Hospital Management Boards (SHMB) for compliance with quality	<ul style="list-style-type: none"> • Promotion of HCT services available • Promote the adapted WHO/CDC training package 				<ul style="list-style-type: none"> • Advocacy meetings to community groups (women, okada riders, drivers, etc) to sensitise their members on STI/HIV issues • Advocacy meetings 	



	discrimination / gender inequalities		standards by hospitals in their state	for HIV rapid testing				<p>with major GSM networks to support bulk text messages on STI/HIV sensitization</p> <ul style="list-style-type: none"> • Advocacy meetings with donors to support STI-related activities • Advocacy meetings with donors to support STI-related activities • Advocacy/ sensitization of medical/health regulatory bodies on comprehensive syndromic management of STIs • Integration of comprehensive Syndromic management of STIs into curriculum of training institutions in Nigeria • Advocate for speedy integration of RH and STI services • Advocate and develop National Policy on STI
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PREVENTION WORKPLAN

Thematic Area: ABc

No.	Objective / Area of Focus	Key Intervention	Activities	Indicator	Responsible Sector	Level of Implementation	Time Line	Budget (Naira)	Risk Assessment	Assumption
1	Update & Implement the National BCC strategy	1.1 Review and update the National BCC strategy, & disseminate the updated version	Review meetings of the BCC strategy	Nature & type of issues incorporated into the BCC strategy	NACA	National	Q1	8,000,000.00	Low	The BCC sub-committee will report the process for the review of the BCC strategy to the NPTWG
			Produce 20,000 hard copies and 5,000 electronic copies each of the guidelines	# of implementers with copies (electronic & hard) of revised strategy	DP	National	Q1	7,275,000.00	Low	
			Hold national, and state level dissemination meetings	# of partners using the revised strategy		□		228,000,000.00	Low	
		1.2 Facilitate integration of BCC strategy into state strategic plans on HIV/AIDS	Hold zonal review meetings with states to integrate BCC strategy into their SSP on HIV/AIDS	# of States with HIV/AIDS Strategic Plans that incorporate issues in the Nat. BCC strategy	SACA	State	Q1 – Q3	36,000,000.00	Low	
2	Improve policy and legislative environment on socio-cultural practices that promote HIV transmission, stigma and discrimination	2.1 Review & Advocate for the passage of the national bill on stigma and discrimination	a) Share Draft Bill Document with all stake holders Electronically for Comments	Nature & type of issues incorporated into the draft bill	NACA	National	Q1 – Q8	1,000,000.00	Medium	Policy to be holistic and inclusive
			b) Hold a 1 day review meeting of the existing draft bill on stigma and discrimination to include stigma & discrimination associated with disabilities	# of law makers with adequate knowledge of the stigma & discrimination bill				7,275,000.00		
			c) Present finalized bill to FEC for onward submission to the national assembly	#of public hearings on the draft bill within 2 years				12,000,000.00		



			d) Hold legislative dialogue with House committee on HIV/AIDS on the bill	Law on Stigma and Discrimination enacted				24,000,000.00		
			e) Print Act on Sigma & Discrimination 20,000 hard copies; 5,000 soft copies	# of partners aware of the law						
			f) Hold dissemination meeting of the bill after passage							
			g) Publicity of the ACT							
		2.2 Advocate for the domestication of the 'National Education Sector policy on HIV/AIDS' at state levels	a) Develop & Produce Advocacy Toolkit for the Education Sector 1000 copies	# of states with domesticated policy on HIV/AIDS in the Education sector	FME	State	Q1 – Q8	2,000,000.00	Medium	
			b) Hold advocacy dialogues with state governments on domesticating HIV/AIDS policies in the education sector during the National Council on Education Quarterly Meeting		SACA/ State MoE					
		2.3 Advocate for the mainstreaming of HIV/AIDS issues in the National Youth Policy and Policy document on people with disabilities	Hold advocacy dialogues with Fed Min of Youth Dev and Fed Min of Women Affairs	Nature & type of HIV/AIDS issues incorporated into the Youth Policy and document on disability	NACA	National	Q2		Medium	Fed Ministry of Youth will be committed to the review of the Youth Policy
				Availability of revised Nat Youth Policy & Policy document on disabilities that reflect HIV/AIDS issues	DP					
		Translate National and youth policies into acceptable formats for blind, deaf and other people with	Engage consultants, set up TORs include people with disabilities in the development teams	Policy and advocacy documents translated into acceptable formats for people with disabilities, Brail etc	NACA, Civil society and private sectors	National, State and LGA levels	Q2	12,000,000.00	Medium	



		disabilities		Printing of translated documents in acceptable numbers for nation wide circulation						
3	Institute a National Guideline on ABC Programme	3.1 Situation assessment of ABC Programming in Nigeria	a) Recruitment of 2 consultants (20 days)	Report of findings from the assessment of ABC Programme in Nigeria	NACA	National	Q2 – 3	2,000,000.00	Low	
			b) See Comment							
		3.2 Develop, adopt & disseminate the Nat Guideline for ABC Programming	a) Circulate Draft Guidelines to Stakeholders	# of implementers with copies (electronic & hard) of developed guideline	NACA	National	Q 3 - 5	2,000,000.00	Low	Guideline to include programming for vulnerable groups including children & hard to reach population
			b) Critique meeting of the key recommendation / draft guideline & Finalization / adoption meeting	# of partners using the guideline						
			c) Produce electronic and hard copies of the guideline							
			d) National & Zonal Dissemination meeting							
		3.3 Coordination of the messages content & material development process for BCC on ABC for target groups	a) Revise TOR of the BCC sub-committee on message content & material development process on ABC	# of implementers who are aware of the revised TOR of the BCC sub-committee on message content & material development process on ABC	NACA	National	Q1	4,000,000.00	Medium	The message harmonization document on HIV/AIDS in Nigeria to be included in the dissemination meeting
				% of BCC materials revised by the sub-committee	NPTWG					
			b) Hold process review meeting on the development of Target Specific BCC materials on ABC in Nigeria.		BCC Comm./ DP			6,000,000.00		



			c)Print and Disseminate developed BCC Materials							
4	Improve HIV prevention intervention for OVC	4.1 Mainstream age-appropriate HIV prevention intervention into OVC Programmes	National briefing meeting with partners on ABC for OVC	# of implementers with adequate knowledge on HIV prevention for OVC	NACA	National	Q2 – Q6	25,000,000.00	Low	Linked to OVC Programme
			Zonal training of implementers on ABC for OVC	Proportion of OVC program that have age-appropriate prevention component	Ministries of Women Affairs/ DP/ SACA	State				
5	Accelerate implementation of FLHE Curriculum in the education sector—paying attention to gender issues	5.1 Train and retraining of teachers on HIV/AIDS Education & Life Skills	State level consensus building meetings with PTAs, Communities and Religious groups on FLHE		FME	State	Q 2 - 8	35,000,000.00	Low	
			Produce 10,000 copies of teaching guides on FLHE curriculum for carrier subject	% of schools with teaching guide on FLHE curriculum in at least 4 carrier subject produced	SMoE	LGA				
			Conduct training and retraining of at least 4 teachers in 20 % of schools per state on FLHE	% of schools with trained teachers on FLHE	DP	Communities				
			Training of at least 2 teacher educators on FLHE in 100 College of Education	# of CoE with trained teachers						
		5.2 Mainstreaming HIV/AIDS issues into school inspection	Revision of Schools Inspection Schedule to include HIV/AIDS issues	# of school inspectors aware of, and using the revised school inspection schedule that reflect issues of FLHE	FME	Federal	Q 2 – 3	10,000,000.00	Low	Continuing commitment of FME to Annual School Censors / Inspection
			Training of at least 10 School Inspectors on FLHE in each state		DP	State				
		5.3 Establishment of service centers in the education sector for age- appropriate information & counseling on HIV/AIDS, condom provision and STI treatment	Training of at least 2 focal points for HIV/AIDS & Condom counseling, & STI treatment in 50 pilot institutions	% of education institutions with trained focal points	FME	Federal	Q 2 – 6	35,000,000.00	Medium	Availability of Training manual
			Procurement of equipment for YFHS in 50 pilot institutions	% of education institutions with YFHS	DP	State				



