



FROM THE DARKEST OF DAYS TO A NEW DAWN

35 YEARS
of the Nigerian Response
to HIV and AIDS



UNITED NATIONS
NIGERIA



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Sources

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MESSAGE FROM THE PRESIDENT

It gives me great joy to introduce this important collection of articles about Nigeria's sustained response to HIV and AIDS. Every article and report herein expertly addresses a critical time in our national response and offers a glimpse into our resilience as a country and people.

We have made good on our commitment at the High-Level Meeting Side Event at the 72nd Session of the UN General Assembly in September 2017 to commence placing 50,000 Nigerians living with HIV on treatment annually, using Government of Nigeria resources. In this regard, I personally granted an exceptional waiver for the use of competitive international tender facilities to procure antiretroviral medicines at more than 30% cost efficiency, enabling more Nigerians to be placed on life-saving antiretroviral treatment with the same budget.

More recently, we increased the budget allocation for the health sector despite constraints in revenue. We are working diligently with state governments to improve the conditions of our Primary Healthcare Centers. We have also rolled out the Basic Health Care Provision Fund to ensure that quality health care is not out of the reach of any Nigerian, no matter how modest their background.

This publication also reminds us of the task we have ahead. The Government of Nigeria is fully committed to the Sustainable Development Goals and other international and regional initiatives toward eliminating AIDS in Africa and indeed the world by 2030. We will continue to work with fellow heads of state and governments across the continent to ensure a sustained high level political engagement in achieving these goals. I made this commitment at the United Nations General Assembly in June 2021 and, today, I use this medium to reinforce this message to the HIV community and the people of Nigeria.

I want to take this opportunity to specifically acknowledge Nigerians living with HIV, and their civil society allies and other friends. Your advocacy and commitment have been pivotal in moving the AIDS response to where it is today. I understand there are difficulties, but there are also great achievements and hopes for a better tomorrow.

I commend our government ministries and NACA, under the leadership of the Office of the Secretary to the Government of the Federation and the Federal Ministry of Health, who work tirelessly toward achieving Nigeria's vision of controlling and ending AIDS as a public health threat by 2030.

Finally, my hearty appreciation goes to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations family, PEPFAR, the Global Fund and our other development partners, for walking this path with us. We are truly together.



Muhammadu Buhari GCFR,
President, Federal Republic of Nigeria



MESSAGE FROM THE SECRETARY TO THE GOVERNMENT OF THE FEDERATION

I am delighted to see this publication, the first of its kind in Nigeria, which has been three years in the making and has delivered everything it promised and more. *New Dawn* shows the progress of the HIV response through the pre-donor era, the donor era, and the present day in which the Government of Nigeria has taken back the reins of the HIV response and faced head-on the COVID-19 and HIV pandemics. My office is proud to have shepherded the HIV response through its evolution, with funding, treatment regimens, support structures, systems, COVID-19 strategies, and data.

Thanks to strong political will and partnership, Nigeria is proud to have moved from a data-poor country to a data-rich country with the results of the largest AIDS Indicator and Impact Survey (NAIIS), which was conducted in 2018. The results of this survey have enabled Nigeria to set realistic targets and identify those who were not being reached with the necessary services. This has further enabled Nigeria, through the support of the US Government, the Global Fund, the United Nations, civil society, and other partners, to enrol almost 1.6 million Nigerians on life-saving HIV treatment. We have recorded tremendous growth in our treatment program, especially between 2019 and 2020.

As the oversight office not only for the HIV response, but also the Presidential Task Force on COVID-19, it is an honor to see this publication connect the dots between the two health emergencies and demonstrate how the lessons from each augment the response to the other.

I want to reiterate the Nigerian government's continuous support for an HIV response that brings to life the commitments made in the clear and ambitious Common African Position and the June 2021 Political Declaration. We will continue to address those inequalities that exacerbate the public health threat of HIV, strengthen resilience to end AIDS and address current and future health emergencies.

Special thanks to the people living with HIV, civil society, The Global Fund, PEPFAR and the UN family, which have been with us throughout this fight. It is through strong partnership that we have been able to move the needle to where epidemic control is in sight.

My sincere gratitude to the UN family, in particular Dr. Erasmus Morah of the Joint United Nations Programme on HIV/AIDS (UNAIDS), for not hesitating to take on the task of collaborating with the Government, NEPWHAN and the people of Nigeria to tell their HIV story, particularly through the voices and images of those who have been part of the response since the first two HIV positive cases were reported in 1986.



Mr. Boss Mustapha,
Secretary to the Government of the Federation



ABOUT THIS PUBLICATION

This book, conceptualized during our leadership, tells the story of Nigeria's response to HIV and AIDS through a compendium of articles written by over 150 contributors; the key actors who were tasked with tackling the AIDS epidemic and those who have been living through it. Inspired by Nigeria's exemplary early-days of the response to the epidemic (1986-2004) and the 2018 Nigeria HIV/AIDS Indicator and Impact Survey—the world's largest population-based HIV survey—it documents the history of the HIV response in Nigeria. It also tells the success stories and cautionary tales as well as outlining the critical historical developments and game-changing achievements in the HIV response.

Chapter 1 highlights the first cases of HIV in Nigeria in the mid-1980s and goes on to tell the story of how it became an epidemic in the 1990s and how the Nigerian people and their government responded boldly and proactively in the early days of the epidemic, both nationally and on the African continent.

Chapter 2 covers the years 2004 to 2015 when Nigeria's HIV response was characterized by reliance on the international support for HIV prevention, testing, treatment, and support programs.

Chapter 3 brings us to the present when Nigeria has once again prioritized national responsibility for its HIV programming and again taken a leadership role in the international response.

Chapter 4 introduces the COVID-19 pandemic, a critical time in the new dawn, when health systems are x-rayed and tested, and the need for urgency and the protection of rights are paramount. Here, lessons from the HIV response were quickly adapted to curtail the dual pandemics.

Chapter 5 concludes the account of the journey so far and rounds off the story with some parting visionary remarks by key figures in the Nigerian HIV leadership.

This publication is, therefore, a testament to what we can achieve when we work together. It offers deep insights into the HIV response in Nigeria; gives hope to those in despair; guides health workers, researchers, and policymakers; and provides a historical reference for future generations.

Like a rising sun that gives hope for a brighter day, *New Dawn* offers the world a new perspective to the Nigerian story.

Dr. Sani Aliyu,
Former Director-General, National Agency for the Control of AIDS



Prof. Isaac Adewole,
Former Minister of Health





FOREWORD

An account of the evolution of the Nigerian HIV response into its current state of maturity is finally available for the world to read in this chronicle of the country's HIV story. It is a story of trials, sacrifice, partnership, and commitment. It is a story of loss and hope. Who better to tell it than the more than 150 people who contributed, fought or experienced the evolution at one time or another?

It is our honor to lead the charge and be bestowed with the stewardship of this dynamic health and HIV response. The milestones reached in the HIV response are noteworthy. More people are being placed and retained on treatment in Nigeria than ever before, facilitating high population-based viral load suppression among HIV-positive persons on ART and a decline in morbidity and mortality. There is an increased ownership of the response as the Federal Government has continued to make good on its promise to place 50,000 people on treatment annually, using government resources.

Sustainable financing for health and HIV is at the forefront of Nigeria's plans, evidenced by the 2021 Framework for National Domestic Resource Mobilization, the State sustainability ownership model, along with integration of HIV services into State Health Insurance Schemes. Another novel strategic direction is the establishment of the HIV Trust Fund of Nigeria, a purely private-sector-driven initiative to support HIV funding and investment for Nigeria in partnership with the Nigerian Business Coalition Against AIDS (NiBUCAA).

Nigeria is in the last mile push for HIV epidemic control, with 90% of the estimated people living with HIV already identified and placed on life-saving ART. Bringing the AIDS epidemic to a point of control is therefore within sight, and the authors have clearly put this into perspective. However, identifying those left behind in order to achieve epidemic control will need all hands-on deck. We need to bolster our partnerships, leverage national systems for resource mobilization and efficiency, and invest in our communities. We applaud our health care teams, PLHIV networks, the UN system, the US Government, the President's Emergency Plan for AIDS

Relief (PEPFAR), The Global Fund, and other partners and allies that have stood beside Nigeria throughout.

The ongoing COVID-19 pandemic is a grim reminder that, despite our best efforts, we cannot rest on our oars, as new public health and development challenges will appear and we must take on board lessons learned and best practices. We must leverage the urgency applied toward the COVID-19 pandemic in ensuring that our current momentum for the last mile push to control and end AIDS in Nigeria as a public health threat by 2030 is sustained. Finally, we must facilitate the institutionalization of sustainable financing and structures capable of responding not just to the HIV and COVID-19 pandemics but also other public health and development emergencies. This will further leapfrog the Federal Government of Nigeria into greater ownership of its response and catalyze action toward the achievement of the Sustainable Development Goals.

Dr. Gambo Aliyu,
Director General, National Agency for the Control of AIDS



Dr. Osagie Ehanire,
Minister, Federal Minister of Health





MESSAGE FROM THE UNITED NATIONS SYSTEM IN NIGERIA

The United Nations system has long stood side by side with the Nigerian government as a close partner and collaborator, sharing and succeeding in the common agenda to halt and begin to reverse the spread of HIV in the country. This partnership has been reflected throughout Nigeria's larger development and humanitarian spaces, where the HIV and now COVID-19 pandemics are situated. It is a proud moment for the UN system to see Nigeria's HIV response story come alive, thus completely transforming the erstwhile negative narrative of the country's track record in fighting the epidemic.

Nigeria has made remarkable progress toward the UNAIDS 90-90-90 targets, especially during the recent years of the response. Between the 2017 and 2021 UN General Assembly High-Level Meetings on HIV/AIDS, Nigeria dramatically improved its standing in the global response to HIV. It displayed global leadership in the collection of vital data for planning the response, with the 2018 Nigerian AIDS Indicator and Impact Survey, the largest survey of its kind to be conducted anywhere in the world. It re-established its National Treatment and PMTCT Program and successfully increased treatment coverage from below 40% to more than 80%. It further committed to place 50,000 Nigerians living with HIV on treatment annually, using government resources.

We therefore take great pride in having been called upon to collaborate with the Government and the people of Nigeria to tell the compelling and exciting story of how the country not only turned around HIV, but also how it once led the continent in responding to the pandemic during the difficult early days, when many African countries and their leaders were in denial. In this regard, we salute President Muhammadu Buhari for his unwavering leadership and commitment to changing the HIV narrative in Nigeria, by lending his political capital to delivering NAHIS, and for committing to, and honoring, a formula of annually increasing the government budget for placing HIV-positive Nigerians on treatment. We salute former

President Goodluck Jonathan for championing elimination of mother-to-child transmission, including globally at the UN General Assembly. We salute president Yar'Adua for his role in resource mobilization for the HIV response by extending the World bank credit for HIV, and for the nationwide mobilization, education, and organization of women, through the First Lady, Hajiya Turai Yar'Adua and the National Women Coalition on HIV/AIDS. We also salute former President Olusegun Obasanjo for being the early pathfinder-leader and political commitment mobilizer for HIV response in both Nigeria and the African continent.

Let us not forget the people who we serve—the people living with HIV, key populations, and young women and girls most-at-risk of infection. We stand proud today because of them, their activism, and their civil society collaborators. Their stewardship, sacrifice and advocacy over the years are what has brought us to this New Dawn. We still have a long way to go but we will get there. We cannot lose sight of the persisting stigma, discrimination and equity challenges you face daily. While there has been progress in responding to services for key populations, we call on the Government to do more to address the justice, legal and institutional barriers they face.

Last, let us emphasize the need for the Government of Nigeria to continue to increasingly invest in the health and well-being of its citizens, and in community-led, youth-led, and women-led programs and services.

Dr. Erasmus Morah,
Country Director,
UNAIDS, Nigeria



Mr. Edward Kallon,
Former Resident and Humanitarian Coordinator,
United Nations, Nigeria



STATEMENT FROM THE UNAIDS EXECUTIVE DIRECTOR



Winnie Byanyima,
UNAIDS Executive Director
and Under Secretary-General
of the United Nations

I congratulate the UN system working on AIDS in Nigeria for collaborating with the government and its people to tell the story of the HIV response, from inception till date, capturing the significant progress over three decades of the HIV response in Nigeria. Nigeria has made good progress on expanding the delivery of HIV testing, treatment, and care services over recent years, contributing to a steep decline in AIDS-related deaths. We must continue to put communities at the center of development, empower them, address social drivers and fight poverty and inequalities. We know, from the evidence, what will work in beating pandemics: access to the latest health technologies for all; communities at the center, shared science, strong services, and social solidarity; plus supporting community leadership to enable all these. We know too that we can only succeed in these together, worldwide.

I look forward to reinforcing UNAIDS' partnership with the government, communities, and all other stakeholders to drive new HIV infections down and kick-start a decade of action to exercise public health leadership to end inequalities and social exclusion, and to end AIDS as a public health threat by 2030. Let's keep the fight on!

STATEMENT FROM THE UNITED NATIONS DEPUTY SECRETARY-GENERAL



Amina J. Mohammed,
United Nations
Deputy Secretary-General

I am delighted to learn about this important effort in documenting history. I join in commending the Government of Nigeria and partners for successfully changing the narrative of the HIV response for the better. I would like to add my voice to President Buhari's appreciation of the contributions of PEPFAR, Global Fund, the UN family, People living with HIV, and civil society in bringing Nigeria this far in this difficult but progressive journey.

I recall when the Global Fund (2003) and PEPFAR (2004) first came to Nigeria. We wanted them to fully support the national HIV and health plan — and they have delivered, saving lives, and strengthening health systems not only in Nigeria but also around the world. The Global Fund and PEPFAR have invested significantly in Nigeria and worked hand in hand with the United Nations and affected communities to demonstrate that working together brings progress and results. The efforts have succeeded to bring HIV, TB, and malaria services to the most vulnerable populations, especially our women and youth, and put affected communities at the centre of the response.

I applaud these unwavering global commitments and investments, with the extraordinary impact of saving millions of lives around the world and currently placing more than 1.6 million Nigerians on HIV treatment. To go the last mile in Nigeria, sub-national engagement will be key.

Let us build on the lessons from the past 20 years and get firmly on track to increasing domestic financing to end AIDS and achieve the Sustainable Development Goals by 2030.