6	Standardize and scale up target specific peer education programs	6.1 Review existing models and manual on Peer Education.	<ul style="list-style-type: none"> Recruitment of consultant 	<ul style="list-style-type: none"> Nature & types of findings from the revision 	<ul style="list-style-type: none"> NACA 	Federal	Q 3	5,000,000.00	Medium	Review will explore interventions for MARPS, married adolescents, in & out of school youth, women & other vulnerable groups
			Desk review meeting on peer education Programme in Nigeria		DP					
		6.2 Develop & disseminate standardize peer education training & programming manual for ABC intervention for each target group.	Hold stakeholders ABC implementers meeting on minimum content & methodology for peer education	# of implementers with copies of the standardized manuals	NACA	Federal	Q3 - 6	49,500,000.00	Low	Commitment of implementers
			Produce electronic and hard copy of standardized copies of the manuals	# of implementers using the standardized manual	DP	State				
			National dissemination meeting (launching & Dist to state) and , State & LGA level distribution							
7	Reinforce ABC information and services in the media	7.1 Sustain target & age specific accurate ABC information in the mass media targeting out of school youth, married adolescents, women and PLHA	Build on media training done by ENHANSE/Internews on information on ABC for target groups	# of media outfits promoting age & target specific info on ABC	NACA	Federal	Q 3 – 8	36,000,000.00	Low	(12 monthly training sessions)
			Hold quarterly media briefing on ABC with media editors and proprietors	# of media outfits maintaining HIV/AIDS issues as an agenda quarterly	SACA	State		.		
			Produce dramas and jingle on ABC for target groups and Air them		DP			120,000,000.00		
8	HIV Prevention for PLHA	8.1 Develop / manual for HIV prevention among PLHA	Critique and adoption meeting	# of Support groups and partners with copies of the manual	NEPWAN	Federal	Q 3	4,000,000.00	Low	
			Produce copies of the training manual		NACA/ DP			7,250,000.00		



		8.2 Training of PLHA on positive prevention at national and zonal levels	Training of at least 50 Master trainers	# of PLHA (by gender & age) who have knowledge and skills for positive prevention of HIV	NEPWAN	Federal	Q4 – 8	6,000,000.00	Low	Each Master Trainer to train 20 pple
			Step-down Training of PLHA		Support Groups	State		8,000,000.00		
			Peer Education Session with PLHA in meetings of support groups		DP			240,000,000.00		
9	Increase Participation of public and private sector workforce including the informal economy in HIV/AIDS prevention programmes	9.1 Advocate to leadership of employers and workers organization on domestication of the national workplace policy on HIV/AIDS.	Dev and pre-test advocacy kit Conduct advocacy dialogues with target group.	# of focal points who have advocacy kit and are using the kits in the workplace	FMOL	national	Q 1 – 8	10,000,000.00	low	
			Organize Best Practice Award for HIV/AIDS Workplace Policy Implementation	% of target organization who have domesticated the Nat workplace policy on HIV/AIDS	NLC/ TUC/ NIBUCAA/ NECA/ NACA/ SFH/ SACA'S			18,000,000.00		
		9.2 conduct mid-term Review on HIV/AIDS in the work place Programmes	Recruit consultants	Nature & type of Info on Work Place Program available	NACA,	National	Q 3	20,000,000.00	low	availability of funds/
			Collect & Collate data	# of implementers who has baseline report and are using it to direct programming	FMOL,	State				commitment of partners
			Produce validated mid-term review report	Printed mid term reports available	NIBUCAA					
			Include workplace component into national surveys	Modified National Surveys	SFH					
		9.3 Finalize the National HIV/AIDS Workplace Training manual	Hold meetings to review the draft National HIV/AIDS Training manual	# of implementers who have copies of the training manual	NACA/ SFH	National/ State	Q 1 – 3			To be produced by SFH
			Pre-test manual		PPPF					
			Produce and disseminate the manual		FMOL/ NIBUCAA					
		9.4 Strengthen the human capacity of workplaces to implement gender friendly HIV/AIDS prevention	Hold at least 12 workshops for focal persons	# of focal points with knowledge & skills on implementation of gender friendly programmes in the work place	NACA	National	Q 2 – 8	36,000,000.00	low	Training to include advocacy skill training



		programmes	reaching at least 360 focal persons in public and Private sector workplaces.	# of peer educators in the work place with knowledge and skills in gender friendly programmes in the work place	PPF	state		36,000,000.00			
			Conduct peer educations trainings		FMOL/ NIBUCAA/ SFH						
		9.5 Scale Up GIPA in both public and private sector workplaces	Hold Advocacy dialogues with workplace management on GIPA principles.	Work place managers committed to GIPA principle	NIBUCAA	National	1-2 nd Q	2,500,000.00	low		
			Place GIPA staff in workplaces	% of workplaces implementing with GIPA in the work place	SFH/ NACA/ FMOL/ UNAIDS	state					
		9.6 Review & Harmonize existing checklists to monitor workplace HIV programme implementation		# and type of checklist available	NIBUCAA	National	1 st Q	4,000,000.00	low		
			Hold stakeholders meeting to review & harmonize existing checklist,	% of workplace using the developed checklist	SFH	state					7,250,000.00
			Print & disseminate the checklist for monitoring Work place HIV/AIDS Programme		NACA/UNAI DS/ FMOL						
SUB-TOTAL								1,085,050,000			



Thematic Area: Condom Programming

Objective / Area of Focus	Key Intervention	Activities	Indicator	Responsible Sector	Level of Implementation	Time Line	Budget (Naira)	Risk Assessment	Assumption
10	10.2 Scale up condom vending mechanism	Consensus building meetings on the integration of condom services into HCT, PMTCT and ART Programme	# of new sites providing condom services	UNFPA	National	Q1 - 8	70,000,000.00	Low	
				SFH	State				
					LGA				
	10.3 Reposition condom for dual protection, (Male & Female)	State level consensus building meetings with CSO, FBO and opinion leader on dual protection and condom	# of opinion leaders who encourages condom use for dual protection	UNFPA	State	Q 2 – 8	25,000,000.00	Low	
				SFH	LGA				
11	Create demand for condom (male & female) use among married sero discordant couples and MARPS	11.1 Scale up condom social marketing for both male and female condoms	# of sero-discordant couples who have information about condom use	UNFPA	State	Q 2 – 8	50,000,000.00	High	
		Awareness raising on the acceptability of condom among sero-discordant couple		SFH	LGA				
	11.2 Condom negotiation training for sero-discordant couple, women and young girls and MARPS	National & Zonal dissemination meetings of the National Condom Strategy	# of sero-discordant couples & MARPS with knowledge and skills	All Sectors	National/ State/ LGA		300,000,000.00		Training conducted using the National Condom Manual & Service Protocol
Training of community-based service providers for condom service provision & dual protection									
Carry out Peer education sessions among sero-discordant couple & MARPS									
TOTAL							445,000,000		



Thematic Area: PMTCT

S/N	Objective/Area of Focus	Key Interventions	Activities	Indicator	Responsible Sector	Level of Implementation	Timeline	Budget	Risk Assessment	Assumptions
1		Scale up to a minimum of 2 additional facility based PMTCT sites per LGA by end of 2009		1,548 PMTCT sites established						Criteria for site location include population, prevalence and presence of health centre
		Advocate to states governments and civil society to support the plan		Number of state governments and civil society supporting the plan	Min. of Health, NACA/SACA, State Min. of Health, NPTIWG	State and LGA	Q1	18.5m	MediumLow	States governments and civil society groups will buy into the plan
		Conduct mapping and rapid assessment of health facilities		1,548 health facilities assessed for PMTCT services	Min. of Health, NACA/SACA, State Min. of Health, NPTIWG, NPHCDA	State and LGA	Q1	33.7m		Assessment and mapping tools available one of the sites to be selected should have the capacity to conduct associated laboratory tests including CD4, blood count and blood biochemistry;
		Revise training manual for personnel at the primary health care level		Training manual revised for use at PHC level	NASCP, PMTCT Task team	Federal Level	Q1	5.0m	Low	
		Produce and disseminate guidelines and training manuals		12,000 national PMTCT guidelines and training manuals produced and disseminated	NASCP, PMTCT Task team	Federal Level	Q1	24.0m(Printing) 26.0m(Dissemination to LGA level)	Low	1 guideline and training manual per trained healthworker. Cost of dissemination included.
		Post national PMTCT guidelines on the NACA website		National PMTCT Guidelines available on the NACA website	NACA	Federal Level	Q1	-	Low	NACA website exists and is constantly updated



		Conduct TOT for Master Trainers on PMTCT		74 master trainers trained	NASCP, PMTCT Task team	Federal and state level	Q2	15,000,000	Low	2 persons per state, 3 batches of training
		Train 6 health care providers per site to provide PMTCT services		9,300 health workers trained to provide PMTCT services	Master Trainers, NASCP, Development Partners	State and LGA	Q2	372,000,000	Low	Each PMTCT site would have at least 6 staff
		Procure and distribute test kits including consumables		1,750,000 test kits and consumables procured and distributed	NASCP	State, LGA and SDP	Q3 - Q8	300,000,000		500 pregnant women reached per site per year (Total 750,000 per year); double parallel algorithm currently in use
		Procure and distribute ARVs		37,500 ARV regimens procured and distributed	NASCP & PMTCT Task team	State, LGA and SDP	Q3 - Q8	300,000,000	Low	
		Produce and distribute registers for data collection		1,600 sets of registers produced and distributed	NASCP & PMTCT Task team	State, LGA and SDP	Q3 - Q8	8,000,000	Low	A set of PMTCT registers consist of a set of 5
2	Promote and introduce community based PMTCT and generate demand for services			750,000 pregnant women accessing PMTCT services per year						2 PMTCT sites per LGA; 500 pregnant women access PMTCT services per site each year
		Advocate for the development and implementation of a government policy for free PMTCT services (including CD4 counts)		Free PMTCT services policy developed and adopted	Min. of Health, NACA & NPTWG	State, LGA and SDP	Q1- Q3		Low	
				Advocate for development of policy on free PMTCT services						
				Provide resources for the dev & dissemination of the free PMTCT policy						
					Min. of Health, NACA & NPTWG					



				Monitoring the Implementation of the Policy		State, LGA and SDP				
							Q1- Q3	1,000,000		
								10,000,000		
								10,000,000		
		Advocate to the community leaders, LGA, CBOs, FBOs, TBAs to promote community PMTCT services and male involvement		Number of community leaders, LGA, CBOs, FBOs, TBAs promoting community PMTCT services and male involvement	CISHAN, NEPWHAN, ASWHAN, SACAs, NPHCDA, NYNETHA	State and LGA	Q1 - Q6	387,000,000	Low	
		Integrate promotion of PMTCT services with other health programmes		Number of health programmes promoting PMTCT	NACA, Min. of Health, SACAs, State Min. of Health, NPHCDA	State and LGA	Q1 - Q8		Low	That other health programmes that will support the plan
		Identify/establish and strengthen support groups of women living with HIV/AIDS to facilitate demand and access to PMTCT services		1,548 existing and new support group of women living with HIV/AIDS identified/established and strengthened to facilitate demand and access to PMTCT services	ASWHAN, NEPWHAN, SACAs	SDP	On-going	387,000,000	Medium	
		Support community mobilization/outreach activities by CBOs/FBOs to reduce stigma in the community and generate demand for PMTCT services		Number of CBOs/FBOs conducting community mobilization/outreach activities to reduce stigma in the community and generate demand for PMTCT services	ASWHAN, CISHAN, Interfaith, NEPWHAN, FBOs, SACAs	LGA and Community	Q1 - Q8	387,000,000	Low	Stigma related to HIV status, infant-feeding, hospital delivery, etc.



		Train TBAs/retired health care workers to provide community based PMTCT services and promote male involvement		1,110 TBAs and retired Health Workers trained to provide PMTCT services and promote male involvement	State Min. of Health, SASCP, NASCP, LACA, SACA, GiSHAN	LGA	Q2 - Q4	45,000,000	Low	Min. Health and Stakeholders working on an appropriate training curriculum; 37 trainings in pilot LGAs; 1 LGA per state; 30 persons per LGA
		Scale up training of TBAs and retired Health Workers		2,220 TBAs and retired Health Workers trained to provide PMTCT services and promote male involvement	State Min. of Health, SASCP, NASCP, LACA, SACA, GiSHAN	LGA	Q5 - Q8	90,000,000	Low	74 scale up trainings in LGAs; 2 LGAs per state; 30 persons per LGA
		Incorporate PMTCT into HCT communication and mobilization strategies		Number of of HCT communication and mobilization strategies promoting PMTCT	NACA/SACA, Min. of Health, NASCP, GiSHAN, Media	Federal, state and LGA	Q3 - Q8	5,000,000	Low	
		Incorporate HCT and PMTCT education into the curriculum for training journalists in HIV/AIDS reporting		Training curriculum for training journalists in HIV/AIDS reporting revised to incorporate HCT and PMTCT education	NACA, NPTWG, JAAIDS	Federal	Q1 - Q2	5,000,000		Training curriculum exists and is subject to revision
		Incorporate HCT and PMTCT access information in media messages at state and LGA levels		Number of media messages providing information on HCT and PMTCT	NACA, SACA, JAAIDS and the Media	State and LGA level	On-going		Low	Media owners will support the plan

TOTAL

2,322,000,000



Thematic Area: MEDICAL TRANSMISSION

S/N	Objective/Area of Focus	Key Interventions	Activities	Indicators	Responsible Sector	Level of Implementation	Timeline	Budget	Risk Assessment	Assumptions
1	To have 95% of transfused blood screened for TTIs (Transfusion, Transmissible Infections)	Improved level of understanding of Blood transfusion Policy	Disseminate and implement policy and guidelines at secondary and primary levels, including the private facilities	Number of centres implementing national blood transfusion policy and guidelines	Min. of Health, NBTS, NPHCDA	Federal, state and LGA	Q1	30,000,000	Low	
			Post national policy and Guidelines on blood safety on the NACA website	National policy and Guidelines on blood safety available on the NACA website	NACA	Federal Level	Q1		Low	NACA website exists and is constantly updated
			Establish at least one NBTS blood bank per state	37 NBTS blood banks established in the country	Min. of Health, NBTS, NPHCDA	State	Q1 - Q8	280,000,000.00	Low	9 NBTS blood banks already in place
			Conduct at least one advocacy visit to State Hospital Management Boards (SHMB) for compliance with quality standards by hospitals in their state	Number of SHMB complying with quality standards on blood safety	FMOH, NBTS, Safe Blood for Africa, NPHCDA	State	Q1-Q4	1,800,000	Low	
			Support at least two site visits by the SHMB to ensure compliance with quality standards in their state	Number of facilities in the state visited by SHMB to ensure compliance with quality standards	SACA, state Min. of Health, SHMB	State	Q1-Q4	3,000,000		
			Development of training manual for blood safety in Nigeria	Training manual developed Manual printed	FMOH, NBTS, SBFA, WHO	Federal	Q1	10,000,000		



			Train health care workers on safe blood transfusion practice	575 health workers trained in safe blood transfusion practice	Safe Blood for Africa, NBTS	State	Q2 - Q8	23,000,000	Low	14 NBTS sites will be in place by end 2007; 25 health workers per site in 23 sites; 1 site per state
			Roll out mass media campaign to promote voluntary and non-remunerated blood donation	Number of media houses participating in the campaign	NBC, NUJ, Media Owners, NBTS, state owned media	All levels	Q1 - Q8	100,000,000	Low	
			Document and disseminate the Lagos State Safe Blood strategy as best practice	Best practice document produced and disseminated	NBTS, LSACA, Safe Blood for Africa	Federal, state and LGA	Q1 - Q8	10,000,000	Low	
2	To ensure safe injection practices in 41 tertiary facilities and 1548 PMTCT sites		Produce and distribute policy and guidelines on medical injection safety to all levels, including the private facilities	Number of health facilities with policy and guidelines	FMOH, NPHCDA, MMIS	Federal	Q1 - Q8	200,000,000	Low	All tertiary facilities and 2 facilities per LGA which are providing PMTCT services
			Post national policy and Guidelines on medical injection safety on the NACA website	National policy and Guidelines on medical injection safety available on the NACA website	NACA	Federal Level	Q1	free	Low	NACA website exists and is constantly updated
			Procure and distribute universal precautions consumables (e.g. soaps, hand gloves, etc.)	Number of health facilities with universal precautions consumables	FMOH, State Min. of Health, NPHCDA, MMIS	Federal, state and LGA	Q1 - Q8	50,000,000	Low	
			Procure and distribute injection safety commodities in health facilities (retractable needles, safety boxes)	Number of health facilities using safe injection commodities	FMOH, State Min. of Health, MMIS, NPHCDA	LGA	Q1 - Q8	50,000,000	Medium	
			Train health care workers on injection safety and universal precautions	All HCW in 1589 facilities trained	FMOH, MMIS, NPHCDA	LGA	Q1 - Q8	30,000,000	Low	Training manual and facilitators available



3	To manage health care waste in a manner that is safe for healthcare facilities, waste handlers, the public and the environment		Support the development of the healthcare waste management policy	Health Care waste management polict adopted	FMOH, Fed. Min of Environment, MMIS	Federal	Q1 - Q4	20,000,000	Low	Draft policy in place
			Produce and distribute policy on health care waste management	Number of health facilities with health care waste management policy	FMOH, NPHCDA,MMIS	Federal	Q6 - Q8	30,000,000	Low	
			Post policy on health care waste management on the NACA website	National policy health care waste management available on the NACA website	NACA	Federal Level	Q6	free	Low	NACA website exists and is constantly updated
			Advocate to policy and decision makers of health care facilities to allocate resources to health care waste management (public and private)	% of facilities with budget line for healthcare waste management	FMOH, Fed. Min of Environment, MMIS	All levels	Q1 - Q8	20,000,000		
			the national healthcare waste management plan	Number of facilities with segregation materials (colour coded bins and liners)	FMOH, Fed. Min of Environment, MMIS, State Min. of Health	Federal, state and LGA	Q1 - Q8	500,000,000	Medium	The plan is available
		Number of facilities with PPE (personal protective equipment)								
		Number of waste handlers trained on health care waste management								
		Number of facilities with incinerators								
		Number of facilities with PEP (Post Exposure Prophylaxis)								
		Number of facilities with spillage control consumables								
TOTAL								1,347,800,000		