ABBREVIATIONS

ABC	Abstain. Be Faithful. Use a Condom	ASWHAN	Association of Women Living with HIV in Nigeria
ABUTH	Ahmadu Bello University Teaching Hospital	AYP	Adolescents and Young People
AFPAC	Armed Forces Programme on AIDS Control	BCC	Behavior Change Communication
AGYW	Adolescent Girls and Young Women	BENSACA	Benue State Agency for the Control of AIDS
AHF	AIDS Healthcare Foundation	BHCPF	Basic Health Care Provision Fund
AIDS	Acquired Immune Deficiency Syndrome	BOT	Board of Trustees
AKTH	Aminu Kano Teaching Hospital	BMO	Business Membership Organization
ANC	Antenatal Clinic	BNA	Bottle Neck Analysis
APIN	AIDS Prevention Initiative in Nigeria	C19RM	[Global Fund] COVID-19 Response Mechanism
APYIN	Association of Positive Youths Living with HIV/AIDS in Nigeria	CAN	Christian Association of Nigeria
ART	Antiretroviral Treatment	CART	Community Antiretroviral Therapy
ARV	Antiretroviral	CBO	Community-Based Organization
ASP	[Global Fund] Additional Safeguard Policy	CCM	Country Coordinating Mechanism
AWA	[African Union] AIDS Watch Africa	CD4	Cluster of Differentiation 4

CDC	United States Centers for Disease Control and Prevention	EID	Early Infant Diagnosis
CHEERS	Center for Health Education Economic Rehabilitation and Social Security	EMTCT	Elimination of Mother-to-Child Transmission
CI	Change Influencer	ENR	Enhancing Nigeria's Response to HIV
CIDA	Canadian International Development Agency	EPA	Eligibility Performance Assessment
CISCGHAN	Civil Society Consultative Group on HIV/AIDS in Nigeria	ETG	Expanded Theme Group
CiSHAN	Civil Society for HIV and AIDS in Nigeria	FCDO	Foreign, Commonwealth & Development Office
CLM	Community-Led Monitoring	FCT	Federal Capital Territory
CRSACA	Cross River State Agency for the Control of AIDS	FHI 360	Family Health International
CSO	Civil Society Organization	FMOH	Federal Ministry of Health
DevComs	Development Communications Network	FOBTAC	Forces Blood Transfusion and AIDS Control Committee
DFID	Department for International Development	FSW	Female Sex Worker
DHIS	District Health Information Software	FTI	Fast-Track Initiative
USDOD	United States Department of Defense	G8	Group of Eight
DTG	Dolutegravir	GBV	Gender-Based Violence
EBOSACA	Ebonyi State Action Committee on AIDS	GHAIN	Global HIV/AIDS Initiative Nigeria
ECHO	Efficiencies for Clinical HIV Outcomes	GHRTC	Gender and Human Rights Technical Committee
		GIPA	Greater Involvement of People with AIDS
		GTC	Gender Technical Committee
		HAART	Highly Active Antiretroviral Therapy
		HCV	Hepatitis C Virus
		HE	His Excellency

HEAP	HIV/AIDS Emergency Action Plan	JAAIDS	Journalists Against AIDS
HIV	Human Immunodeficiency Virus	JICA	Japan International Cooperation Agency
HPDP	HIV/AIDS Program Development Project	JUTH	Jos University Teaching Hospital
HSPH	Harvard School of Public Health	KP	Key Population
HSS	Health Systems Strengthening	LACA	Local Government Committee on AIDS
HSS	HIV Sentinel Survey	LFA	Local Fund Agent
HTF	HIV Trust Fund	LGA	Local Government Area
HTS	HIV Testing Services	LGBTQ+	Lesbian, gay, bisexual, transgender and queer, and others
IBBSS	Integrated Biological and Behavioural Surveillance Survey	LUTH	Lagos University Teaching Hospital
ICASA	International Conference on AIDS and STIs in Africa	M&E	Monitoring and Evaluation
ICW	International Community of Women Living with HIV	MAP	Multi-Action Program
IDP	Internally Displaced Person	MAT	Medication-Assisted Treatment
IEC	Information, Education and Communication	MDG	Millennium Development Goal
ILO	International Labour Organization	MHNN	Men's Health Network Nigeria
IMHIPP	Integrated Most-at-Risk Populations HIV Prevention Programme	MNCH	Maternal, Newborn and Child Health
ITPC	International Treatment Preparedness Coalition	MPPI	Minimum Prevention Package of Interventions
		MSF	Medicines Sans Frontiers
		MSM	Men who have Sex with Men
		MTCT	Mother-To-Child Transmission

MTSS	Medium-Term Sector Strategy	NEMA	National Emergency Management Agency
NAAC	National AIDS Advisory Committee	NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NACA	National Agency for the Control of AIDS (previously National Action Committee on AIDS)	NFACA	National Faith-Based Advisory Council on AIDS
NACP	National AIDS Control Programme	NFM	[Global Fund] New Funding Model
NADR	National Data Repository	NGO	Non-Governmental Organization
NAFDAC	National Agency for Food and Drug Administration and Control	NHA	National Hospital Abuja
NAIIS	National HIV/AIDS Indicator and Impact Survey	NHRC	National Human Rights Commission
NARHS	National HIV & AIDS and Reproductive Health Survey	NiBUCAA	Nigerian Business Coalition Against AIDS
NASACA	Nasarawa State AIDS Control Agency	NiMART	Modified Nurse-Initiated Management of ART
NASCP	National AIDS and STIs Control Programme	NIMR	Nigerian Institute of Medical Research
NAUTH	Nnamdi Azikiwe University Teaching Hospital	NiSRN	National Integrated Sample Referral Network
NAWOCA	National Women Coalition on AIDS	NMOD	Nigerian Ministry of Defence
NCDC	Nigeria Center for Disease Control	NPHCDA	National Primary Health Care Development Agency
NDHS	Nigeria Demographic and Health Survey	NSCIA	Nigerian Supreme Council for Islamic Affairs
NEACA	National Expert Advisory Committee on HIV/AIDS	NSHDP	National Strategic Health Development Plan
		NSP	National Strategic Plan
		NTPP	National Treatment and PMTCT program



NYNETHA	Nigeria Youth Network on HIV/AIDS	PHC	Primary Health Care
OAFLAD	Organization of African First Ladies for Development	PIP	People in Prison
OAU	Organisation of African Unity	PLACE	Priorities for Local AIDS Control Efforts
ODA	Overseas Development Assistance	PLHIV	People Living with HIV
OGAC	Office of the US Global AIDS Coordinator	PLWA	People Living with AIDS
OIG	[Global Fund] Office of the Inspector General	PMTCT	Prevention of mother-to-child transmission
OSIWA	Open Society Initiative for West Africa	PPP	Public-Private Partnership
PAC	Presidential AIDS Council	PR	Principal Recipient
PACE	Partnership for Achieving Control of Epidemic	PTF	Presidential Task Force
PATA	Positive Action for Treatment Access	PVA	Place Value Agent
PCA	Presidential Committee on AIDS	PWD	Persons with Disability
PCDF	Positive Care and Development Foundation	RSSH	Resilient and Sustainable Systems for Health
PCR	Polymerase Chain Reaction	RTK	Rapid Test Kit
PCRP	President's Comprehensive Response Plan for HIV/AIDS	SACA	State Action Committee on AIDS
PEEP	Patient Education and Empowerment Project	SAPC	States AIDS Programme Coordinator
PEPFAR	President's Emergency Plan for AIDS Relief	SASPC	State AIDS/STI Programme Coordinator
PforR	Performance-for-Results	SEMA	State Emergency Management Agency
		SGF	Secretary to the Government of the Federation
		SMOH	State Ministry of Health
		SOML	Save One Million Lives
		SPIU	State Project Implementation Unit

SRH	Sexual and Reproductive Health	UNGA	United Nations General Assembly
SSLN	South-South Learning Network	UNIC	United Nations Information Center
STD	Sexually Transmitted Disease	UNICEF	United Nations Children's Fund
STI	Sexually Transmitted Infection	UNJTA	United Nations Joint Team on AIDS
SURE-P	Subsidy Reinvestment and Empowerment Programme	UNODC	United Nations Office on Drugs and Crime
TAM	Treatment Action Movement	UNSDCF	UN Sustainable Development Cooperation Framework
TB	Tuberculosis	UNTH	University of Nigeria Teaching Hospital
UBTH	University of Benin Teaching Hospital	UPTH	University of Port Harcourt Teaching Hospital
UCH	University College Hospital (Ibadan)	USAID	United States Agency for International Development
UHC	Universal Health Coverage	USG	United States Government
UMTH	University of Maiduguri Teaching Hospital	VAPP	Violence Against Persons Prohibition
UNAIDS	Joint United Nations Programme on HIV and AIDS	VCT	Voluntary Counselling and Testing
UNCT	United Nations Country Team	WCA	West and Central Africa
UNDP	United Nations Development Programme	WFP	World Food Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization	WHO	World Health Organization
UNFPA	United Nations Population Fund		



TIMELINE OF KEY EVENTS

1985

First two HIV cases (reported in 1986 at the 2nd International AIDS Conference in Paris)

1986

National Expert Advisory Committee on HIV/AIDS (NEACA) set up

1988

NEACA dissolved and replaced by National AIDS and STIs Control Programme (NACP)

1 December. First World AIDS Day in Nigeria

Three-year Medium-Term Plan developed

1987

National AIDS Advisory Committee (NAAC) set up

1989

Nigerian Army Expert Committee on AIDS and Emerging Infections formed

1999

National Action Committee on AIDS (NACA) established

Dr. Jeremiah Abalaka puts forward a controversial claim for discovery of HIV 'vaccine' and 'cure'

1994

UNAIDS Secretariat established globally in Geneva

1998

Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) established

1997

AIDS activist and former health minister Olikoye Ransome-Kuti announces that his brother Fela Kuti has died of AIDS

1991

National AIDS Control Programme (NACP) expands to become National AIDS and STD Control Programme (NASCP)

First government sentinel surveillance of pregnant women in antenatal clinics. Prevalence rate: 1.8%

2000

Bill & Melinda Gates Foundation gives US\$25 million to Harvard School of Public Health for AIDS prevention in Nigeria

UNAIDS Nigeria Country Office established with Costa Berhe as the first Country Programme Adviser and Head of Office

2001

United Nations General Assembly Special Session on HIV/AIDS

Pilot National PMTCT program begins

First African Heads of State Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. Abuja Declaration: African countries commit to allocating a minimum of 15% of their annual budget to health and call for the establishment of Global Fund to fight HIV, TB and Malaria

Establishment of AIDS Watch Africa with President Olusegun Obasanjo as the first chairman

1 December. World AIDS Day. President Olusegun Obasanjo announces that Nigeria will be first country in Africa to launch a national treatment program

2001–2004

HIV/AIDS Emergency Action Plan (HEAP), 2001–2004 developed as first multi-sectoral medium-term plan

2002

The Global Fund to Fight AIDS, Tuberculosis and Malaria established globally

Nigeria's Global Fund Country Coordinating Mechanism (CCM) inaugurated as a public-private partnership

National ART program begins in 25 tertiary hospitals targeting 10,000 adults and 5,000 children

2003

The first Global Fund grant received in Nigeria in the form of three grants awarded to the value of US\$2.5 million

U.S. President's Emergency Plan for AIDS relief (PEPFAR) launched globally

WHO and UNAIDS launch "3 by 5" initiative to provide 3 million people living with HIV/AIDS in low- and middle-income countries with life-prolonging antiretroviral treatment by the end of 2005

International Treatment Preparedness Coalition (ITPC) formed at Cape Town Summit

National PMTCT Guidelines developed

Treatment Action Movement (TAM) launched in Nigeria

ART drug stock-out prompts Harvard and APIN to apply for PEPFAR grant to support Nigeria's national HIV and AIDS response

Federal Government institutes national free ART program along with treatment interventions provided by donors

2004

First integrated surveillance survey jointly conducted by two largest NGOs in Nigeria (FHI and SFH)

2004 PEPFAR is inaugurated in Nigeria and begins operations

2004 Federal Ministry of Health inaugurates National Task Team on HIV counseling and testing

Association of Women Living with HIV/AIDS established

2005

PEPFAR commits an additional US\$113.4 million to support Nigeria

Nigeria hosts 14th International Conference on AIDS and STIs in Africa, Abuja, Nigeria

National Workplace Policy put in place (reviewed 2013)

National HIV/AIDS Strategic Framework 2005–2009

National Agency for the Control of AIDS (NACA) Governing Board established with Prof. Umaru Shehu as pioneer Chairman

2008 Launch of the Champions for an AIDS-Free Generation with former President Olusegun Obasanjo as a founding member

2008

2007

National Action Committee on AIDS becomes full government agency: National Agency for the Control of AIDS (NACA)

Formation of National Women Coalition on AIDS (NAWOCA)

Health Ministry includes key populations in second National Integrated Biological and Behavioural Surveillance Survey (IBBSS) for the first time

2006

Federal Ministry of Health produces National HIV counseling and testing guidelines

2006 UN General Assembly Political Declaration on HIV/AIDS

2006 UNAIDS Executive Director, Dr. Peter Piot, visits Nigeria to address the Special Assembly of the Heads of State and Government in Abuja

2010

National HIV/AIDS Strategic Plan 2010–2015 developed

2011

UN General Assembly High-Level Meeting on AIDS. President Goodluck Jonathan and Nigerian HIV activist, Ebube Taylor address the Assembly and provide leading voice for advocating elimination of mother-to-child transmission

2012

Nigeria, with support from UNAIDS, develops domestic resource mobilization strategy

2014

People living with HIV demonstrate at NACA to protest living conditions of their members

Same sex prohibition Act enacted

National HIV/AIDS Anti-Discrimination Act enacted

Nigeria institutes Basic Healthcare Provision Fund founded on the National Health Act

New Strategy instituted to achieve treatment saturation in 12 high-burden states plus FCT

The President's Comprehensive Response Plan Developed

2013

National workplace policy on HIV and AIDS put in place

2015

EMTCT initiative launched by President Muhammadu Buhari at a sideline event of the United Nations General Assembly

Plan of Action: Addressing Gender-based Violence and HIV/AIDS Intersections (2015–2017) by NACA, with Federal Ministry of Women Affairs and Social Development and UNDP

2016

National HIV/AIDS stigma-reduction strategy launched

Nigerian Fast-Track Plan launched, derived from UNAIDS WCA Catch-up Plan to address bottlenecks, and accelerate national responses

Nigeria adopts the WHO Treat All guidelines, subscribing to initiative to provide ART for life to *all* PWHIV

Key Populations Secretariat established following its registration with Corporate Affairs Commission in 2014 with Mr. Ifeanyi Orazulike as the first Chair

2017

UN General Assembly High-Level Meeting in New York. President Muhammadu Buhari commits Nigeria to shared responsibility and ownership of the response by making government resources available to maintain 60,000 PLHIV on treatment and treat a further 50,000 PLHIV annually

2017 Regional consultation organized by UNAIDS, and Caritas in Abuja leads to establishment of a new Coalition and Strategic Working Group of Faith-based Organisations. NFACA reconstituted

Nigeria crosses the milestone of one million people on antiretroviral therapy

National HIV/AIDS Strategic Plan 2017–2021 launched

2018

Re-establishment of the National Treatment and PMTCT program, significantly strengthening national ownership of the response

FMOH launches National Data Repository

Start of the world's largest HIV survey (NAIS) flagged off by President Muhammadu Buhari, with US\$100 million in financial support from PEPFAR and the Global Fund

Mrs Dr. Aisha Buhari, wife of President Muhammadu Buhari, launches Free to Shine campaign.