Thematic Area: HCT

S/N	Objective/Area of Focus	Key Interventions	Indicator	Responsible Sector	Level of Implementation	Timeline	Budget	Risk Assessment	Assumptions
1	To have a minimum of 2 existing health facilities providing PICT (Provider Initiated Counseling and Testing) and 2 CBOs per LGA providing HCT		At least 1548 health facilities and 1548 CBOs providing HCT services					Low	Baseline of 600 HCT sites; CiSHAN & NEPWHAN establishing CBOs in the communities with offices under the GF R5
		Advocate to state governments and civil society to support the plan	Number of state governments and civil societies supporting the plan	Min. of Health, NACA, CiSHAN, State Min. of Health, NPTWG	State and LGA	Q1	18,500,000	Low	State governments and Civil Society Organisations will support the plan
		Conduct mapping and rapid assessment of CBOs and facilities (including all existing TB sites for integration with HCT)	3096 HCT facilities and CBOs identified	Min. of Health, NACA, CiSHAN, State Min. of Health, NPTWG	State and LGA	Q1	68,000,000	Low	Assessment and mapping tools available
		Revise HCT guidelines and manuals, to include WHO/CDC rapid testing protocol and CT and partners and couples HCT	HCT guidelines revised and training package adapted	HCT TWG, NACA, NASCP	Federal	Q1	5,000,000	Low	HCT TWG working on the document
		Produce and disseminate revised HCT guidelines and training manuals	18,600 guidelines produced and disseminated	NASCP	Federal	Q1	19,000,000	Low	
			18,600 manuals produced and disseminated	NASCP	Federal	Q1	19,000,000		
		Post revised HCT guidelines and training manuals on the NACA website	Revised HCT guidelines and training manuals available on the NACA website	NACA	Federal Level	Q1	0	Low	NACA website exists and is constantly updated



		Train and retrain counselors and testers	9,300 counselors and testers trained	NASCP & Development Partners	LGA	Q2 - Q8	372,000,000	Low	2 counselors and 1 lab technician available per PICT site
		Engage PLWHA as remunerated counselors in community based HCT sites	1548 PLWHA engaged as remunerated counselors	NASCP, CiSHAN & NEPWHAN	LGA	Q3 - Q4	380,000,000		At least one Support group of PLWHAs exist in each
		Procure and distribute test kits & consumables	6, 250,000 test kits and consumables procured and distributed	NASCP & NACA	LGA	Q3 - Q8	937,000,000	Low	Test kits will be supplied with consumables
		Produce and distribute cue cards	30,960 cue cards produced and distributed	NASCP, NACA & HCT task team	LGA	Q3 - Q8	5		10 cue cards per site
		Produce and distribute IEC materials on STI/HIV prevention	3,000,000 IEC materials produced and distributed	NASCP & NACA	LGA	Q3 - Q8	30,000,000		IEC given to each client, 1000 clients per site/year
2	To ensure that HCT effectively serves as an entry point for prevention, treatment, care and support	Provide quality post-test counseling for positive and negative clients	Number of clients who received quality post-test counseling	HCT Centres	SDP	Q3 - Q8	From above		Standards for quality counseling are contained in the training manuals
		Produce and distribute referral and tracking forms across services (HCT to Prevention, PMTCT, Treatment Care and support)	300,000 each of referral and tracking forms produced and distributed	NASCP, NACA, Network TWG	State, LGA & SDP	Q1	90,000,000	Low	Network TWG already working on tools and forms for referral network system
		Procure and distribute male and female condoms for all HCT centres	21 million male and 3 million female condoms procured and distributed	SFH, NASCP, Private sector, UNFPA	Federal, state, LGA, SDP	Q3 - Q8	120,000,000	Low	7 male condoms per client per month



3	To generate demand by 3,000,000 people for HCT services per year		3,000,000 clients received counseling and testing for HIV and received their result					Low	3,096 HCT facilities provide services to an average of 1,000 clients
		Support the development and implementation of a government policy for free HCT services	HCT policy developed and adopted	Min. of Health, NACA & NPTWG, National HCT Task Team	Federal	Q1 - Q2	10,000,000	Medium	
		Provide Standard Operating Procedures (SOPs)	6,192 SOPs provided	NASCP, NACA & HCT task team	LGA	Q3 - Q9	6,000,000	Low	SOP already developed by GoN; 2 SOPs per site
		Advocate to the community leaders, LGA, CBOs, FBOs, TBAs to promote community HCT services	Number of community leaders, LGA, CBOs, FBOs, TBAs promoting community HCT services	GISHAN, NEPWHAN, SACAs, NPHCDA, LACA	State and LGA	Q1 - Q6	19,000,000		
		Integrate promotion of PICT & HCT with other health programmes	Number of health programmes promoting HCT	NACA, Min. of Health, SACAs, State Min. of Health, NPHCDA	State and LGA	Q1 - Q8			
		Support community mobilization/outreach activities by CBOs/FBOs to reduce stigma in the community and generate demand for HCT services	Number of CBOs/FBOs conducting mobilization and outreach activities per LGA	GISHAN, NEPWHAN, FBOs, SACAs, NYNETHA	LGA and Community	Q1 - Q8	18,000,000	Low	
		Support outreach activities by CBOs/FBOs targeting MARPS	Number of outreach activities conducted by CBOs/FBOs targeting MARPS per LGA	GISHAN, NEPWHAN, FBOs, SACAs, NNSWP, Alliance Rights, NYNETHA	LGA and Community	Q1 - Q8	20,000,000		



		Encourage provision of services during weekends and off hours by community based HVCT sites	Number of Community based HCT sites providing services during off hours	CISHAN, NEPWHAN, FBOs	LGA and Community	Q1 - Q8	20,000,000	Low	
		Introduce 'Testing week', with a formal declaration including promotion of partners and couples HCT and formal declaration	1 testing week campaign conducted each year	NACA, Min. of Health, Min. of Information, SACA, State Min. of Health, State Min. of Information, NPTWG, NYNETHA, Electronic and Print Media	Federal, State, LGA, Community	Q4 & Q8	30,000,000	Low	
		Create and regularly update a database of available HCT sites in the country	Regularly updated database on HCT services available	NACA, NASCP	Federal, state, LGA	Q3 - Q8	4,000,000	Low	
		Post regularly updated database on available HCT services on the NACA website	Regularly updated database on available HCT services available on the NACA website	NACA	Federal Level	Q6		Low	NACA website exists and is constantly updated
		*Develop a strategy to communicate importance of male circumcision to identified/ stratified audience (uncircumcised men, media, HCP.	*Guide on appropriate reporting on male circumcision developed *Print 20,000 copies of guide	NACA, NASCP/ Media/ NGOs/ Consultants			50,000,000		



		*Produce jingles, IEC materials (like a “what you need to know and do”) on male circumcision (viz: importance of early male circumcision, risk of engaging in sex before the cut fore skin is healed)	*IEC development workshop on male circumcision organized *Scripts developed, vetted and adopted for production *Scripts developed, vetted and adopted for production *Jingles produced and pretest *Final copy developed for broadcast	NACA, NASCP/ Media/ NGOs/ Consultants			50,000,000		
		*develop mechanism for periodic media engagement on male circumcision in each zone including Lagos and Abuja (roundtables, workshops, seminars, etc.	8 media roundtables on male circumcision held	NACA, media/ NGOs			40,000,000		
		*Develop media clearing house on male circumcision (eg a website with locally-relevant information for journalists and other communicators	Information/resources on MALE CIRCUMCISION in Nigeria linked to NPT website and promoted amongst journalists	ETG,NACA, Media/ Consultant/NGOs			10,000,000	Low	
		*Mapping exercise to delineate communities not practicing male circumcision or circumcision of male adults	Identify consultants for mapping exercise Conduct mapping exercise to identify communities not practicing male circumcision	NACA,NASCP			5,000,000	Low	



		*Outreach to communities not practicing male circumcision	Outreaches conducted in identified communities				4,000,000	Low	
		*Incorporating male circumcision advocacy issues into agendas of networks such as NEPWHAN,CISHAN,NAWOJ, Interfaith Coalition, etc through training and access to information	6 Sensitization meetings with AIDS advocacy groups, networks held			Q2	24,000,000		
		*Place funding support for male circumcision advocacy on priority list				Q3	10,000,000		
		*Form partnerships with identified CBO's interested in advocacy on male circumcision advocacy	Mapping exercise to identify relevant CBOs' conducted	NACA,NASCP		Q3	20,000,000		
		*Training programmes for							
		a) Key (existing) AIDS advocacy groups/networks on male circumcision advocacy.				As Above	15,000,000		
		b)Health Care Providers(nurses, midwives)				As Above	60,000,000		



		*Develop or review existing (and adopt) training modules for:	*Identify relevant resource persons for consultation on curriculum development *Curriculum development workshop conducted *Guidelines/curriculum developed Guideline reviewed and adopted *20,000 copies of curriculum produced and disseminated	NACA,NASCP/ Media consultant/ NGOs	National	Q2-Q3	10,000,000	Low		
		a)Media advocacy communication on male circumcision		BCC Comm/ Media/ NGOs/ NASCP	National/ State		15,000,000			
		b)Community mobilization on male circumcision		BCC Comm/ Media/ NGOs/ NASCP	National/ State		50,000,000			
		*Adopt and disseminate Standard of Practice (SOP) for conduct of male circumcision in health care centres.	40,000 SOP developed	NACA,NASCP			5,000,000	Low		
		Advocacy for male circumcision to be done as part of post natal services or offered free of charge(this is to encourage its continuity and discourage urge to use crude/traditional means)	Male circumcision incorporated into national health policy.	NACA/ NGOs/ NASCP	National/ State	Q2-Q4	10,000,000			
TOTAL							2,563,500,005			



Thematic Area: RESEARCH

S/N	Objective/Area of focus	Key Interventions	Indicators	Responsible Sector	Level of Implementation	Timeline	Budget	Risk Assessment	Assumptions
	Provide reference laboratory support for STI management	· Establish/strengthen zonal public health laboratories to provide STI reference services	· 6 zonal STI reference laboratories established and functional	NACA, NASCP, Partners	Federal	Q3	100,000,000	High	Funds available for equipment
	Evaluate quality of STI management services	· Carry out biannual assessment of quality of care in STI management service outlets	· STI Technical Study Group constituted and functional	NASCP	Federal	Q1	10,000,000	Low	
			· Biannual assessment of quality of STI management in service outlets carried out	NASCP	Federal	Q2,Q4,Q6,Q8	200,000,000	Low	
			· Annual validation of Abnormal Vaginal Discharge algorithm carried out	NASCP	Federal	Q4,Q8	50,000,000	Medium	
		· Evaluation of impact of syndromic management of STIs at service delivery levels	Evaluation report disseminated		Federal	Q4	40,000,000	Medium	



		<ul style="list-style-type: none"> · Biennial drug resistance monitoring 	<ul style="list-style-type: none"> · Drug resistance monitoring done biennially by STI Technical Study Group 	NASCP	Federal	Q8	50,000,000	Medium		
	Evaluate media strategy for HIV prevention through STI management	<ul style="list-style-type: none"> · Media monitoring for content and frequency of messages on STI control as a means to preventing HIV infection 	Monitoring report disseminated	NACA, NASCP, Media consultant	Federal	Q4,Q5,Q6	30,000,000	Medium		
	Explore new methods of expanding STI management	<ul style="list-style-type: none"> · Pilot studies on use of PPTs in STI management by STI Technical Study group 	Study report published and disseminated	NASCP	Federal	Q3	40,000,000	Medium		
		<ul style="list-style-type: none"> · Pilot studies on delivery of STI management services through pharmaceutical and patent medicine outlets 	Study report published and disseminated	NASCP	Federal	Q3	40,000,000	Medium		
		<ul style="list-style-type: none"> · Commission research/studies on factors perpetuating STI and HIV spread in communities and locally-relevant means of addressing them 	Study report published and disseminated		Federal	Q3	40,000,000	Low		
TOTAL							600,000,000			



Thematic Area: STI Management

S/N	Objective/Area of focus	Key Interventions	Indicators	Responsible Sector	Level of Implementation	Timeline	Budget	Risk Assessment	Assumptions
	Increase public awareness on relationship between STI and HIV infection	<ul style="list-style-type: none"> Design/update resource/press kits for media practitioners on relationship between STI and HIV 	<ul style="list-style-type: none"> Training curriculum for media practitioners on STI/HIV developed 	NACA, NASCP	Federal	Q1	12,367,000	Low	Periodic review of all IEC interventions as discussed in the Jos meeting is missing from this draft
			<ul style="list-style-type: none"> Media-based NGOs in each state identified and sensitisation workshop held for 20 of their members on role of preventing/managing STI in preventing HIV infection 	SACA, SACP	State	Q1-Q2	28,342,000	Low	The number here is subject to change particularly since a minimum of 2 participants per state should be considered
			<ul style="list-style-type: none"> STI/HIV Press kit development workshop held 	NACA, NASCP	Federal	Q1	4,460,000	Low	The budget here is based on the assumption that the training will hold only ONCE in each of 36 states
			<ul style="list-style-type: none"> 20000 press kits disseminated to media practitioners 	NACA, NASCP, NUJ NUJ and other relevant media NGOs	Federal, State	Q2	36,000,000	Low	
			<ul style="list-style-type: none"> Quarterly interactions held with media organizations in each state to review their contribution to STI/HIV control efforts and provide new information 	SACA, SACP, NUJ and other relevant media NGOs	State	Q3-Q8	7,548,000	Low	Media related CSOs and NGOs should also be included



									The total number of Quarterly interactions to be held is 6
		<ul style="list-style-type: none"> Commission and air 15-minute weekly drama programs on major radio stations to sensitise on linkage between STI and HIV 	<ul style="list-style-type: none"> Creative brief developed- For costing this segment , technical input from Script writers; and programme producers is required 	NACA, NASCP	Federal	Q1	78,000,000	Low	That 4 radio stations per State are being considered – Federal, State and 2 private radio stations for 52 weeks
			<ul style="list-style-type: none"> STI/HIV script review workshop held 	NACA, NASCP	Federal	Q1		Low	
			<ul style="list-style-type: none"> 8 quarter scripts written and reviewed 	Drama consultant, NACA, NASCP	Federal	Q1-Q2		Low	
			<ul style="list-style-type: none"> Artistes recruited and trained 	Drama consultant, NACA, NASCP	Federal	Q1-Q2		Medium	
			<ul style="list-style-type: none"> Episodes recorded 	Drama consultant, NACA, NASCP	Federal	Q1-Q3		Medium	
			<ul style="list-style-type: none"> Major radio stations in each state identified and contracted to air radio drama episodes 	Drama consultant, NACA, NASCP	Federal, State	Q1		Low	
			<ul style="list-style-type: none"> Weekly radio drama episodes aired weekly 	Drama consultant, radio stations	State	Q1-Q8	88,400,000	Medium	
			<ul style="list-style-type: none"> Audience listenership groups established to provide feedback on STI/HIV media outputs 	Drama consultant, NACA, NASCP	Federal	Q1-Q8	482,000,000	Medium	
		<ul style="list-style-type: none"> Commission and air jingles on facilitative role of STIs on HIV infection 	<ul style="list-style-type: none"> Creative brief developed 	Media consultant, NACA, NASCP	Federal	Q1	48,000,000	Low	



			· Jingle message design workshop held	Media consultant, NACA, NASCP	Federal	Q1		Low		
			· Artistes recruited/trained and jingles recorded	Media consultant, NACA, NASCP	Federal	Q1		Low		
			· Major radio stations in each state identified and contracted to air jingles	Media consultant, NACA, NASCP	Federal, State	Q1		Low		
			· Jingles aired as contracted	media consultant, radio stations	State	Q1	288,000,000	Low		
		· Promote bulk text messages on STI/HIV sensitization	· Creative brief developed	Media consultant, NACA, NASCP	Federal	Q1		Medium		
			· Advocacy visits paid to CEOs of major Telecom networks to solicit support for STI/HIV bulk text messages	NACA, NASCP	Federal	Q1	2,000,000	Medium		
			• Text Messages to all Mobile Networks in English, Pidgin and 3 major languages							
			· workshop to sensitize relevant officers of Telecom networks on relationship between STI and HIV and need to promote/intensify BCC and Text message design workshop held	NACA, NASCP, Media Consultant, Telecom Networks	Federal	Q1	12,000,000	Low		
		· Develop, print and disseminate general and audience-segmented IEC materials on STI prevention and treatment as a means of preventing new HIV infections	· IEC message development workshop held	NACA, NASCP, IEC consultant	Federal	Q1	15,000,000	Low		



			· IEC materials printed in English, Pidgin English and 3 major local languages	NACA, NASCP, IEC consultant	Federal	Q1	10,000,000	Low	
			· IEC materials disseminated through mass media organizations, CBOs/CSOs/STI management facilities, ART sites, etc	NACA, NASCP, SACA, SACP, CBOs, CSOs, health facilities, ART facilities, Media organisations	Federal, State, LGA	Q2	5,000,000	Low	
		· Sensitisation of community leaders against stigmatising MARPs	· Community level advocacy visits against stigmatising SWs done for community/religious leaders	SACA, SACP	State	Q2	40,000,000	Low	
			· Advocacy meetings with community groups and MARPs (women, okada riders, drivers, etc) to sensitise their members on STI/HIV issues	SACA, SACP	State	Q2	200,000,000	Low	
			· Sensitisation workshop held in at least 3 major communities in every LGA for community/religious leaders	SACA, SACP	State	Q2	774,000,000	Low	
		· Commission community participatory dramas on role of STI prevention/treatment in preventing HIV infection	Selection criteria for drama groups designed	NACA, NASCP, Drama consultant	Federal	Q1		Low	
			At least 3 drama groups in every LGA identified and trained on participatory drama technique and relationship between STI and HIV	SACA, SACP, LGA	State, LGA	Q2	155,000,000	Medium	
			· Emerging issues identified and fed into drama scripts	NACA, NASCP, SACA, SACP	Federal, State	Q2		Low	
			· Participatory drama sessions held in every LGA ward once every quarter	SACA, SACP, LGA, Drama groups	State, LGA	Q2-Q8	1,400,000,000	Medium	