UNAIDS appoints Madam Dr. Aisha Buhari, First Lady of the Federal Republic of Nigeria, as Special Ambassador for the Elimination of Mother-to-Child Transmission of HIV

2019

UNAIDS Nigeria achieves full diplomatic accreditation

Game-changing results of NAIS, together with the revised National HIV Strategic Framework, are launched by President Muhammadu Buhari, joined by UNAIDS Executive Director Michel Sidibé

National Basic Health Care Provision Fund (BHC PF) launched

National Surge Strategy initiated by PEPFAR and government to accelerate achievement of epidemic control using NAIS results

National survey on HIV among prisoners led by NACA and supported by UNODC and USAID

2020

UNAIDS-PEPFAR Faith -Based Initiative launched

Nigeria defies COVID-19 impact to achieve historic number of 279,000 PLHIV being placed on treatment

UN Country Team and bilateral donors adopt the Four Ones principle of HIV for the management of COVID-19 in Nigeria. One UN Basket Fund for COVID-19 in Nigeria established in June and mobilizes US\$73 million

2021

Nigeria leads the Third Committee of the UN General Assembly that coordinated the common HIV Africa position. President Muhammadu Buhari addresses the UN General Assembly

First visit of UNAIDS Executive Director Winnie Byanyima to Nigeria to garner support for the Global AIDS Strategy 2021–2026 and the 2021 Political Declaration

2021 HIV IBBSS establishes more accurate prevalence among KPs

Adoption of the grand reform of the Nigerian Coordinating Committee Mechanism for the Global Fund with a 15 plus-1 voting membership, including a representative for key populations

2022

62 Billion Naira HIV Trust Fund Launched on Feb 1 by HE President Buhari together with Mr. Aliko Dangote, CEO Dangote Foundation, Dr. Herbert Wigwe, Managing Director Access Bank

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**NETWORK OF PEOPLE LIVING WITH
HIV/AIDS IN NIGERIA (NEPWHAN)
NATIONAL COORDINATORS' PROFILE**



John Ibekwe
1997-2000

The pioneer national coordinator of NEPWHAN, John Ibekwe, granted press interviews which were widely published and televised in national dailies and TV stations in the early days of the epidemic. This caused him a termination of his job with two months' salary in lieu of notice. He was the first healthy Nigerian to publicly declare his HIV positive status locally in 1997 and internationally in 2000, in the presence of presidents Olusegun Obasanjo and Bill Clinton of USA. In 2006, during the development of Behavioural Change Communication materials, he led efforts to demystify HIV by volunteering to appear on TV and Radio programmes, and on posters as against the practice of downloading pictures from the internet or using the face of non-HIV positive persons and foreigners. For three years, he featured daily on different TV and radio stations, thereby encouraging other healthy HIV positive Nigerians to join HIV support groups.



**Dr. Patrick O.
Matemilola**
2000-2009

A medical practitioner who worked within the Nigerian Armed Forces medical services, Dr. Matemilola took over the leadership of NEPWHAN in 2000 and placed NEPWHAN firmly on the path of growth. During his tenure, he worked to massively mobilize PLHIV at community level leading to expansive growth in the formation of PLHIV support groups from 5 registered groups in 1998 to over 520 in 2008. He supervised the extensive knowledge building of PLHIV in counselling, psychosocial support and community mobilization. He also instituted home based care at support groups and established organizational linkages to regional and global organizations as well as linkages between various community-based organizations across Nigeria. He established a PLHIV friendly clinic and opened access to quality and affordable health services to military personnel. He also massively mobilized resources with over 500 million Naira mobilized during his administration.



Ogenyi Edward
2009-2015

Mr Ogenyi steered the reigns of NEPWHAN between 2009 and 2015. He is credited for leading the CSO efforts towards the enactment of the Anti-HIV stigma and Discrimination law, the Nigeria Stigma Index studies and ensuring strong governance and financial systems for accountability. In addition, he worked to ensure that PLHIV are represented not only in national and international processes but that their fundamental human rights are respected at all levels.



**Victor Olaore
Omosehin**
2015-2019

Mr Omosehin during his tenure was passionate about NEPWHAN playing its statutory role and leading on its mandate. He was keen on supporting young people living with HIV; having served as the national coordinator of the Association of Positive Youths in Nigeria (APYIN). He worked towards giving NEPWHAN the required visibility. He also worked towards strengthening the state wings of the network as well as strengthened the relationship with other HIV implementing partners.



Abdulkadir Ibrahim
2019-to date

On taking over the leadership of NEPWHAN in 2019, Mr Ibrahim facilitated the development of a National Strategic Framework for NEPWHAN, developed jointly by all PLHIV constituencies and KP communities with the support of UNAIDS. He has mobilized all PLHIV constituencies especially women and youths to identify and engage with the activities of the network. He has successfully built the confidence of implementing partners in the leadership of NEPWHAN through accountability and transparency mechanisms which has attracted more funds to the network.

INTRODUCTION

FROM SINGLE CASE TO EPIDEMIC: THE HISTORY OF THE AIDS RESPONSE IN NIGERIA

In 1985 in Nigeria, a 13-year-old girl in Lagos and a female sex worker in Enugu tested positive for the human immunodeficiency virus (HIV). When the information was made public, the Federal Ministry of Health set up a National Expert Advisory Committee on HIV/AIDS, or NEACA, in 1986, to plan activities to prevent the spread of HIV in the country. With the support of the World Health Organization and other partners, a six-month, short-term plan was developed focusing on public awareness activities and capacity building for laboratory testing.

The early HIV and AIDS response was largely uncoordinated and marked by denial, skepticism, indifference, misconceptions, and only tentative action.

The initial emphasis was on heterosexual transmission and through unscreened

blood transfusions, and this formed the focus of the communications strategy in the first three years of the HIV and AIDS control activities. The WHO supported the establishment of active laboratory screening, which was increasingly made available in selected health facilities, resulting in more cases being identified.

In April 1988, to encourage voluntary testing, cabinet ministers submitted to HIV blood tests in a widely televised event. However, this did little to break the stigma around the disease.

That year, NEACA was dissolved and replaced by the National AIDS Control Programme (NACP), in the Federal Ministry of Health. The program had four main areas of operation: epidemiology and laboratory services; information, education, and communication; blood transfusion services;





and program development. This formed the nucleus of the health sector response.

Following clinical trials, the first single-dose antiretroviral treatment was approved globally in 1987, but it was beyond the means of most Nigerians.

The first World AIDS Day was marked on 1 December 1988 with a growing recognition that the epidemic was disproportionately affecting sex workers. A multi-sectoral approach was embraced. Ministries such as Youth, Education, Information, and Women Affairs were included in the planning and implementation of the program, which expanded to include the states. AIDS program coordinators were appointed by each state government. A three-year medium-term plan was developed in 1988 with the support of WHO, the World Bank and other partners, while development partners and countries with bilateral relations with Nigeria made pledges to mobilize resources in support of the plan.

Based on the South African model, a unit was established to study and develop home-based care. In 1991, the NACP was expanded to include sexually transmitted infections and is now called the National AIDS, Viral Hepatitis and Sexually Transmitted Infections Control Programme (NASCP).

The key intervention areas of the program were also expanded to include syndromic management of sexually transmitted infections, voluntary counseling and testing, and the treatment of opportunistic infections. The main theme of the health education messaging was the ABC of AIDS prevention: A | Abstinence, B | Be faithful, C | Correct and Consistent use of a Condom.


Several epidemiological studies were conducted at the onset of the epidemic and helped direct the focus of government prevention and control efforts. In 1991, the first national sentinel surveillance was conducted among pregnant women attending antenatal clinics. The prevalence among them was found to be 1.8%.

But the studies showed a wide variation of HIV prevalence among the states. This emphasized the need to undertake targeted control efforts tailored to each state. Several further sentinel studies—collecting data on pregnant women aged 15 to 49 attending antenatal clinics in selected health facilities in all zones, states, towns and rural areas of the country—indicated a rising prevalence.

More effective combination antiretroviral treatment (ART) was introduced in 1995 but, due to high costs, not everyone was able to benefit, especially in low-income



His Excellency,
Chief Olusegun Obasanjo, GCFR
President Federal Republic of Nigeria
(1999 - 2007)



countries. From 1997, a limited number of persons living with HIV in the country were commenced on antiretrovirals. These were largely managed in large, urban teaching hospitals by consultants, mostly in departments of hematology, which procured drugs through private and special arrangements.

In 1999, Olusegun Obasanjo became President of Nigeria. That year, HIV counseling and testing, the gateway to HIV care and support services, was rolled out, although it was largely uncoordinated and lacked clear guidelines. The Federal Government realized that its health-focused approach was not yielding the expected outcomes and decided to adopt a more robust multi-sector approach as recommended by the WHO. Obasanjo's intervention in the country's HIV and AIDS response would mark a watershed in the multi-sectoral approach. He placed a premium on HIV and AIDS prevention, treatment, and care, and showed leadership in HIV and AIDS activities not just at home but also in the international community.

In 2001—the year Nigeria's HIV prevalence peaked at 5.8%—the country hosted the first African Heads of State Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. The summit raised

concerns about the high incidence of mother-to-child transmission of HIV in Africa and underscored the impact of the HIV and AIDS pandemic on youth. The leaders recognized that stigma, silence, denial, and discrimination against people living with HIV increased the impact of the epidemic and were major barriers to an effective response. They therefore decided to prioritize more involvement of people living with the virus in the regional response. The major outcome of the summit was the Abuja Declaration, in which African countries agreed to allocate a minimum of 15% of their annual budget to health. Another major outcome from the summit was a call by the then UN Secretary-General, Kofi Annan, for the establishment of a Global Fund to fight HIV, TB and Malaria.

On World AIDS Day that year, President Obasanjo announced that Nigeria would be the first African country to launch a national ART program, with the government providing HIV treatment to 10,000 adults and 5,000 children in 25 tertiary hospitals, committing to investing US\$3.7 million annually to procure antiretroviral drugs.

Beginning with the 25 tertiary health institutions, the Federal Government began providing ART to people upon the payment of an access fee of N1,000.

When it was discovered that even this cost was unaffordable for many Nigerians living with HIV, access to treatment was made entirely free. But it was still difficult to persuade people to take an HIV test. The government had to step up its advocacy and sensitization efforts in collaboration with civil society groups.

AIDS, tuberculosis, and malaria were on the rise. The Global Fund to fight AIDS, tuberculosis and malaria was established in 2002, and intervened through a call for grant proposals from countries affected by these three diseases. Nigeria was one of the first recipients of the Global Fund grants and was awarded three grants.

Global Fund to Fight AIDS, Tuberculosis and Malaria

In 2000, AIDS, tuberculosis and malaria appeared unstoppable. The African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in Abuja in 2001 called for a global commitment of at least US\$7 billion to US\$10 billion a year for HIV programming and proposed the creation of a global fund dedicated to HIV/AIDS and other infectious diseases. The Global Fund to Fight AIDS, Tuberculosis and Malaria was launched at the G8 Summit in Genoa, Italy, in 2002, with the G8 committing US\$1.3 billion in initial resources. As a partnership of governments, civil society, technical agencies, the private sector, and people affected by the diseases, the Global Fund pools the world's resources to invest strategically in programs to end the epidemics of AIDS, tuberculosis and malaria.

Various global health initiatives soon arrived on the scene with financial and technical support. Through its President's Emergency Plan for AIDS Relief (PEPFAR), the United States has invested close to US\$6 billion in Nigeria's national HIV/AIDS response since 2004. Other organizations that have

contributed immensely to the response include the Global Fund, the US Center for Disease Control and Prevention (CDC), the United States Agency for International Development (USAID), the World Bank through its Multi-Country HIV/AIDS Program, the United Kingdom through



DFID, the European Union, the Government of Japan, (through Japan International Cooperation Agency (JICA), Canada, (through Canadian International Development Agency (CIDA) and others.

The recipients of PEPFAR and Global Fund grants worked closely with the Federal Government toward achieving HIV epidemic control while promoting the long-term sustainability of their responses to find, link and maintain patients on life-saving HIV treatment. Other partners also brought in significant resources to assist the government. However, the financing and ownership of the program, over time, reduced significantly.

Selected hospitals were upgraded, health workers trained in the management of HIV, and more studies conducted to better understand the epidemic and the behavioral patterns driving it. Also, the availability of drugs and the provision of protective equipment reduced risks to hospital workers and motivated them to attend to HIV patients.

By 2004, the Federal Ministry of Health had inaugurated the National Task Team on HIV Counseling and Testing, and national HIV counseling and testing guidelines and training materials were produced two

years later. By 2005, it was estimated that the government had contributed US\$10.7 million to the national response. President Obasanjo also established the Presidential Committee on AIDS and the National Action Committee on AIDS (NACA). In 2007, NACA was transformed into a full agency, the National Agency for the Control of AIDS, to coordinate the multi-sectoral response. With the establishment of NACA, the coordination of the national response to HIV and AIDS was domiciled in one agency, under the Secretary to the Government of the Federation in charge of all the line ministries of the government.

The states and local governments also established action committees on AIDS. The first multi-sectoral medium-term plan of action, the HIV/AIDS Emergency Action Plan (HEAP) from 2001 to 2004, was developed, followed by the National HIV/AIDS Strategic Framework from 2005 to 2009. This framework is reviewed regularly, and subsequent iterations covered 2010 to 2015 and 2016 to 2020.

The involvement and activities of civil society in the prevention and control of HIV and AIDS in Nigeria have increased significantly over the years. A body of faith-based organizations and NGOs formed the Network of People Living with HIV/AIDS

in Nigeria (NEPWHAN) in 1998 and, two years later, a national network of civil society organizations was formed as the Civil Society Consultative Group on HIV/AIDS in Nigeria (CISCGHAN). These organizations, together with the military and paramilitary services, contributed significantly towards HIV and AIDS prevention.