		<ul style="list-style-type: none"> Conduct Inter-personal communication with community groups on preventing HIV infection through STI control 	Selection criteria for drama groups designed	NACA, NASCP, Drama consultant	Federal	Q1	1,400,000,000	Low	
			<ul style="list-style-type: none"> Relevant CSOs/CBOs in every LGA identified and 5 selected 	SACA, SACP, LGA	State, LGA	Q2		Low	
			<ul style="list-style-type: none"> IPC guide on STI/HIV developed 	NACA, NASCP, SACA, SACP	Federal, State	Q1	6,000,000	Low	
			<ul style="list-style-type: none"> 3 staff/members of each selected CSOs/CBOs trained on IPC method and use of IPC guide in conducting IPC on STI/HIV for different community groups 	SACA, SACP, LGA,	State, LGA	Q2	200,000,000	Low	
			<ul style="list-style-type: none"> IPC activity implemented in every community in every LGA 	SACA, SACP, LGA, CSOs, CBOs, NGOs	State, LGA	Q2-Q8	774,000,000	Medium	
		<ul style="list-style-type: none"> Implement Peer Education program on STI control as a means of preventing HIV infection among general population as well as different segments of the population 	<ul style="list-style-type: none"> Peer education training kits for different population groups and MARPS developed on STI/HIV 	NACA, NASCP	Federal	Q1	6,000,000	Low	
			Selection criteria for umbrella NGOs designed	NACA, NASCP	Federal	Q1		Low	
			<ul style="list-style-type: none"> Umbrella NGOs in every state identified and 5 staff/members of each trained as Peer Education master trainers using the designed kits 	SACA, SACP	State	Q2		Medium	



			<ul style="list-style-type: none"> At least 2 CBOs/CSOs/NGOs working with women and MARPS in every LGA identified and 5 staff/members trained as PE trainers by state teams 	SACA, SACP, Umbrella NGOs	State, LGA	Q2	155,000,000	Medium	
			<ul style="list-style-type: none"> LGA PE trainers trained at least 100 women and each MARP 	PE trainers	LGA	Q2-Q3		Medium	
			<ul style="list-style-type: none"> MARPs trained on correct of use of condoms 	Peer educators	State, LGA	Q2-Q8		Low	
			<ul style="list-style-type: none"> Peer educators supervised/mentored by LGA trainers and state master trainers 	PE trainers, master trainers	State, LGA	Q2-Q8	4,600,000,000	Low	
		<ul style="list-style-type: none"> Mobilise resources for STI/HIV activities 	<ul style="list-style-type: none"> Advocacy meetings held with donors and development partners to support STI/HIV-related activities 	NACA, NASCP	Federal	Q1	2,000,000	Low	
			<ul style="list-style-type: none"> Proposal development /Project management workshops held for community groups to promote community-initiated STI control projects 	SACA, SACP	State	Q2-Q3	225,000,000	Low	
	Expand Access to Quality Management of STIs	<ul style="list-style-type: none"> Commission and air jingles on STI/HIV prevention, symptoms, management and management facilities 	<ul style="list-style-type: none"> Creative brief developed 	NACA, NASCP	Federal	Q1		Low	
			<ul style="list-style-type: none"> Jingle message design workshop held 	NACA, NASCP	Federal	Q1		Low	
			<ul style="list-style-type: none"> Artistes recruited/trained and jingles recorded 	NACA, NASCP, Media consultant	Federal	Q1		Low	
			<ul style="list-style-type: none"> Major radio stations in each state identified and contracted to air jingles 	NACA, NASCP, SACA, SACP	Federal, State	Q1		Low	
			<ul style="list-style-type: none"> Jingles aired as contracted 	Media consultant, radio stations	Federal, State, LGA	Q1-Q8		Low	



		· Conduct BCC campaigns to prevent STIs and promote service utilisation	· Materials development workshop held and materials pre-tested	NACA, NASCP	Federal	Q2		Low	
			· BCC materials printed and disseminated among general populations groups and MARPs	NACA, NASCP, Media consultant	Federal	Q2-Q3		Low	
			· Media articles, feature stories, etc on STI/HIV published	NACA, NASCP, Media consultant	Federal	Q1-Q8		Low	
		· Build effective linkage/referral systems for STI management in communities	· Inventory of STI management facilities compiled in each LGA	NASCP, SACP	Federal, State	Q2		Low	
			· STI management referral system established in every LGA	SACP, LGA	State, LGA	Q2	3,900,000,000	Low	
			· Proportion of STI clients that are MARPs	NACA, NASCP	Federal	Q1-Q8		Medium	
		· Build efficient revolving drug system for STI management services to promote sustainability of services	· Pharmacy staff of STI managing facilities trained in DRF implementation	NASCP, SACP	Federal, State	Q2	3,900,000,000	Low	
			· Seed grant for DRF provided by MOHs and LGAs	NACA, NASCP, SACA, SACP	Federal, State	Q2		Medium	
			· %age of STI facilities reporting out-of-stock STI drugs		Federal, State, LGA	Q1-Q8		Low	



		<ul style="list-style-type: none"> Develop partnership with ART centres to provide STI management services for PLWHA undergoing care and treatment to prevent transmission of HIV infection especially among discordant couples 	<ul style="list-style-type: none"> STI management offered in ART facilities 	NASCP, SACP	Federal, State	Q1-Q8		Medium	
		<ul style="list-style-type: none"> Collaborate with and support private health facilities to provide effective and comprehensive STI management services using national treatment protocols 	<ul style="list-style-type: none"> %age of private health facilities offering syndromic management in line with the national protocols 	NACA, SACA, NASCP, SACP	Federal, State	Q1-Q8		Medium	Medical records are up-to-date and made available
		<ul style="list-style-type: none"> National sensitization workshop for lecturers /tutors of health training institutions 	<ul style="list-style-type: none"> Advocacy/sensitization workshop held for medical/health regulatory bodies on incorporation of syndromic management of STIs in curricula of health training institutions 	NACA, NASCP	Federal	Q2	5,000,000	Low	
			<ul style="list-style-type: none"> Advocacy/sensitisation workshop held for NUC, provosts of medical schools and heads of schools of nursing/midwifery and health technology on incorporation of syndromic management of STIs in curricula of health training institutions 	NACA, NASCP	Federal	Q2	5,000,000	Low	
			<ul style="list-style-type: none"> Sensitisation workshops held for lecturers/tutors of medical schools, schools of nursing, schools of health technology on teaching syndromic management in training institutions 	NACA, SACA, NASCP, SACP	Federal, State	Q2	12,000,000	Low	



		<ul style="list-style-type: none"> · Zonal syndromic management TOT (Pre-service and in-service training) for HCPs 	<ul style="list-style-type: none"> · National STI management guidelines and training instruments reviewed 	NASCP	Federal	Q2	12,000,000	Low	
			<ul style="list-style-type: none"> · 30 HCPs trained as syndromic management master trainers trained in each zone 	NASCP	Federal	Q2	36,000,000	Low	
		<ul style="list-style-type: none"> · Step down syndromic management training at States and LGAs for HCPs 	<ul style="list-style-type: none"> · 30 HCPs trained as syndromic management trainers trained in each state by master trainers 	NASCP, SACP	Federal, State	Q2-Q3	225,000,000	Low	
			<ul style="list-style-type: none"> · State syndromic management trainers train 200 HCPs from private and public facilities at LGA level 	SACP, LGA	State, LGA	Q2-Q3	12,400,000,000	Low	
			<ul style="list-style-type: none"> · At least 30% HCPs in each health facility trained in syndromic management 	NASCP, SACP, LGA	Federal, State, LGA	Q2-Q3		Medium	
		<ul style="list-style-type: none"> · Training of TBAs to recognise STI syndromes and refer 	<ul style="list-style-type: none"> · %age of TBAs referring clients for STI management 	SACP, LGA	State, LGA	Q1-Q8		Medium	Availability of records of TBAs and their activities
		<ul style="list-style-type: none"> · Training of traditional health practitioners to recognise symptoms of STI and refer 	<ul style="list-style-type: none"> · %age of traditional health practitioners referring clients for STI management 	SACP, LGA	State, LGA	Q1-Q8		Medium	Availability of records of TBAs and their activities
		<ul style="list-style-type: none"> · Provide STI services in all clinics and RH service outlets to reach clients who either may not be aware of infection status or may otherwise not utilise services of special treatment centres 	<ul style="list-style-type: none"> · 50% of all clinics offer syndromic STI management services 	NASCP, SACP, LGA	Federal, State, LGA	Q1-Q8		Low	



			· 50% RH outlets offer syndromic STI management services	NASCP, SACP, LGA	Federal, State, LGA	Q1-Q8		Low		
		· Establish designated youth-friendly centres to reach the youth	· At least 2 youth-friendly centres in every LGA	SACP, LGA	State, LGA	Q4	4,000,000,000	Medium		
		· Integrate STI services into services already existing in MARP communities	· At least 2 STI centres for MARPS in each LGA	NACA, NASCP, SACA, SACP, CBOs, CSOs, health facilities	Federal, State, LGA	Q4	4,000,000,000	Medium		
		· Print and disseminate clinic aids (Wall charts, management manual, IEC, etc)	· Print 1m syndromic management clinic wall charts, 5m syndromic management clinic manuals for HCPs, 3m syndromic management flipcharts for TBAs and traditional health practitioners, 5m STI IEC materials for clinic clients	NACA, NASCP	Federal	Q2	7,000,000,000	Low		
		· Review and disseminate STI M&E tools	M&E tools review workshop held	NASCP	Federal	Q1	12,000,000	Low		
			M&E tools disseminated to states and LGAs	NASCP	Federal	Q1	55,500,000	Low		
		· M&E training for health facilities, program managers and community groups implementing STI activities		NASCP	Federal	Q1		Low		
TOTAL								46,616,617,000		



Thematic Area: New Prevention Technology/Male circumcision

S/N	Objective/Area of focus	Key Interventions	Indicators	Responsible Sector	Level of Implementation	Timeline	Budget (Millions)	Risk Assessment	Assumptions
		*Establish a corps of media professionals to support advocacy for microbicides/HIV vaccine research and development	-No of media professionals interested in NPT advocacy -50 media NPT advocates enlisted	NACA, NHVMAG, Media consultant			20,000,000		
		*Incorporate skills for effective reporting of new prevention technology(NPT) in ongoing media training on HIV/AIDS reporting	-Hand book on media reporting of NPT -Quantity/quality of coverage of NPT issues in the media	NACA, Media consultant			10,000,000		
		*develop media/information clearing house on NPT-media resource centres, periodic bulletins, websites, access to principal investigators of clinical trials	-Content developed for NPT website	NACA, NHVMAG, Media consultant			10,000,000		
		* science/media roundtables on NPT in Lagos, Abuja and in 4 other zones	-6 Science/media roundtables held	NACA, NHVMAG			30,000,000		
		*Incorporating NPT advocacy issues into agendas of networks such as NEPWHAN, CISHAN, NAWOJ, Interfaith Coalition, etc through training and access to information	-No of advocacy workshop held	NACA, NASCP, NHVMAG					
		*Place funding support for clinical trails on NPT on priority list of NACA and development partners working in Nigeria	-Advocacy meetings held with development partners -NPT to feature prominently at ETG meetings	ETG, NACA			5,000,000		
		*Form partnerships with groups such as the Nigeria HIV Vaccine Microbicide Advocacy Group (NHVMAG), International Partnerships for Microbicides(IPM) and other relevant groups working on	-Inventory of local and international organizations working on NPT identified -Partnerships formed/strengthened with such groups	NACA			2,000,000		



		vaccine and microbicides advocacy.								
		* TOT programmes for heads of key(existing) AIDS advocacy groups/networks on NPT advocacy.	-TOT held for 10 members each of CISHAN, NEPWHAN, NYNETHA,	NACA, NHVMAG			15,000,000			
			-Step down training held for other members				30,000,000			
		*Develop or review existing (and adopt) training modules for: a)Media advocacy on NPT, b)Community mobilization on NPT	-Media NPT training module developed	NACA, NHVMAG			10,000,000			
			-Training module on community mobilization/advocacy developed				10,000,000			
		*Adopt or localise and disseminate international ethical protocol for conduct of NPT clinical trials	-Review existing international/guide protocol				10,000,000			
			-National guide/protocol on ethical conduct of clinical trial developed.							
			-Launch/dissemination of guide				20,000,000			
TOTAL								172,000,000		

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Annex A:
Prevention Monitoring and Evaluation Plan

The Monitoring and evaluation framework of the National HIV/AIDS Prevention Plan 2007-2009 is based on the NNRIMS operational plan. The M&E framework will support the tracking of progress and support the utilization of information to improve programs, policies and service delivery as part of the multi-sectoral HIV and AIDS response in Nigeria.

The prevention result framework detailed the indicators to monitor and evaluate the implementation of plan. Most of these indicators are derives from the relevant sections of the NNRIMS operational plan. The framework also defines the sources of data from where information will be obtained for the measurement of the indicators. The data will feed into the NNRIMS database as the NNRIMS service delivery form and summary is the vehicle for data generation through the data transmission format clear defined by the NNRIMS Operational plan.

Prevention Result Framework

Objectives	Outcomes	OVI	MOV	Risk and assumption
<p>To have 95% of the general population and most at risk groups make appropriate behavioral changes (safe sex, abstinence, etc) through the implementation of the National HIV/AIDS Prevention plan by 2009</p>	<ul style="list-style-type: none"> • Increased demand for HIV and AIDS services • Increased behavioural change indices among the general population and most at risk groups • Increased health facilities supply of HIV and AIDS services • Increased access to adolescent friendly health services (life skills, counseling and health services) for young people • Increased number of people exposed to strategic information on HIV and AIDS • Community owned and driven strategic information for HIV prevention Action • Increased HIV and AIDS related policies that support • Reduction in stigma and discrimination 	<ul style="list-style-type: none"> • Percentage of female and male young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission • Percentage of schools with teachers who have been trained in FLHE and who taught it • Percentage of never married young men and women aged 15-24 who have never had sex • Percentage of never married women and men 15-24 who had sex in the last 12 month • Percentage of young women and men aged 15-19 who have had sex with a non-martial, non-cohabiting sexual partner in the last 12 month • Percentage of women and men reporting the use of condoms the last time they had sex with a non-martial, non-cohabiting sexual partner • Percentage of high risk groups reporting the use of condoms the last time they had sex with a non-martial, non-cohabiting sexual partner 	<ul style="list-style-type: none"> • Survey reports (IBSS, BSS, NARHS, NDHS, etc) • Annual school survey • Special survey 	<ul style="list-style-type: none"> • Effective implementation of the national HIV/AIDS prevention plan • Collaboration of member states • Availability of fund • Leadership commitment at all levels of public and private sectors • Active Technical working groups

		<ul style="list-style-type: none">• Percentage of sex workers who in the past 12 months used a condom correctly and consistently during sexual intercourse with clients• Percentage of women and men aged 15-49 reporting that the last health care injection was given with a syringe and needle set from a new and unopened package• Percentage of blood units transfused in the last 12 months that have been screened for HIV• Percentage of individuals who ever received counseling and testing for HIV and received their test result• Percentage of high risk groups who ever received counseling and testing for HIV and received their test result• Percentage of the general population with accepting attitude towards PLWHAs		
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Thematic Areas	Outcomes	OVI	MOV	Risk and assumption
ABC	<p>Availability of HIV prevention manual for PLHA</p> <p>Enacted Stigma and Discrimination law</p> <p>Gaps in ABC programming identified</p> <p>implementation age appropriate HIV prevention action</p> <p>Improved quality of PLWHA</p> <p>Improved workplace programmes and activities</p> <p>Increased access to HIV prevention programme/activities for PLHA</p> <p>Increased access to workplace policy and program interventions</p> <p>Increased availability of strategic information on age specific accurate ABC HIV prevention among out of school youth, married adolescents, women and PLHA</p> <p>Increased behavioural change indices among men and women</p> <p>Increased meaningful involvement of PLHA</p> <p>Increased number of disable centres implementation HIV prevention action</p> <p>Increased number of implemented National Youth policy and policy</p>	<ul style="list-style-type: none"> • Number of school inspectors aware of, and using the revised school inspection schedule that reflect issues of FLHE • Areas of improvement identified • No of organization (private and public) providing progress report on HIV workplace interventions • Number of ABC programming strategies developed • Number of AFHS centres • Number of CoE with trained teachers on HIV/AIDS Education & Life Skills • Number of condoms distributed • Number of disable centres implementation HIV prevention action • Number of high risk group (female and male) reached with HIV and AIDS prevention programs • Number of IEC materials distributed • Number of new condom outlets at community level • Number of organizations (private and public) with employed PLHA in management levels • Number of organizations (public and private) utilizing National HIV/AIDS Workplace Training manual 	<p>Survey reports</p> <p>Facility records and reports</p> <p>Activity report</p> <p>Registers</p> <p>Forms</p>	<p>Strong participation of media groups and organization</p> <p>Enabling policy environment</p> <p>Commitment to implement policies and guidelines</p>