Nigeria's response to the HIV and AIDS epidemic has been robust and inclusive. Between 2010 and 2020, the number of people living with HIV (PLHIV) that have access to ART increased more than fourfold from 360,000 to almost 1.5 million. The use of scientific data—especially the 2018 National HIV/AIDS Indicator and Impact Survey (NAIIS)—to develop its strategies and the massive mobilization of people, especially civil society organizations, has helped raise awareness and put positive pressure on policy influencers and policymakers. Seventeen years from its 5.8% peak, HIV prevalence in Nigeria decreased significantly to 1.3% in 2018.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) reported in 2019 that 37.2 million people were living with HIV/AIDS worldwide, the majority in sub-Saharan Africa, where it had become a threat to

security, community stability and economic growth. While Nigeria has consistently ranked among the countries with the largest HIV burden, it has made tremendous progress in meeting the challenges of the epidemic in recent times.

Without the leadership of Nigeria, in collaboration with other African countries, ensuring adequate policy and financing frameworks in the early days of the epidemic, the progress achieved so far on the continent would have been difficult.

The COVID-19 pandemic has added greater urgency to the HIV work. The pandemic has severely challenged every country's ability to fight both pandemics and maintain HIV services and programs, and Nigeria is no exception. At the same time, COVID-19 has laid bare the impact of health inequities, with the most vulnerable in every society bearing the brunt of the impact of the disease and disruption to daily life. It has also reinforced the lesson that 35 years of dealing with HIV has taught us: that to prevail and to succeed in reaching our common goal of a world free of AIDS, we must work together to challenge inequalities, and all of us have a part to play in this regard.





About 20,000 Nigerians die of aids every month

HOW MANY MORE PEOPLE WILL DIE OF AIDS BEFORE

SAVE OUR LIVES IMPLEMENT PCR

SAVE OUR LIVES IMPLEMENT PCR IN 3 STATE AND NOW !!!

ABOUT 20,000 NIGERIANS DIE OF AIDS EVERY MONTH

PLHIV protest for access to HIV antiretroviral medication

CHAPTER 1

THE BEGINNING OF AIDS, ACTION AND
LEADERSHIP IN NIGERIA (1985–2004)



Starting as an unknown disease in the mid-1980s with just a handful of detected cases, HIV went on to become one of the leading causes of death in Nigeria. The first phase of the country's AIDS epidemic illustrates a journey that the whole world took to realize that the disease was not just a health problem but a development and societal one that could only be addressed by multiple sectors all pulling together.

The Nigerian government's response took off in 1987 with the establishment of the National AIDS Advisory Committee (NAAC) and the implementation of the National Expert Advisory Committee on HIV/AIDS (NEACA). At this time, HIV was considered purely a health problem, but, as cases steadily rose in the 1990s, it became clear that only a multi-sectoral approach would have a hope of succeeding in halting and reversing its march. Nigeria's multi-sectoral response began in 1999, coordinated by the National Action Committee on AIDS (NACA).

The shift that happened in Nigeria echoed what was happening elsewhere: the 1990s saw global agencies take up the cause of tackling the HIV epidemic as it raged across the world. In 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was launched, co-sponsored by 10 UN agencies. Multi-sectoral calls to action on

AIDS were adopted across the UN and by other global development agencies and entities. A year later, the World Bank launched its Multi-Country AIDS Program (MAP) for Africa. The new millennium heralded renewed commitment to the AIDS response. There was the UN Security Council's first-ever debate on a health issue (AIDS) and, in 2001, the UN General Assembly Special Session on HIV/AIDS. This cemented AIDS as a global political issue with the Declaration of Commitment on HIV/AIDS, and "halting and reversing the AIDS epidemic by 2015" as one of the eight Millennium Development Goals (MDGs).



Mr Edward Ogenyi (2nd L), Secretary of NEPWHAN and later NEPWHAN National Coordinator—at the consultation on access to treatment—Abuja, 2002



Georgina Ahamfele presents a poster at the AIDS conference in 2005. Georgina was dismissed from her job as an auxiliary nurse in 1995 when she tested positive for HIV. She later successfully filed a lawsuit against her employer.

Still, the politics of “morality,” driven by misinformation, got in the way of a practical, pragmatic and effective response to HIV. Fear and stigma surrounding the disease made it all but impossible for people living with HIV to be open about their status and seek help. Before the advent of effective

treatment, PLHIV were preyed upon by unscrupulous health practitioners and charlatans who claimed to have a cure. However, PLHIV were also organizing, and this activism, fragmented early on, in time coalesced into the Network of People Living with HIV and AIDS in Nigeria (NEPWHAN). As part of the global network of PLHIV, Nigerian activists were inspired by the 2003 creation of the International Treatment Preparedness Coalition (ITPC) and were supported by their counterparts in other countries to work to achieve universal access to HIV treatment and other life-saving medicines in Nigeria.

In 1999, President Olusegun Obasanjo’s intervention marked a watershed in the country’s response, with a call for a multi-sectoral approach. He placed a premium on HIV and AIDS prevention, treatment, and care, and was vocal at home and in the international community. On World AIDS Day 2001, the President announced that Nigeria would be the first country in Africa to launch a national treatment program.

By the 2000s, HIV had become a leading cause of death in Africa, prompting calls for a global financial response. In 2000, Nigeria was among the top five countries affected by the global HIV pandemic. The following year, Nigeria’s first HIV/AIDS Emergency Action Plan guided the country’s multi-



Dr Pat Matemilola, NEPWHAN Coordinator (2nd left) addressing a press briefing on the dismissal of Frederick Adegboye from the Nigerian Institute of Journalism on the grounds of his HIV status—Lagos, 2004.

sectoral response and helped communities access HIV prevention and treatment. It identified over 200 activities the Federal Government intended to pursue. The same year, African Union member states met in Abuja, and committed to allocating 15% of their government budgets to health. The World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria (formed in 2002) and the US President's Emergency Plan for AIDS Relief (PEPFAR) all provided resources to Nigeria. At the forefront of the AIDS response from the beginning, Nigeria also played a key role in the action for the sub-region and continent. However, by the mid-2000s, funding for the Nigerian AIDS response was heavily supported by external



L-R: UN Secretary General Kofi Annan, President Olusegun Obasanjo and President George Bush Jr. discuss funding for AIDS, TB and Malaria (ATM) in 2001. President George Bush pledged the first US contribution to the Global Fund in 2001. He later went on to launch the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003.

funding agencies. It would be another decade before the country again took the reins of financing the AIDS response.

From isolation to activism

Living with HIV in the early days of the epidemic was a harrowing experience because, for many, testing positive meant facing stigmatization and ostracization, so they kept their status secret. In the 1980s

and 1990s, the dearth of information on the disease resulted in ignorance, fear, hysteria, discrimination, and shame. Nigerians living with the virus had to deal with a society that generally viewed them as sexual deviants and was not willing to associate with them. Thus, PLHIV carried both a physical and a psychological burden.

Hospitals had AIDS isolation wards and families had separate eating utensils for people who tested HIV positive. There was little space for respectful conversations. In addition to psychosocial trauma, the virus and resulting diseases also placed a huge financial burden on individuals and families because the cost of HIV tests and treatment was high. Only the rich and influential could

afford these. At a time when the federal minimum wage in the country was only N7,500, antiretroviral drugs for a month cost as much as N100,000.

Securing and retaining employment was challenging because employers rejected HIV-positive jobseekers and swiftly terminated the employment of existing staff should their positive status become known. Many PLHIV lost their jobs during this era.

When the wife of a former Nigerian president was invited to an event and discovered on arrival that it was hosted by PLHIV, she took offense, saying that inviting her was an insult.

Bill Clinton's "Amazing Encounter": John and Angela Ibekwe's Story

In 1995, when John Ibekwe sought to marry his fiancé Angela, who was HIV-positive, several priests refused to conduct the marriage ceremony. Later the same year, the late Catholic Archbishop Emeritus of Onitsha, Albert Kanene Obiefuna, granted permission for the wedding to be held in the church on the basis that the Bible did not forbid marriage based on health status. John sero-converted and became HIV positive in 1996 during his marriage. In 1998, Angela became pregnant and, the same year, John attended the 12th World AIDS Day Conference in Geneva, Switzerland, where he learned about the possibility of preventing mother-to-child transmission of HIV. He saved enough money from his conference food allowance to buy antiretroviral medication for his wife, and on October 8, 1998, their baby was born HIV-free.



United States President Bill Clinton engages with John Ibekwe and his wife during his mission to Nigeria in 2000. The couple demonstrated the success of the PMTCT programme by giving birth to an HIV free baby. The President later invited them to dinner at the White House in Washington to share their PMTCT success story

Almost two years later, John was invited to speak at an event organized for the then US President Bill Clinton. John told his story to the invited audience of 1,200 people, including Nigerian President Olusegun Obasanjo. The Ibekwes were later guests of President Obasanjo and his wife, who embraced them, and the story was widely reported in the media.

The story of this remarkable man clearly made an impression on President Clinton. Speaking at a reception for African leaders in New York City two weeks later, he said that he had been through a lot of interesting and profoundly emotional experiences in the past eight years, but that meeting the Ibekwes, and the widespread reaction to their being publicly embraced by President Obasanjo was one of the most moving things that had happened to him. "It was all over the press in Nigeria the next day. It changed the whole thinking of a nation about how to approach this disease, to treat the disease as the enemy, but not the people who are gripped with it. It was an amazing encounter." Afterward, John, Angela and their daughter, Maria, were guests of President Clinton at the first White House World AIDS Day event in Washington, DC, in 2000.

John Ibekwe went on to become the first president of the Network of People Living with HIV in Nigeria (NEPWHAN), a non-governmental organization serving as the collective voice of people living with HIV.

At best, traditional and community leaders were often slow to acknowledge the urgency of the epidemic, and at worst contributed to hysteria, misinformation, and stigmatization. Many faith-based institutions encouraged their congregants to seek care and treatment outside of medical facilities. Capitalizing on widespread fear and misinformation, unscrupulous health practitioners, “miracle” peddlers, spiritualists and herbalists claimed to have a cure for HIV.



One of the early treatment access consultation meetings organized by Journalists Against AIDS—Abuja, 2002

The message that with proper counseling and treatment adherence, PLHIV could live longer, healthier lives was not widespread; prevention materials were limited considering the huge population; and access to treatment was very low.

Because of stigmatization, treatment provision was shrouded in secrecy. For this reason, and because treatment facilities were initially not available across the country, many Nigerians sought help outside their state of residence. People in Benue, for example, had to travel to Enugu, those in Sokoto went to Abuja, while many in the South-West went to Lagos, a large city that provided anonymity.

During this period, government agencies focused on prevention, raising awareness, correcting misconceptions, enlightening people on how to stay safe, and encouraging abstinence, fidelity, and the use of condoms. However, some of the early campaigns relied heavily on scare tactics, using such images as crosses, skulls, and skeletons, to instill fear of the disease. This approach recorded little success.



Prof Femi Soyinka, Dermatologist and one of the early advocates and care providers for PLHIV in Oyo State. Also President of the Society for AIDS in Africa and Chairman of ICASA in 2005

Groups of PLHIV across the country began to actively engage in the struggle for affordable, life-saving medications. Activism was centered on access to life and dignity for PLHIV, and issues of stigma and discrimination. PLHIV began to engage with pharmaceutical companies to reduce the costs of antiretrovirals and drugs for opportunistic infections.

This early activism was fragmented until 2000, when Femi Soyinka called a joint meeting of activists in Abuja, after which national leaders for the Network of People Living with HIV and AIDS in Nigeria (NEPWHAN) were elected and John Ibekwe became its national coordinator.

At that time, the supply of generic drugs was at risk because large pharmaceutical companies were against generics. But the government negotiated with generic producers in India, enabling Nigeria to start its own treatment program.

Even when President Olusegun Obasanjo introduced ARV treatment, people were still paying a N1,000 drug-user fee, and between N12,000 and N25,000 for pre-treatment tests. Some PLHIV opted to use private facilities, which charged as much as N65,000 for a single month of treatment.

International agencies, like the Ford Foundation and USAID, supported activists, and PLHIV also had support from the National Action Committee on AIDS, under the chairmanship of Prof. Ibironke Akinsete.

International funding partners heeded the global call for the Greater Involvement of People with AIDS (GIPA) in programs designed for optimum health outcomes. NEPWHAN worked closely with NACA in mobilizing and registering groups, and NACA continued to monitor their progress. The women's wing of NEPWHAN was birthed, and later registered as an independent NGO, the Association of Women Living with HIV in Nigeria (ASWHAN).

The clamor for free and decentralized treatment began to gain momentum. The argument was that treatment should not be limited to only teaching hospitals and federal medical centers. Individuals like Femi Soyinka, Morolake Odetoyinbo, Patrick Matemilola, Obatunde Oladapo, Mohammed Auwalu, Samaila Garuba, Yinka Jegede and the late Omololu Falobi of Journalists Against AIDS championed this cause. Some faith-based organizations and Médecins Sans Frontières also joined the campaign for free treatment.

In 2003, the International Treatment Preparedness Coalition (ITPC)—a global network of PLHIV, community activists and their supporters working to achieve universal access to HIV treatment and other life-saving medicines—was launched in Cape Town, South Africa. At its launch, participants from various countries were encouraged to return home and start advocating for HIV treatment access.


International treatment activist groups provided technical support for Nigerian activists to push for safeguarding access to essential medicines when Nigeria was drafting the Trade-Related Aspects of Intellectual Property Rights without consideration for health and medicines.

The Treatment Action Movement (TAM) was launched in Nigeria in 2003, with Morolake Odetoyinbo as its founding coordinator. It was a loose coalition of organizations that included PLHIV, Nigerian Labour Congress representatives, media practitioners, researchers and other AIDS-serving NGOs.

In 2005, when Nigeria hosted the 14th International Conference on AIDS and STIs in Africa, activist groups worked with Médecins Sans Frontières to organize large demonstrations in Abuja.

Following the demonstrations at the conference, President Obasanjo declared the removal of HIV user fees for health care facilities and the provision of free antenatal care and delivery in federal hospitals for pregnant women living with HIV. He also mandated the Nigerian HIV program to increase its treatment reach significantly within two years. This was a watershed for access to HIV treatment. But activists continued to encourage NASCP, NACA and the Federal Ministry of Health to do much more. As a result, treatment for HIV and AIDS was decentralized, from teaching hospitals and federal medical centers to state hospitals in all 36 states and the Federal Capital Territory.





Thus, HIV activism resulted in expanded treatment, treatment literacy, access to testing, and capacity building of PLHIV. The wider result was a far greater understanding of HIV and AIDS by Nigerians at all levels, and a more informed discourse in the public arena.

Institutional Responses to the HIV Epidemic: NACA, SACA and LACA

Acquired Immunodeficiency Syndrome (AIDS) which results from HIV infection remains one of the greatest threats to development in Nigeria as it brings devastating consequences in its wake in almost every aspect of human development, including trade, socioeconomic issues, politics, migration, religion, culture, and tradition. This is compounded by the fact that there is no cure or vaccine for the virus.

Nigeria's national response to HIV and AIDS commenced shortly after the official report of the first cases. The report was initially greeted with skepticism, resulting in a delayed response by government. However, in 1986, the Federal Ministry of Health set up the National AIDS Advisory Committee

(NAAC), followed by the National Expert Advisory Committee on AIDS (NEACA). A year later, the National AIDS and STIs Control Program (NASCP) replaced it to implement the Federal Ministry of Health's interventions—antiretroviral therapy (ART), voluntary counseling and testing—marking the beginning of a more coordinated response in the health sector.

HIV was assumed to be only a health problem, and thus the response was domesticated primarily in the health ministry, and the response between 1987 and 1999 was health-sector focused and driven by NASCP. This era was guided by strategies including a health sector response with short-term plans; a health-sector-led multi-sectoral response with medium-term plans; and health-sector strategic plans with long-term coverage.

As the cases of HIV steadily increased, the government realized that a health-sector response was not as effective as it could be because the epidemic affected other sectors. The establishment of UNAIDS, a joint response to the epidemic by several United Nations organizations, encouraged the new multi-sectoral approach, which the Nigerian government adopted.


The era of the multi-sectoral response began in 1999 with the formation of the National Action Committee on AIDS (NACA) to coordinate the multi-sectoral response. When President Olusegun Obasanjo created NACA under the leadership of Prof. Ibironke Akinsete, it became the true beginning of the multi-sectoral approach to tackling HIV/AIDS which was already understood to be also a social problem under the office of the Secretary to Government of Nigeria. The President was advised to remove the central intervention organ from the Ministry of Health and put it under the office of the Secretary to the Government of the Federation (SGF) for it to be managed multi-sectorally. The SGF's office manages all the ministries, agencies, and departments (MDAs) in the country.

All ministries, agencies and parastatals were, accordingly, mandated to mainstream HIV/AIDS interventions into their core activities for both staff and their constituencies. The ministries of health, labor, finance, education, communication, etc., all came together to develop the national response. NACA reported to the Presidential Committee on AIDS (PCA) and was based at the presidency to give it the highest level of authority and to generate buy-in by other sectors besides health.

In 2001, the HIV/AIDS Emergency Action Plan, or HEAP (2001–2004), was developed by NACA with the support of United Nations' consultants and other stakeholders, to guide the multi-sectoral response to the epidemic. Although HEAP was not a detailed plan, it helped to surmount barriers to HIV prevention and treatment, and support interventions at the community level.

The country also started to receive funding from international organizations such as the World Bank, the Global Fund and PEPFAR. The World Bank's Multi-Action Program funded many activities in the multi-sectoral plan and supported the institutionalization of the HIV response at the state level under the HIV/AIDS Program Development Projects (HPDP 1 and 2) aimed at expanding public sector response, private and civil society engagements, and strengthening project coordination and management. The Federal Government provided some funding and material resources.

When HEAP expired, NACA midwived and launched a comprehensive National Strategic Framework (2005–2009) with guidelines for the sectors. The plan was built on and guided by the previous HIV/AIDS policies established in 1997 and 2003. It was more explicit than HEAP, especially



on roles, responsibilities and interventions for the private sector and line ministries in the public sector. NACA also developed a National HIV/AIDS Policy which included interventions with a people-centered approach.

Several guidelines and policies were developed to guide workplace programs and the private sector on employment of people living with HIV. Other policies guided harmonization of data, counseling, and testing, managing and coordination of civil society organizations, and organizing associations of people living with HIV.

In 2007, NACA transformed into a full agency—the National Agency for the Control of AIDS (NACA)—by an Act of the National Assembly, to further strengthen its coordinating role and the overall national response. This was the first time an agency of government was created to tackle just one disease.

The multi-sectoral response was characterized by coordination of various sectors, initially under the Presidential AIDS Council (PAC), and was followed by the HIV/AIDS Emergency Action Plan. The establishment of NACA was the ultimate culmination of the involvement and coordination of the various sectors at

the highest level of government. Various National Strategic Frameworks were developed and implemented under NACA, and it is currently guided by the National HIV and AIDS Strategic Plan 2017–2021.

The inclusion of several sectors can be seen in the diverse and important roles played by some of the ministries:

- **Health Ministry:** Guided health response.
- **Labor Ministry:** Coordinated the implications of HIV for workers, such as stigmatization.
- **Finance Ministry:** Released funds for the response. Instituted waivers for HIV commodities brought into the country.
- **Education Ministry:** Introduced HIV awareness into the school curriculum.
- **Communication Ministry:** Developed information for the media.
- **Budget Ministry:** Allocated resources.

To better coordinate activities and responses at the state and local government levels, there was the need to set up sub-coordination systems.

When NACA was still the National Action Committee on AIDS, the State Action Committees on AIDS (SACAs) and the Local Government Action Committees on AIDS (LACAs) were established. The SACAs

coordinate interventions at the state level to ensure that every sector mainstreams HIV and AIDS in its activities. Both committees have guidelines in line with the religion, beliefs, culture, and vulnerability of the target groups.

However, when NACA became an agency, it advocated for SACAs at the state level to be set up as agencies. SACAs became State Agencies for the Control of AIDS, with laws from state Houses of Assembly. They were situated in state governors' offices and received funding from their respective states and the World Bank MAP fund.

Although at the local government level LACA remained a committee situated in the health department, it did not only address HIV, but also engaged in community development, education, water, etc. The committee comprises traditional leaders, religious leaders, women and youth groups, and community-based organizations (CBOs) and others and was chaired by the chairman of the local government.

The fundamental reason for setting up NACA, and the SACAs and LACAs, was to mainstream HIV and AIDS into official and non-governmental activities at all levels of governance. To date, NACA continues to mobilize resources for HIV, provide strategic

information, develop policy documents, manage partnerships, and coordinate the national response to HIV.

The National Strategic Framework 2021-2026 emanates from the National HIV and AIDS policy, which guides and directs NACA in its planning, administration, and coordination roles.

The Network of Persons living with HIV/AIDS in Nigeria (NEPWHAN), and its affiliate bodies/constituencies, i.e., sub-networks of women and youth, received grants for HIV prevention and the care of those infected. Since the members of the networks knew their peers, it was easy for them to implement effective interventions. It was also easy for NACA to reach those infected through support groups at the state level.

The response to HIV and AIDS in Nigeria has gone through several stages that were informed by the internal lessons learned, the external context of the disease globally, and funding support both from within and outside of the country.



External Partners Support Establishment of NACA and Multi-Sectoral Response

The multi-sectoral response would not have been possible without the support of international partners, such as the UN, the World Bank, the (UK) Department for International Development (DFID), the United States Agency for International Development, Japan, Canada, and other critical partners.

NACA had a mandate to recruit consultants in monitoring and evaluation, partnership coordination, public-private partnership and policy. DFID and USAID paid the salaries of the four consultants that provided leadership of the four departments that were set up. The National Strategic Plan was also developed with contributions from partners.

After the consultants had developed the first strategic plan, the need to establish an agency became imperative. Thus, in 2007, NACA became an agency, the National Agency for the Control of AIDS, by an Act of the National Assembly. The new agency then recruited staff whose salaries were paid by the Federal Government. Still, the government funding was not enough, and partners continued to pay for NACA's activities through diverse funding modalities.

For example, the World Bank provided the Federal Government with credit to be repaid at an interest rate of 2% over several years through the Federal Ministry of Finance with the participation of all 36 states and the Federal Capital Territory. It was called the Multi-Action Program (MAP). State governments in turn received US\$5 million each from the Federal Government, which was refundable directly from their federal allocations that came through the Federal Ministry of Finance.

The states used the money through their State Action Committees on AIDS (SACAs) to implement activities at the state level. However, states could not access that funding unless they had counterpart funding of N10 million. SACA staff salaries were paid from

the state counterpart funds, not from the credit allocation.

Work plans were developed in line with the National Strategic Plan and reviewed centrally. State plans were sent to the procurement department of the World Bank for approval before funds were disbursed.

The Bill & Melinda Gates Foundation supported civil society organizations to work on HIV and AIDS although it did not directly fund NACA. Pathfinder International also provided grants to CSOs for interventions and participated in the development of policies and guidelines.

Expanded Theme Group meetings brought together heads of agencies, donors, embassies and others, and the group was the coordination platform of NACA with two co-chairs: UNAIDS and NACA. Other partners, such as UNICEF, UNFPA, DFID, USAID, Japan, Canada, and Pathfinder International, came together during the ETG meetings to provide information, review performances, address challenges and chart the way forward.



Rolling Out AIDS Treatment in Nigeria

Nigeria's first case of HIV was recorded in 1985 and, by 2000, it was among the top five countries affected by the global HIV pandemic. The same year, the Harvard School of Public Health helped establish the AIDS Prevention Initiative in Nigeria (APIN) supported by a US\$25 million grant from the Bill & Melinda Gates Foundation. APIN supported over 30 HIV prevention and surveillance initiatives.

Although in early 2001 the government had bought ARVs for 10,000 adults and 5,000 children, by 2003, a drug stock-out had created problems that prompted Harvard and APIN to apply for a grant through PEPFAR to support ART in the country. The grant award covered 2004 to 2013.

APIN's implementation of a hub-and-spoke model of services emanating from tertiary care down to primary care facilities expanded coverage and access to HIV services. APIN notably supported three national laboratories in achieving international accreditation and assisted in preparing many more for future accreditation. From the outset, APIN successfully deployed electronic medical

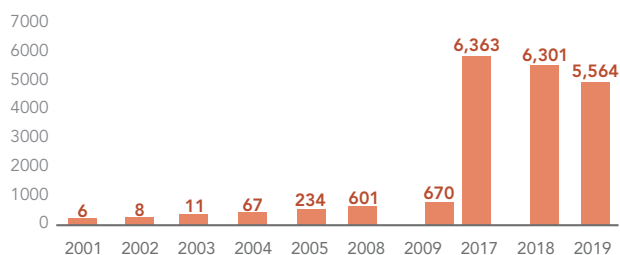
records at all its facilities, resulting in more efficient delivery of high-quality care and treatment for the patients. Training of all cadres of health care workers began with the Gates-funded APIN program through the Nigerian Institute of Medical Research; this work continued under APIN when it became an independent Nigerian non-governmental organization in 2007.

APIN was also key to the development of the country's prevention of mother-to-child HIV transmission. Women are disproportionately affected by HIV, and pregnant mothers infected with HIV can transmit the virus to their babies. In 2001—the year of the Abuja Declaration that saw African leaders pledging to allocate 15% of their annual budgets to improving the health sector—Nigeria's pilot national prevention of mother-to-child transmission (PMTCT) program was first implemented in six tertiary institutions—Ahmadu Bello University Teaching Hospital (ABUTH), Lagos University Teaching Hospital (LUTH), University of Maiduguri Teaching Hospital (UMTH), University of Nigeria Teaching Hospital (UNTH), University of Port Harcourt Teaching Hospital (UPTH) and National Hospital Abuja (NHA)—with the support of UNICEF, the United Nations Children's Fund. The following year, two further sites—Jos University Teaching Hospital (JUTH) and University College

Hospital (UCH)—were added with the support of APIN. In 2003, the number of sites rose to 11, with the addition of Aminu Kano Teaching Hospital (AKTH), University of Benin Teaching Hospital (UBTH) and Nnamdi Azikiwe University Teaching Hospital (NAUTH), with the support of the Centers for Disease Control and Prevention. By the end of 2004, there were 67 PMTCT sites in various parts of the country and this

PMTCT facilities in operation

Number of PMTCT Sites in Nigeria (2001–2019)



increased to 234 by the end of 2005; 601 in 2008, and 670 in 2009, in various health and non-health institutions and organizations, including NGOs.

Epidemiological studies were conducted every two years with a focus on people who were infected, such as pregnant women; those who were indirectly affected, such as family members; and people who were at high risk of getting infected because of the nature of their work, such as sex workers,

long-distance taxi and truck drivers, military personnel, and people who inject drugs.


According to the Federal Ministry of Health, 207,107 pregnant women were tested for HIV in 2007, an estimated coverage of 4%. The coverage of PMTCT services in Nigeria for 2007 was reported as 7% for ARV prophylaxis during pregnancy, and 2% for ARV prophylaxis to infants born to infected mothers. This was achieved under the National HIV/AIDS Emergency Action Plan and the National Health Sector Plan for HIV/AIDS, which underpinned the then National Treatment & PMTCT Programme.

In 2016, the Minister of Health, Prof. Isaac Adewole, approved the WHO Test and Start strategy to promote immediate access to treatment after an HIV-positive test, improve health outcomes, and harness the preventive benefits of ART in pregnancy.

Improvement in treatment coverage was facilitated by:

- Decentralization of treatment to lower tiers of service delivery
- Same-day treatment initiation
- New service delivery models of differentiated care

It is argued by experts that Nigeria could have had better results if, during the early stages of the epidemic, it had focused on using primary



health care centers, which enjoyed a broader coverage than general and teaching hospitals. With earlier on-site training of primary health care workers, the government might have reached more people more quickly.

Globally, WHO estimates that, since 2017, 94.9% of mother-to-child transmission of HIV globally has been prevented. In South Africa, the United States and Europe, the figure of prevention for such cases ranges between 97 and 99%. The elimination of mother-to-child transmission (EMTCT) must remain a priority.

Nigeria's EMTCT initiative was launched by President Muhammadu Buhari during the 2015 United Nations General Assembly. Over 85% of pregnant women who come to a facility in Nigeria now receive the necessary ARV drugs. With more concerted efforts, elimination of mother-to-child transmission in Nigeria is attainable.

APIN's books *AIDS in Nigeria: A Nation on the Threshold (2016)* and *Turning the Tide: AIDS in Nigeria (2018)* provide an important record of over a decade of progress in responding to the HIV epidemic in Nigeria, while identifying the many challenges that lie ahead. Increasing domestic funding for

the HIV response will be critical to promote greater sustainability and ownership of the program. The revised Nigerian national treatment guidelines require that all positive patients, upon diagnosis, be initiated on ART. Then health minister Prof. Isaac Adewole implemented the WHO Test and Start strategy, which had considerable implications for the health system, ranging from financing and logistics management to workforce and information management. The emergence or re-emergence of infectious diseases will add even more pressure to the already stretched health care system and its budget.

Demographic and socioeconomic changes in the last decade have affected the pace and characteristics of the Nigerian HIV epidemic. A younger population and heightened poverty levels have led to an increase in vulnerable and marginalized segments of society that will require special interventions. The national response should continue its multi-sectoral approach, with policies and strategies that extend well beyond the health sector, to achieve epidemic control. The present momentum in eradicating HIV should be exploited and maximized to make the end of the epidemic in Nigeria feasible.