	<p>document on people with disabilities integrating HIV and AIDS components</p> <p>Increased number of implementing National Education sector policy on HIV/AIDS</p> <p>Increased number of media organization providing accurate ABC information in the mass media targeting out of school youth, married adolescents, women and PLHA</p> <p>Increased number of OVC Programmes</p> <p>Increased number of peer education programmes/activities</p> <p>Increased number of peer educators</p> <p>Increased number of schools with HIV and AIDS integrated in inspectors activities</p> <p>Increased number of service centers in the education sector providing age- appropriate information & counseling on HIV/AIDS, condom provision and STI treatments</p> <p>Increased number of states adopting, adapting and implementing the national BCC strategy</p> <p>Increased number of states</p>	<ul style="list-style-type: none"> • Number of outcome indicators achieved • Number of parents, FBOs groups trained on HIV prevention in young people • Number of people trained to provide HIV and AIDS peer education • Number of PLWHAs in paid employment in public and private sectors • Number of review meetings held • Number of schools with staff members trained in and regularly teaching life skill based HIV and AIDS education • Number of schools with trained teachers on FLHE and regularly teaching it • Number of SG providing micro credit facilities • Number of SGs utilizing / manual for HIV prevention among PLHA • Number of states with domesticated stigma and discrimination bills • Number of trained mass media personnel on accurate ABC information • Number of trained peer educators • Number of trained strategic information on HIV prevention 		
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	<p>adopting, adapting and implementing the national guideline for ABC programming</p> <p>Increased number of trained teachers on HIV/AIDS Education & Life Skills</p> <p>Increased uptake of HIV and AIDS services</p> <p>Reduced stigma and discrimination</p> <p>Standardised and qualitative BCC materials on ABC</p> <p>Standardised peer education training & programming manual</p> <p>Updated national BCC strategy implemented</p>	<p>employees providing</p> <ul style="list-style-type: none"> • Number of trained strategic information on HIV prevention employees providing • Number of treatment literacy campaigns conducted • Percentage decline in stigma index • Percentage of discordant couple reporting the use of condoms • Percentage of employee counseled, tested and received test results • Percentage of employee men and women reached with strategic information on HIV prevention • Percentage of health workers trained on adolescent friendly health services (AFHS) • Percentage of media practitioners trained to report adolescent friendly health issues and services • Percentage of men and women accessing HCT services • Percentage of men and women out of school youth, married adolescents and PLHA reached with strategic information on HIV prevention • Percentage of men and women PLWHA accessing ARVs • Percentage of men and women reached with strategic information on 		
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		<p>HIV prevention</p> <ul style="list-style-type: none">• Percentage of men and women trained on life skills for the HIV prevention• Percentage of organization health facilities with capacity to provide HIV counseling and testing• Percentage of OVC reached with information on appropriate HIV prevention• Percentage of people with disabilities reached with information on HIV prevention• Percentage of PLHA accessing ARVs• Percentage of PLHA trained on positive prevention• Percentage of schools with teachers who have been trained in life skills based HIV and AIDS education and who taught it during the last academic year• Percentage of service providers trained on adolescent friendly health services• Percentage of the general population with accepting attitude toward PLWHAs• Percentage of young people including people with disabilities reached with information on HIV prevention		
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		<ul style="list-style-type: none"> • Percentage of young people reached with information on life skills for HIV prevention • Percentage reduction in stigma index • Proportion of FBOs leaders and groups providing adolescent friendly services • Proportion of health facilities providing adolescent friendly services • Proportion of health facilities providing adolescent friendly services • 		
PMTCT	<p>Increased availability of PMTCT services</p> <p>Increased linkages and access to PMTCT, family planning services and HCT</p>	<ul style="list-style-type: none"> • Number of pregnant women counseled for HIV • Number of pregnant women counseled and tested for HIV • Number of pregnant women counseled, tested and received test result 	<p>Survey reports</p> <p>Facility records and reports</p> <p>Activity report</p>	<ul style="list-style-type: none"> • Collaboration of member states • Availability of fund • Enabling policy environment • Effective running

		<ul style="list-style-type: none"> • Percentage of pregnant women counseled , tested for PMTCT and received test result • Number of pregnant women accessing a complete course of ARV prophylaxis from PMTCT centres • Percentage of pregnant women accessing a complete course of ARV prophylaxis from PMTCT centres • Number of health facilities providing a complete package of PMTCT services • Percentage of LGA's with at least one PMTCT centre offering the complete package of PMTCT services • Number of family planning clients counseled for HIV • Number of family planning clients counseled and tested for HIV • Number of family planning clients counseled, tested and received test result • Percentage of family planning clients counseled , tested for PMTCT and received test result • Number of support groups established for HIV positive women • Number of male partners tested for HIV • Number of trained health workers to provide PMTCT services 	Registers Forms	of the other related health programmes and policies
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		<ul style="list-style-type: none"> • Number of events organized to mobilize pregnant women to access PMTCT services • Number of PMTCT IEC materials distributed 		
Blood Safety / Injection Safety	<ul style="list-style-type: none"> • Increased number of states adopting, adapting and implementing the national guideline for medical injection safety and injection safety and universal precaution • Increased access to PEP services 	<ul style="list-style-type: none"> • Number of events/community campaigns organized to mobilize donors • Number of events/community campaigns organized on injection safety • Number of events/community campaigns organized on medical waste management • Number of blood safety IEC materials distributed • Number of donor bank centres formed • Number of facilities using quality guidelines on medical injection safety • Number of health workers trained in safe blood transfusion practices • Number of facilities using quality guidelines in HIV screening • Number of health workers trained on injection safety and universal precaution • Amount spent on universal precaution consumable • Number of facilities practicing 	<p>Survey reports Facility records and reports Activity report Registers Forms</p>	<p>Commitment to implement policies and guidelines</p>

		<ul style="list-style-type: none"> universal precaution • Number of health facilities using safe injection commodities • Number of blood collected from regular low risk donors • Percentage of health facilities that have safe blood transfusion practices • Percentage of health facilities that have on injection safety and universal precaution in place • Percentage of health facilities that have waste management plan in place • Proportion of women and men aged 15-49 reporting that the last health care injection was given with a syringe and needle set from a new unopened package • Percentage of blood units transfused in the last 12 month that have been screened for HIV • Number of health workers reporting needle stick injuries • Number of health facilities providing PEP • 		
HCT	Increased uptake of HCT Increased linkages and access to HCT and family planning services	<ul style="list-style-type: none"> • Amount spent on test kits • Number of IEC materials distributed • Number of retrained HCT counselors and testers 	Facility reports Activity reports	Community participation and ownership

		<ul style="list-style-type: none"> • Number of newly trained HCT counselors and testers • Number of new testing and counseling service points established • Number of clients counseled for HIV • Number of clients counseled and tested for HIV • Number of clients counseled, tested and received test result • Percentage of clients counseled, tested and received test result • Percentage of person tested for HIV in relation to pregnancy, TB • Percentage of family planning clients counseled, tested and received test result • Number of male and female condoms distributed • Number of referral made • Number of events organized to create demand for HCT services • 	Survey reports	
Male Circumcision /New prevention technologies	Increased HIV and AIDS new prevention technologies	<ul style="list-style-type: none"> • Percentage of men and women reached with strategic information on NPT • Number of ethical review boards established • Number of tested new technological products • Percentage of men and women 		Strong advocacy groups Observance of ethical issues

		accessing microbicides and vaccines <ul style="list-style-type: none"> • Number of clinical trials on NPT • Number of IEC materials on NPT distributed • Number of community campaigns/events organized to create awareness for NPT 		
Research	Increased availability of updated STI/SHIV/AIDS information on the general and high risk groups Increased STI/HIV/AIDS research conducted Increased information on the dynamics of STI/HIV/AIDS	<ul style="list-style-type: none"> • Number of pilot, assessment and impact studies conducted 	Research reports Survey reports	Availability of fund Supportive environment

<p>Condom programming and other prevention (OI Rx, etc)</p>	<p>Increased access to condoms</p>	<ul style="list-style-type: none"> • Number of condoms (male and female) distributed • Number of condoms (male and female) distributed by social marketing outlets • Number of MARPS couples who use condom correctly and consistently • Number of new condom outlets at community levels • Number of opinion leaders who encourages condom use for dual protection • Number of outlets reached through community mobilization • Number of people reporting condom use • Number of sero-discordant couples who use condom correctly and consistently • Percentage of discordant couple reporting the use of condoms • Percentage of family planning clients reporting condom use • 		<p>Availability of commodities Availability of funds Community, parent and religious leaders supports</p>
<p>STI Management</p>	<p>Increase access to STI information Increased behavioural change indices among men and women Increased health seeking behaviour Declined rate of STIs infections</p>	<ul style="list-style-type: none"> • Number of media personnel training on STI and HIV prevention issues • Number of health facilities with capacity to appropriately diagnosed STI cases 	<p>Facility reports Survey reports Activity</p>	<p>Commitment to implement policies and guidelines Supportive environment</p>

	<p>Increased community participation Increase Access to Quality Management of STIs</p>	<ul style="list-style-type: none"> • Number of health facilities with capacity to appropriately counsel patient with STI • Number of health facilities with capacity to appropriately treat patient with STI • Percentage of health facilities with capacity to appropriately diagnosed, counsel and treat patients with STI • Number of radio and TV stations providing sensitizations on the linkages between STIs and HIV • Number of • Percentage of men and women reached with strategic information on STI/HIV prevention • Number of IEC materials on STI prevention and treatment (Wall charts, management manual) as a means of preventing new HIV infections distributed • Number of MARPS seeking and reporting cases of STIs • Number of STIs referral made • Number of community campaigns/sensitizations conduction on role of STI prevention/treatment in HIV prevention • Number of trained peer educators on STI prevention/treatment 	<p>report</p>	
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		<ul style="list-style-type: none">• Number of YFC providing STIs services (counseling, diagnosis and testing)• Number of trained health providers on syndromic management• Number of health institutions with STI case management by syndromic approach integrated in the curricula• Number of private health facilities offering syndromic management in line with the national protocols• Percentage of STI facilities reporting out-of-stock STI drugs		
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