The Kaduna Example

In 2016, an estimated 37,000 babies were born with HIV in Nigeria, 23% of the world's total. However, Nigeria's Kaduna State is a good example of the successes in elimination of mother-to-child transmission (EMTCT). There, the percentage of pregnant women living with HIV who accessed antenatal care rose to 66% in 2017 from 27% in 2013.

Following a PMTCT program review in 2013/14, Kaduna State, with support from UNICEF, rolled out an evidence-based response plan for EMTCT until 2020. The plan had four major targets: demand creation, service delivery, planning and coordination, and sustainable financing.

Demand creation

The First Lady and wives of the 23 Local Government Area chairmen were engaged to coordinate demand for ANC and PMTCT services, and 1,181 voluntary community mobilizers were trained to reach pregnant women in their communities and ensure they completed the whole series of ANC/PMTCT visits. Some 255 religious leaders were sensitized to promote the uptake of the services, and 157 mentor mothers were involved in providing pre-test and post-test counseling and tracking of HIV-positive clients.

About 4,000 pregnant women in six LGAs were connected to a mobile health platform through which short pregnancy-age-specific mobile phone messages, recorded in local languages, were shared regularly. Journalists and media executives were invited to sensitization meetings, and radio jingles and live discussions with health specialists were aired to encourage people to take advantage of ANC and PMTCT services.

Service delivery

UNICEF supported Kaduna to train more service providers and provide HIV rapid test kits to additional health facilities. This increased the service delivery points providing HIV testing services in ANCs from 312 in 2013 to 833 in 2018, i.e., 80% coverage of all

facilities providing ANC in the state. Services were also scaled up in the private sector. By 2020, Kaduna had 78 private health facilities equipped to provide PMTCT services.

Planning and coordination

UNICEF helped strengthen the capacity of technical working groups and data managers and reinforced the planning and coordination processes. The quality and flow of data improved through quarterly data quality assurance, integrated supportive supervision, and data validation exercises. Kaduna and its LGAs were supported to develop decentralized, equity-focused PMTCT plans at the grassroots level using the Bottle Neck Analysis (BNA) approach. The capacity of the state and local government teams was strengthened to better implement and monitor the plans.

Sustainable financing

The Kaduna government took steps to ensure sustainable financing for health care delivery. It included PMTCT as one of the six building blocks of the World Bank-funded Saving One Million Lives Programme for Results initiative and the three-year costed Sector Implementation Plan. The intervention has also been mainstreamed into the public health care system as part of implementation of the government's PHC Under One Roof (PHCUOR) policy.

Challenges and goals

Despite notable successes, there are still obstacles, including a third of women not reached with ANC services, and only 23% of births attended by skilled personnel. There are still not enough facilities providing PMTCT services, especially in the private sector, and a lack of skilled health care workers. Other obstacles include a low proportion of HIV-exposed infants receiving Early Infant Diagnosis (EID) services and prophylaxis within two months of birth.

Achieving the goals of Kaduna's integrated EMTCT plan will require a joint effort by the government and its partners, including the private sector.

PEPFAR Sets Up in Nigeria


By 2002, 75% of the 42 million people infected with HIV were living in Africa and the Caribbean, and over 19 million people in sub-Saharan Africa had died because of AIDS. In response, President George W. Bush in January 2003 announced the five-year President's Emergency Plan for AIDS Relief, or PEPFAR, to prevent 7 million new HIV infections, treat 2 million people with life-extending drugs, and provide humane care for millions suffering from HIV/AIDS.

In May, the bipartisan United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 was passed by Congress, and the US Global AIDS initiative was launched. Some US\$15 billion was released to support HIV and AIDS prevention, treatment, and care programs in developing countries from 2004 to 2008, and Nigeria was one of the 15 countries endorsed by Congress to benefit from PEPFAR, at the time, the largest global health initiative devoted to a single disease.

When PEPFAR set up in Nigeria, HIV prevalence was at 5% and the epidemic characterized as primarily among heterosexuals with trends shifting toward key populations. The government of President Olusegun Obasanjo had

announced delivery of generic antiretroviral (ARV) drugs for 10,000 adults and 5,000 children and was offering HIV testing and counseling at antenatal care clinics within the framework of the National HIV/AIDS Emergency Action Plan and the National Health Sector Plan for HIV/AIDS. Nigeria's efforts were supported by development partners, including the UN System, the World Bank, the Bill & Melinda Gates Foundation, and the UK Department for International Development, focusing mainly on prevention and, subsequently, treatment. Despite these efforts, the HIV/AIDS epidemic rapidly grew and spread in the country.

In its first year of implementation, PEPFAR procured ARVs for over 25,000 people, rapidly scaled up treatment in 54 ART service outlets and identified 23,987 new PLHIV who were placed on ARVs. The program strengthened the national ARV program and expanded access to treatment services by establishing ART sites in existing national Prevention of Mother-to-Child Transmission (PMTCT) sites, instituting management of pediatric HIV and supporting community systems for care and support. Some 568 health workers were trained, according to national and international standards, in the provision of treatment at ART sites. About 36,982



people received treatment at ART sites, 23,937 of whom were newly identified PLHIV.

PMTCT programs already existed on a small scale but knowledge on preventing mother-to-child transmission was low. Less than one in 10 people was aware that a woman living with HIV could take drugs during pregnancy to reduce the risk of transmission. PEPFAR embarked on a rapid scale-up of PMTCT to address knowledge gaps and increase uptake of PMTCT services to reduce the incidence of infection in HIV-exposed babies. Voluntary Counseling and HIV Testing (VCT) centers to support PMTCT were established with over 1,000 private and public sector health care workers, including physicians, nurses and volunteers trained to deliver and manage comprehensive PMTCT services. About 306,538 pregnant women were counseled and tested in ANC clinics; 64,500 received PMTCT services; and 3,870 received ARVs.

The program also supported the national response and private sector in the development of policy and strategic

plans, guidelines, and protocols for the PMTCT program, including monitoring and evaluation. It also facilitated greater involvement of civil society, including PLHIV communities to advocate for policy change and demand accountability.

Partnership with government and expansion of services for PMTCT and HIV treatment between 2004 and 2008 resulted in the establishment of over 500 ARV sites and just over 600 PMTCT outlets. PEPFAR also supported the government to establish basic packages of services for PLHIV as well as laboratory support for diagnosis and monitoring.

PEPFAR provides treatment services in 34 states and the Federal Capital Territory, with Government taking over its previously supported facilities in Abia and Taraba States. Since its inception in 2004, PEPFAR has invested close to US\$6 billion in Nigeria and provided treatment for 867,000 people. Based on the 2018 National AIDS Indicator and Impact Survey (NAIIS) data, these investments contributed significantly to improved ART service coverage and reduced the unmet needs in Nigeria.

A Multi-Agency U.S. Government Effort

The **U.S. Department of State's Office of the U.S. Global AIDS Coordinator and Health Diplomacy (S/GAC)** oversees PEPFAR and drives policy, provides oversight and accountability, sets annual budgets, and manages country-level collaboration and coordination. PEPFAR leverages a whole-of-government approach to controlling the global HIV/AIDS epidemic, through several U.S. government agencies which play critical roles combatting HIV and COVID-19.

The **U.S. Centers for Disease Control and Prevention (CDC)** Nigeria Country Office—established in 2001—aims to achieve “Public Health Excellence for Healthy Nigerians” by working closely with the Government of Nigeria, local implementing partners and other U.S. Government agencies to strengthen Nigeria's public health infrastructure. With 16 implementing partners, CDC supports the Nigerian Federal Ministry of Health to implement key public health programs, evaluate disease surveillance and response efforts and provides comprehensive HIV services to over one million people living with HIV by 2020 across 19 states. CDC Nigeria supports the public health infrastructure and has established a national data repository with de-identified data for decision making for over 1.8 million people living with HIV.

Since 1960, the **U.S. Agency for International Development (USAID)** has collaborated with Nigeria on multi-sectoral development assistance with programming in: agriculture and food security, democracy and governance, human rights, economic growth, education, health, water and sanitation, and humanitarian assistance. The health portfolio addresses priorities in maternal and child health, nutrition, reproductive health and family planning, malaria, tuberculosis, HIV, and global health security (including the COVID-19 response) while strengthening key health systems. Through PEPFAR, USAID supports delivery of comprehensive HIV prevention and treatment services in 17 states including: nationwide procurement and delivery of HIV related commodities, support to the National Integrated Sample Referral Network, comprehensive services to vulnerable children, health financing, data systems strengthening, and quality improvement and capacity building for the health workforce.

Since 2005, the **U.S. Department of Defense (DoD)** has implemented a holistic HIV prevention, care, and treatment program for Nigerian military service members and their surrounding communities. This includes health system strengthening of laboratory services, strategic information, capacity building, and policy development. The DoD also collaborates with Nigeria on programs and research addressing biosecurity, malaria, and emerging infectious diseases.

Global Fund Early Grants and Operational Reforms in Nigeria

In 2000, AIDS, TB and malaria appeared to be unstoppable. The world fought back through the establishment of The Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002. As a partnership of governments, civil society, technical agencies, the private sector, and people affected by the diseases, the Global Fund pools the world's resources to invest strategically in programs to end AIDS, TB and malaria as epidemics. The Federal Government through the Federal Ministry of Health facilitated the establishment of Nigeria's Country Coordinating Mechanism (CCM) in March 2002 as the recognized entity with the mandate to receive Global Fund grants on behalf of the country. Since inception in 2002, the Global Fund has committed the sum of US\$2,585,537,824 to operations in Nigeria, which are split

into four program areas: HIV/AIDS, tuberculosis, malaria, and Resilient Systems Strengthening for Health, (RSSH).

The Global Fund intervened through a call for proposals from countries affected by the three diseases. Each call for proposals was called a Round, with successful proposals funded by the Global Fund. Nigeria was one of the first recipients of Global Fund grants and was awarded three grants in Round 1. The National Action Committee on AIDS served as Principal Recipient to two of these grants while the National AIDS and STIs Control Programme was the sub-recipient for both grants.

The Grants:

1. NGA-102-G01-H-00—Expansion of Prevention of Mother-to-Child Transmission Centers of Excellence. Grant Value: US\$6,632,182
 - a. Develop 6 Centers of Excellence to provide services for pregnant

- mothers—LUTH, UNTH, UMTH, National Hospital, UPTH and ABUTH
- b. Provide VCT services to 18,000 women
- c. Provide ART for pregnant women and families
- d. Improve quality of care through training of health workers
- e. Conduct Operations Research to identify best practices in PMTCT to enable rapid expansion to additional sites

2. NGA-102-G03-H-00—Expansion of Antiretroviral Treatment in Nigeria. Grant Value: US\$17,772,103
 - a. Treat more than 14,000 people
 - b. Strengthen the capacity of 25 ARV centers throughout Nigeria
 - c. Improve quality of care by training 100 doctors, 100 nurses and 100 counselors within the first year
 - d. Improve coordination between the public and private sector
 - e. Remove barriers to treatment of low-income people living with HIV/AIDS by making laboratory tests free

This was the first attempt by the Global Fund at executing its mandate/vision and, as expected, there were challenges in the implementation of the grant which resulted in the issuance of various implementation


letters providing further information on revised or updated implementation processes during the grant life. The Global Fund was an unusual grantor as it had no offices within grantee countries but worked through fiduciary organizations who served as the eyes of the Global Fund within implementing countries.

Nigeria faced the challenge of having two treatment programs but could not fully implement as it took about one year to get approval for the procurement plan from the Global Fund. NACA as Principal Recipient strengthened the procurement unit by engaging Crown Agents to serve as the Procurement Agent for the grant. Following this, the procurement plan was approved.

As a result of the lateness in approval of the procurement plan, most of the treatment targets were not met: 25% for the adult ART and 39% for the pediatric ART. Since the treatment program started late, all the operational research studies also started late. All the other targets were 100% achieved and even in some instances at more than 100%. The successes achieved in Q7 and Q8 were not enough to save the grants as both grants received B2 ratings.

The Global Fund Round 1 grants assisted the National Treatment Program in building the capacity of health workers, and





strengthening the systems and structure. The lessons learned from the Round 1 grants were applied to Round 5. This led to the successful implementation of the new grant which received an A rating after the 18th month review.

U.K. Early Support to Nigeria to Tackle the HIV Response

The U.K. Foreign, Commonwealth & Development Office's (FCDO) (formerly DFID) bilateral £100 million Enhancing Nigeria's Response to HIV (ENR) program (2009-2016) was an innovative integrated HIV prevention and institutional strengthening program. It followed on from two successful predecessor programs: Strengthening the National Response to HIV, and Promoting Sexual and Reproductive Health and HIV/AIDS Reduction Programme, both running from 2002 to 2009.

The ENR program significantly strengthened the organizational capacities and systems of the National and State AIDS Control Agencies and enabled them to analyze, strategically plan, coordinate, and manage the national and state AIDS responses. ENR also strengthened civil society organizations in their planning and management

processes and capacities, and enabled them to play a substantial role in implementing prevention interventions at the community level. ENR also built the capacity of the Ministry of Health at the national and state levels in streamlining data collection, management, and use. The National and State AIDS and Reproductive Health Surveys supported by ENR have been of huge value for the HIV response in Nigeria, and the Modes of Transmission studies championed by ENR were a game changer for the HIV response, facilitating an evidence-based shift in focus toward the general population from the initial focus on traditionally defined key populations at risk. Through direct intervention, ENR increased knowledge of HIV among the population and contributed to stigma reduction. Anti-stigma laws were promulgated in at least seven ENR states. The proportion of people in ENR-supported states with non-stigmatizing attitudes doubled from 27% to 53% among men, and from 24% to 52% among women.

ENR was the major driver in shaping the condom market in the country, distributing over 1.4 billion condoms over eight years, with a deliberate focus on rural and underserved areas. This is estimated to have provided 12 million couples with years of contraceptive protection, averted 3.3 million unintended pregnancies, prevented 77,000 maternal deaths, and averted 14 million

disability-adjusted life years. During this time, the proportion of rural areas in which people could buy a condom increased from 50% to 91%, and condom use at last higher risk sex increased from 56% to 78% as reported by men, and from 40% to 57% as reported by women. In the final two years, the project implemented a transition from FCDO-subsidized condom social marketing to a full cost recovery social enterprise model. The FCDO-supported Gold Circle condom brand has now become part of a portfolio of health products marketed by the Society for Family Health's new Social Business Enterprise unit, which became a self-sustaining social enterprise delivering public health goods indefinitely without donor support.

Although there is no longer a U.K. bilateral HIV program in Nigeria, since ENR closed in 2016, the FCDO remains one of the largest financial contributors to the Global Fund. The U.K. pledged US\$1.1 billion to the Global Fund for 2017-2019 and £1.4 billion for 2020-22.

The Key Role of Nigerian Civil Society


The contributions of civil society organizations in advancing the HIV response have been crucial and substantial since

Nigeria's first recorded case of HIV in 1985, and the involvement and activities of civil society in the prevention and control of HIV and AIDS has increased significantly over the years. Civil society pioneered several interventions, including providing care and support for people living with HIV prior to the national government's earliest response. It was only in 1987 that the government set up the National AIDS and STIs Control Programme and it was not until 1991 that the government committed N20 million to addressing HIV/AIDS.

The initial response of civil society organizations to the epidemic was largely uncoordinated due to the absence of state policies and guidelines, and government commitment and investment. These early efforts were also funded almost exclusively by donor resources and, consequently, activities were duplicated and ad hoc, with implementation driven by donor agenda and not necessarily by the needs of the target population.

The creation of the Network of People Living with HIV and AIDS in Nigeria (NEPWHAN) in 1998, the UNAIDS-supported Civil Society Consultative Group on HIV/AIDS in Nigeria (CISCGHAN) in 2000, and other civil society coordination entities strengthened the coordination of civil society-related activities.





NEPWHAN, a body of faith-based and non-governmental organizations, was formed as a collective voice of people living with HIV. The network has branches (or chapters) in all 36 states and the Federal Capital Territory. With the responsibility of coordinating, supervising and monitoring the activities and programs of over 1,030 support groups, it is one of the largest patient networks in Africa. With the support of NACA and other partners, the network has been transformed from a beneficiary organization into a vital partner in the national HIV and AIDS response.

The Civil Society for HIV and AIDS in Nigeria (CiSHAN) was established as a national umbrella network of civil society organizations working on the prevention and mitigation of HIV and AIDS. The network was the outcome of a consultative workshop of CSOs involved in HIV and AIDS held in Abuja. A total of 74 organizations drawn from 35 states and the Federal Capital Territory participated in the formation of the network, and it has since grown to include almost 3,000 member organizations across the country. These organizations, together with the military and paramilitary services, have contributed significantly toward HIV and AIDS prevention.

CSOs have evolved from focusing on advocacy and being watchdogs, to

providing support to enhance the quality of HIV prevention, treatment, and care services, largely through technical and financial support from external donors.

However, funding from external bodies—especially World Bank support for HIV prevention activities mainly implemented by CSOs—has dwindled in recent years. This lack of sustainable funding has influenced interventions, and the institutional capacity and impact of CSOs. In some instances, CSOs are unable to fund their operations or retain program staff. The challenges to sustain their work and survive in the changing funding landscape have constrained their efforts.

Another troubling implication of funding gaps is that CSOs are unable to hold policymakers accountable to the ideals of quality, transparency, and efficiency through independent monitoring. This is because they sometimes receive funding as sub-recipients of the very organizations and agencies they are expected to monitor. The relationship thus becomes compromised and, in practice, untenable.

To adapt to funding uncertainty, some CSOs have begun to experiment with social entrepreneurship as an alternative means of sustaining their activities. Some have sought to generate revenue by renting

out office space, providing consultancy and specialized services in key areas, and engaging in commercial ventures. This route is commendable, but the organizations should be careful not to lose their focus and direction.

It is also crucial for the government to step up its efforts toward attaining full independence and domestic ownership of the country's HIV response. It remains a concern that only about 20% of HIV programs are domestically financed. The government funds treatment for about 50,000 people in Abia and Taraba states, less than 5% of the total number of people on antiretroviral therapy. This can be addressed through the HIV Trust Fund, greater financial commitment from the government, increased backing from the private sector, and the setting up of ARV drug manufacturing plants in the country.

CSOs should be empowered to become the stable third leg of the country's tripod of HIV response, which also constitutes the government and the private sector. Community-level actions should be prioritized for resource allocation.

If Nigeria is to achieve the national goal of ending the HIV epidemic by 2030, the role of CSOs is vital as they directly engage


people. Funding is an important element of CSOs delivering on their crucial role, and innovative fundraising models should be explored, including social contracting and crowdfunding.

As an advocate for transparency and holding government and implementing partners to account, civil society is itself called upon to exhibit a higher level of transparency and accountability in raising and mobilizing resources.

Civil society will need to be deliberate in its focus and priorities and be guided by data and concrete evidence to understand what works, and how resources can be more effectively used or applied for impact.

Dr. Jeremiah Abalaka's Claim of HIV/AIDS 'Vaccine' and 'Cure'

The case of Dr. Abalaka, a consultant surgeon with no formal training in virology or vaccinology, is one reminiscent of the harrowing days of the early HIV epidemic in Nigeria. Using blood products to treat HIV/AIDS patients at his hospital in Abuja, Dr. Abalaka claimed that he had a "cure" or



“vaccine” for the virus. He claimed that his preliminary laboratory tests were efficacious in a limited number of clients, including himself, who volunteered to be injected or infected with HIV-positive blood samples prior to being inoculated with his supposed “vaccine blood product discovery.”

On the presumed strength of his preliminary findings, Dr. Abalaka formally sought and was granted a patent right (Patent No. RP13567) for his “vaccine” or “cure” on 22 July 1999 by the Nigerian Institute of Pharmaceutical Research and Development. The patent, however, only served as a *proof of ownership of an invention*, not an assurance of “vaccine” or “drug” safety and efficacy.

Dr. Abalaka’s so-called vaccine or cure did not go through scientifically validated clinical trials and neither was it approved or registered by the National Agency for Food and Drug Administration and Control (NAFDAC). Consequently, the Minister of Health, on the instruction of the President, amid growing reports of poor treatment outcomes among patients under Dr. Abalaka’s care, placed a ban on the “vaccine” or “cure” on 20 July 2000. In response, Dr. Abalaka approached the court

in August 2000, seeking relief to lift the government ban. A Federal Government court in Abuja delivered a judgment on the case 15 years later, on 13 November 2014, nullifying the ban on his “vaccine” or “cure.”

But the dust has yet to settle on this controversial case. To-date, the Ministry of Health, NAFDAC, NACA and NEPWHAN have all voiced their strong opposition to the lifting of the ban or any further use and/or experimentation with the supposed “vaccine” or “cure.”

As jointly expressed by the current and former National Coordinators of NEPWHAN, Abdulkadir Ibrahim and Edward Ogenyi “... the ruling would revert all the gains in the HIV response and spell serious catastrophe for persons living with the virus.” NACA had this to say: “In Dr. Abalaka’s case, his product was never tested conventionally for dosage, safety, immunogenicity and efficacy in human subjects. Going forward, we call on the concerned Government authority to live up to its responsibilities, regulatory wise, to avoid unnecessary deaths among vulnerable persons living with HIV that are understandably desperate for a cure.”

NASCP NATIONAL COORDINATORS



Dr. Edugie Abebe

At various times

Dr. Abebe is a public health physician with national and international training. She served as the pioneer National Coordinator of NASCP after it was transformed into the Federal Ministry of Health's HIV Programme and

succeeded in laying a solid foundation for the brand new program. She was Director Public Health, FMOH, from 1999 to 2005 and retired as a federal Permanent Secretary.



Dr. Alti Zwandor

(1995-1996)

A public health specialist with vast public health and development work experience, Dr. Zwandor moved on to work with UNAIDS as National Programme Officer and then worked in several Western, Eastern and Southern African

countries, rising to be UNAIDS Country Director in Lesotho and then Namibia.



Dr. Abiola Thompson

Tilley-Gyado

(1992-1995)

A proactive public health physician with a distinguished career spanning over 35 years in health and development, Dr. Tilley-Gyado was National Coordinator during the period in which the world was just coming to terms with the new epidemic. Her extensive

experience in presenting critical information in multiple languages and in diverse cultural environments enabled her to provide the needed direction in the development and transmission of customized HIV prevention messages.



Dr. Nasir Sani Gwarzo

(1996-2004)

Dr. Sani-Gwarzo is a public health physician with in-depth knowledge and skills in the areas of policy, strategy, leadership, management, and partnerships, as well as health and risk communications. A

hallmark of his strategy and innovation during his stewardship as NASCP National Coordinator was the development of critical HIV policy documents.



Dr. Toyin Salawu
(2004-2007)

A consultant public health physician with national and international training, Dr. Salawu led the NASCP team in the development of the first Health Sector HIV Strategic Plan and National Patient and

Programme HIV Monitoring tools. A stickler for transparency and due process, she provided an enabling environment for the strengthening of donor partnership and support.



Dr. Annette Akinsete
(2007-2008)

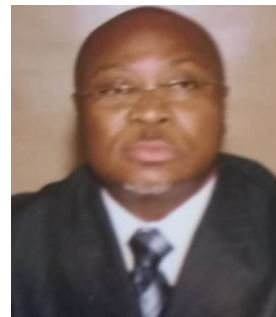
An outstanding leader of leaders, Dr. Akinsete, a consultant public health physician, was able to use her vast experience in managing a national survey for non-communicable diseases to improve the National HIV Seroprevalence Survey in ANC settings.

The Division enjoyed tremendous goodwill from within and outside of the FMOH during her tenure. She is currently National Director/CEO of the Sickle Cell Foundation Nigeria.



Dr. Henry Akpan
(2008)

A consultant public health physician, Dr. Akpan brought his experience with working in both national and international organizations to bear during his tenure as National Coordinator.



Dr. E.B.A. Coker
(2008-2009)

A public health physician and former Chief Consultant Epidemiologist of the FMOH, Dr. Coker's key achievements during his tenure were the review of the National Policy on HIV/AIDS in Nigeria, finalization of the National Early Infant Diagnosis Training Manual and a review of the PMTCT Child Follow-up Register.



Dr. Wapada Balami
(2009-2011)

A seasoned consultant obstetrician and gynecologist and public administrator, Dr. Balami's notable achievements were the review of the Guideline on Prevention of Mother-to-Child Transmission, development of the

Global Fund R10 Proposal, mapping of HIV (health sector) services across the country, the strengthening of national validation of HIV testing laboratory services and improved access to ARVs.



Dr. Sunday Aboje
(2016-2018)

A public health physician with many years of experience working in the clinical field, Dr. Aboje provided considerable support to the National HIV Treatment Programme. He was particularly passionate about ensuring that adolescents and young

people living with the virus had access to ARVs. The journey toward the re-establishment of the National Treatment and PMTCT Programme commenced under his leadership.



Dr. Evelyn Ngige
(2012-2016)

A consultant pediatrician with a focus of preventive medicine and public health, Dr. Ngige's leadership of NASCP saw the Prevention of Mother-to-Child Transmission program receive a significant boost with the development and

implementation of the National Plan for the Elimination of Mother-to-Child transmission of HIV. Dr. Ngige later became the Director/Head of Department, Public Health Department, FMOH and is currently a Federal Permanent Secretary.



Mr. Araoye Segilola
(2018-2020)

An experienced and seasoned public health officer and administrator, Mr. Segilola recorded a few firsts as Head of the Monitoring & Evaluation Branch and coordinated the joint proposal writing for the Global Fund

grant on several occasions. His vast experience in HIV programming assisted him in strengthening NASCP to deliver on the mandate and objectives of the National Treatment and PMTCT Programme.



Dr. Akudo Ikpeazu
(2020-to date)

A doctor of medicine and public health, Dr. Ikpeazu was previously Director at NACA and has over 20 years of progressive experience in public health policy, health planning, program design, community and social mobilization, resource mobilization and health systems strengthening. Her strong professionalism, leadership skills and vast experience in multi-sectoral HIV/AIDS coordination have helped to reinvigorate and validate NASCP's role, especially among international developing partners.



CHAPTER 2

THE DONOR DEPENDENCY ERA (2004–2015)

With the inauguration of the President's Emergency Plan for AIDS Relief in Nigeria in 2004, a new era of international support for the AIDS response began. The country received over US\$70 million from PEPFAR to support a comprehensive HIV program, the largest investment in containment of a single disease by any government. PEPFAR committed an additional US\$113.4 million for Nigeria a year later to fund the Global HIV/AIDS Initiative Nigeria (GHAIN) and other development interventions.

There was clearly an urgent need as a public health crisis was unfolding: the population prevalence rate for HIV stood at 5% in 2004. That year, the Federal Ministry of Health inaugurated the National Task Team on HIV counseling and testing, and the country's two largest NGOs—Family Health International (now FHI 360) and the Society for Family Health—jointly conducted the country's first integrated HIV surveillance survey. Nigeria's hosting of the 14th International Conference on AIDS and STIs in Africa turned out to be a watershed for the HIV response in the country, as President Obasanjo announced an end to user fees for HIV services, and the decentralization of HIV and AIDS treatment. Also in 2004, the country's first five-year National HIV/AIDS Strategic Framework set the tone for the tough task ahead.



Public protest for access to free anti-retroviral treatment for PLHIV during ICASA—Nigeria, 2005

With the massive injection of donor funding, all HIV commodities were being funded externally. The number of PMTCT testing sites rose—there were 67 that year compared to 11 in 2003—and the next four years saw a rapid expansion of PMTCT services and HIV treatment. By 2008, there were over 500 ART sites and 700 PMTCT outlets.

The UN General Assembly Political Declaration on HIV/AIDS in 2006 galvanized both national action and global donor responses. Nigeria's National Action Committee on AIDS became a full government agency in 2007 and was renamed the National Agency for the Control of AIDS. This was the first time



Dramatic Visual Activism

The Treatment Action Movement knew that President Obasanjo would attend the opening ceremony of the 14th International Conference on AIDS and STIs in Africa, and thus staged a “body bag display.” Activists posed in mortuary body bags like dead bodies, while others wept over them. When President Obasanjo saw people crying, he inquired what the problem was, providing the group with an opportunity to speak to him about the plight of people living with HIV.

a government agency in Nigeria was created to tackle just one disease. NACA’s mandate was coordination and resource mobilization, while treatment was the function of the National AIDS and STI Control Programme (NASCP) in the Federal Ministry of Health.

At the same time, non-governmental action was gearing up. The AIDS Prevention Initiative in Nigeria (APIN)—which, with funding from the Bill & Melinda Gates Foundation, had supported dozens of HIV prevention and surveillance initiatives—became an independent NGO in 2007. The first Interfaith coalition meeting was convened, and the National Women Coalition on AIDS (NAWOCA) was formed.

Nigeria’s hard work was also contributing to the global body of knowledge about HIV: analysis of Elsevier’s Scopus database in 2010 ranked Nigeria second in Africa behind South Africa for scientific publications.

The new decade began with a major policy shift in the Nigerian AIDS response, with the second National HIV/AIDS Strategic Plan 2010–2015. There was a significant decline in prevalence over the next four years, with new infections falling by about 10% from 2010 to 2019. But the global donor funding landscape was also shifting.

By the 2010s, there was increasing emphasis on domestic responsibility for the AIDS response, and the need for countries that could afford it to step up their own funding efforts, so that reduced levels of donor funding could be more specifically targeted. At the 2011 UN General Assembly High-Level Meeting on AIDS, there was a stocktaking of the previous 30 years and a hard look at how to shape the future AIDS response. For Nigeria's part in that, President Goodluck Jonathan promised to increase domestic funding of HIV/AIDS from 7% to 50% by 2015. This commitment led Nigeria to develop the President's Comprehensive Response Plan (2013–2015) with the overarching goal of improving domestic resourcing of the AIDS response and strengthening the States' capacities to respond to AIDS through the operations of the various States Management Teams on AIDS (SMTs).


The Evolution of Nigeria's HIV Response: The Shift to Risk-based Testing, Decentralization and Mentoring

HIV program approaches that were once the cornerstone of the response have either been discarded or modified as stakeholders gain fresh insights from emerging evidence from global bodies like UNAIDS and WHO.

In line with the UNAIDS "Know Your Status" campaign and the WHO "3 by 5" initiative—launched in 2003 to ensure three million people living with HIV/AIDS in low- and middle-income countries would receive ART by the end of 2005—Nigeria embarked on an aggressive testing campaign. The national HIV response urged every individual to know their HIV status. Programming was aligned with this perspective and HIV testing was randomly conducted at motor parks, places of worship, schools and other public places. Those who were tested also received guidance on how to avoid risky behaviors and manage their health to stay HIV free.

In 2021, however, the focus has shifted to risk-based testing, which prioritizes those perceived to be most-at-risk. The rationale for this new approach is to make best use of





the limited resources available and ensure that more PLHIV are placed on treatment.

In a similar fashion, the conversation has moved from providing HIV services at tertiary public health facilities to the decentralization of services to secondary and primary health care facilities and prioritizing high-burden regions over low-burden regions. Reaching as many people as possible is no longer the goal. The response is now more focused, thanks to data from the 2018 National HIV/AIDS Indicator and Impact Survey (NAIIS).

The use of electronic medical records is now more widespread, allowing for more efficient data collection. Levels of data analysis and presentation have also changed. It is now possible to find state and local government data instead of only national data. This enables granular evidence-driven programming to address the heterogeneous nature of the HIV situation in Nigeria.

The survey data showed that it was productive to pay attention to sub-population groups such as female sex workers, men who have sex with men, people who inject drugs, as well as adolescents and young people—particularly girls. As a result, interventions have now been developed to target the different

groups with respect to their unique vulnerabilities.

Whereas, in the past, there was a great emphasis on training highly qualified health personnel, such as medical doctors, to provide HIV treatment and some prevention services, there has been increasing recognition that structured trainings do not necessarily translate into improved capacity. As resources have dwindled, emphasis has shifted to mentoring, supportive supervision, and learning-on-the-job approaches.

But not all the changes have had a positive impact. Deprioritizing projects—which in the HIV response’s earlier days included the Minimum Prevention Package of Interventions (MPPI) and behavior change communication that enlightened the public about safe sex practices—has left a widening gap in knowledge about HIV among Nigerians. Similarly, the defunding of socioeconomic interventions, through which vulnerable populations like PLHIV and sex workers were supported to acquire vocational skills and given grants to start small businesses to reduce their exposure to further HIV risk, has also had negative consequences. There are ongoing discussions to reinstate funding for such programs and to relaunch a national behavior change communication

campaign focused on HIV stigma mitigation and the dissemination of positive messaging about HIV.

The lack of resources and dwindling external funding has had a tremendous negative effect on the shape of the national response. Due to its large population, Nigeria receives much less external support per capita than other African countries and cannot afford to design similar programs. There is always going to be a debate about what programs are appropriate, and an environment must be created in which this conversation can flourish.

To ensure that HIV programs in Nigeria are sustainable, two things must be done. First, the government should be encouraged to be more financially committed to investing in the health sector, not just to cover the wages of the workforce but to fund all pillars, including data management, infrastructure and access to treatment. Second, stakeholders at the grassroots level should be supported and encouraged to own local initiatives. Nigeria has learned the hard way that it cannot keep doing things *for* community members, it must do these things *with* them.

Partnership with Religious Leaders

Nigeria is a country of diversity in which Islam is found largely in the north and Christianity largely in the south. These coexist with animist and traditional religions. While there are no reliable estimates of the number of churches and mosques in the country, they are found in every corner, as a trip across any major city on a Friday or Sunday will quickly reveal. Considering the reach of religious leaders and organizations, they have a role to play in addressing the HIV and AIDS scourge in the country.

The effect of this realization was an interfaith coalition meeting convened in 2007, which paved the way for several working groups on HIV and AIDS. This resulted in the establishment of the National Faith-Based Advisory Council on AIDS, or NFACA, in 2009, with a mandate that was largely advisory in nature. NFACA was short-lived due to funding challenges.

A new coalition and strategic working group of faith-based organizations was born out of a regional consultation meeting jointly organized in 2017 by UNAIDS and the Catholic Caritas Foundation of Nigeria in





UNAIDS Deputy Executive Director, Dr Luiz Loures (C); Archbishop of Abuja, Cardinal John Onaiyekan (3rd R); Executive Secretary, National Mosque Alhaji-Ibrahim-Jega (2nd R); Chief Strategy Officer, PEPFAR, Sandra L. Thurman; Women Leader and CEO of CHEERS NGO, Ajia Ogugua (2nd L); Director, UNAIDS, Eastern and Southern Africa, Dr Sheila Tlou and Community Support Advisor, UNAIDS, Gabriel Undelikwo at the regional consultation on early diagnosis and treatment for HIV positive children—Abuja, 2017

Abuja. The meeting exposed coordination gaps in the implementation of set programs. Following that meeting, the reconstitution of a National Faith-Based Coordinating Body for AIDS came into effect.

Consequently, the Catholic Caritas Foundation put together another stakeholders' meeting of all the religious leaders from the two major faith groups—Christians and Muslims—led by the Christian Association of Nigeria (CAN) and

the Nigerian Supreme Council for Islamic Affairs (NSCIA), respectively.

The main outcome of that meeting was the formation of a 15-member working group that developed a plan alongside the national working group. This working group has held several meetings, and its suggestions and recommendations have been integrated into the production of the faith-based strategic plan. Challenges in coordination make quantifying its contribution difficult.

The painstaking effort of finding a meeting point for coordinating faith-based organizations has been rewarding. This is because religious leaders play a very important role in the dissemination of information to communities. Faith-based organizations have helped tremendously in improving knowledge of the epidemic among their respective congregations.

An example of this sort of engagement is that of Cardinal John Onaiyekan, then Catholic Archbishop of Abuja, who said in 2002, "Once the church imbibes the need to dissociate AIDS from moral guilt, it becomes easy for us to treat HIV-positive people as simply people who have a medical condition and who need assistance. And I think the church is in a better position to do that."

The strategy of involving religious leaders and faith-based organizations in the HIV and AIDS response received a massive boost through the UNAIDS-PEPFAR faith-based initiative. In 2016, PEPFAR and UNAIDS launched a two-year initiative to strengthen the capacity of faith-based leaders and organizations to advocate for and deliver sustainable HIV responses.

In 2020, a new PEPFAR-UNAIDS initiative aimed to leverage global and country leadership by FBOs in the HIV response. This initiative addresses five priority areas ranging from HIV stigma reduction to gender-based violence and human trafficking in the humanitarian context, as well as pediatric HIV adherence, counseling and referral. Led by NACA, the UNAIDS-PEPFAR initiative is centered on critical ownership by religious stakeholders, while being guided by the draft Faith-Based HIV and AIDS Strategic Plan (2018–2022) and the National Strategic Framework (2021–2025).

An important aspect of the impact of faith-based organizations is on building synergies and partnerships with the government and its agencies. This creates an effective network of contact points that can be coordinated toward maximizing broad-based cooperation in aspects of the National HIV/AIDS Strategic Plan for Nigeria.

The conclusion is that for Nigeria to achieve the objective of ending the AIDS epidemic by 2030, leaders from the two major religions must be actively involved in the process. The inclusion of religious organizations must continue to be fostered and expanded. Religious and faith-based groups are important social networks and plugging into these, as is now being done, is a step in the right direction.

Religious leaders should be encouraged to fully enter the arena of the fight to stem HIV and AIDS prevalence in Nigeria.






The Association of Women Living with HIV/AIDS in Nigeria (ASWHAN): Giving a Voice to Women and Girls Living with HIV

The Association of Women Living with HIV in Nigeria (ASWHAN) is the outcome of women's desire for greater visibility and involvement in the national HIV/AIDS response, to adequately address issues specific to HIV-positive women and girls. The association was established in March 2005 and registered with the Corporate Affairs Commission to promote and facilitate gender equity, and women's and girls' access to comprehensive HIV treatment, care and support services. Since its inception, ASWHAN has been working to ensure that women's and girls' needs, fundamental human rights—including sexual and reproductive health rights—and gender-based violence, get the needed attention.

ASWHAN has grown into a vibrant, progressive, women-led and women-focused rights-based association with vast experience in activism, advocacy, policy engagement and social mobilization. It adopts inclusive, participatory and innovative approaches to advancing its mandate and better serving its members.

ASWHAN's major contribution to the HIV/AIDS national response in Nigeria has been efforts toward the elimination of mother-to-child transmission of HIV, advocacy for comprehensive and appropriate HIV/AIDS prevention, mobilizing women of child-bearing age to access antenatal care, the elimination of sexual and gender-based violence, and treatment services for vulnerable groups—especially women living with HIV, female sex workers and children.

ASWHAN uses its comparative advantage, experience, and capacity to accelerate effective mobilization of trained women living with HIV as mentor mothers, peer educators, community mobilizers and treatment advocates to deliver appropriate HIV/AIDS prevention, treatment and stigma-reduction messaging. It serves as a bridge between health facilities and their communities: making referrals, and creating linkages for HIV testing, ART initiation and retention.



ASHWAN facilitates demand creation for the uptake of PMTCT services and engages support groups and mentor mothers to provide treatment adherence support to clients receiving ART, including defaulter tracking, home or hospital visits, psychosocial support, stigma reduction, and referrals to ensure effective facility and community linkages. It also conducts community dialogue to scale up uptake of services and promote stigma reduction. ASHWAN has built strong partnerships and collaboration with government, relevant partners and stakeholders at the national and state levels. Recently, the association has taken up more vigorously the protection of human rights, the prevention of gender based violence, and the strengthening of household

economies. However, reduced funding and support, unpleasing data, setbacks on attaining the elimination of EMTCT targets, increased cases of gender-based violence, declining institutional capacity to respond to the needs of its members and many other issues have significantly diminished and challenged the association.

The ability of ASHWAN to reinvent itself, remain relevant and make a difference as the world strives to end AIDS is the association's next battle.



Regional Director, International Community of Women Living with HIV/AIDS, West Africa who also wears the title of National Coordinator for the Association of Women living with HIV Mrs. Ukam Assumpta Reginald, participates in a global strategic planning meeting for women.



The Hidden Epidemic: Spotlight on Key Populations

Where there are inequalities, power imbalances, violence, marginalization, taboos, stigma and discrimination, HIV takes hold —UNAIDS 2019.

Historically and globally, certain key populations (KPs) experience disproportionate risks in both acquiring and transmitting HIV. These include men who engage in sexual activities with men, female sex workers, people who inject drugs, transgender people and people in closed settings.

Recently, the HIV/AIDS program in Nigeria also recognized people in the custody of the correctional services as a key population due to their higher HIV prevalence than the general population. According to the 2019 National Assessment of HIV and AIDS and Health Services Situation in Nigerian Prisons, HIV national prevalence in prison populations was 2.8%, and higher among women (6.9%) than men (2.7%).

UNAIDS estimates that, in 2019, 62% of all new HIV infections globally occurred among key populations and their immediate sexual or social partners due to limited access to

critical HIV counseling, testing, care and treatment services, because of the pervasive stigma and discrimination they face.

Globally, rates of key populations accessing safe, effective, and quality HIV and AIDS services are extremely low, while homophobia, stigma and discrimination, as well as gender-based violence, are high. Significant barriers—such as police harassment, societal discrimination, and insufficient community-based capacity—prevent key populations from accessing the services they need.

A female sex worker was one of the first two cases of HIV reported in 1986 in Lagos. Yet, it was not until 2007 that the Federal Ministry of Health included key populations such as sex workers in the second round of the national Integrated Biological and Behavioural Surveillance Survey (IBBSS).

The survey not only confirmed the existence of key populations, but also revealed that compared to the 2010 national prevalence of 4.1%, prevalence of HIV among female sex workers, MSM and people who inject drugs was 27.4%, 17.2% and 4.2%, respectively. While the third and fourth IBBSS in 2010 and 2014, respectively, reported a declining prevalence of HIV among female sex workers and people who inject drugs (albeit still well above the national prevalence), the rates have steadily increased among MSM.

The results of surveys and studies have heralded significant changes in the national HIV response, which initially assumed a heterosexual epidemic but was later refined to consider a mixed or concentrated epidemic. The Mode of Transmission (MoT) studies of 2010 and 2012 point to these facts. In the past decade, several policy documents, guidelines and intervention plans have been developed to address HIV among key populations. For instance, the National HIV and AIDS Strategic Frameworks, prevention and treatment plans and guidelines have undergone a series of revisions to include issues related to key populations. Also, there has been increased funding and technical support from development and implementing partners in this area.


The efforts have enabled the scale-up of HIV combination intervention programs and test-and-treat services. The Centers for Disease Control funded the first project that provided comprehensive and combined HIV services to high-risk men including MSM between 2008 and 2013 as part of the Men's Health Network Nigeria project implemented by the Population Council and partners. This was closely followed by a USAID-supported Integrated Most-at-Risk Populations HIV Prevention Programme (IMHIPP) implemented by



Director General, NACA, Dr. Sani Aliyu (2nd L); UNICEF, Dr Dorothy Ochola- Odonge (L) and Executive Secretary, Kaduna State Agency for the Control of AIDS, Dr. Mark Anthony (3rd L), UNAIDS, Tseday Alemseged (4th L), present IEC materials at the launch of HIV Prevention Campaign for Adolescents and Young People (AYP)—Abuja

Heartland Alliance International between 2009 and 2019.

In the past decade, in addition to several other intervention programs, there has also been an increase in the number of visible members of this group, as well as KP-led and KP-friendly community-based organizations and non-governmental organizations that are contributing significantly to the HIV and AIDS response in Nigeria. These efforts may have contributed to the reduction in the prevalence of HIV among the general population as well as specific key population groups.



However, despite the efforts of the Presidency through NACA, to create an enabling environment for achieving HIV control in Nigeria, many challenges remain. For instance, available epidemiological and bio-behavioral data on transgender women and men—another emerging subset of key populations—are sparse, if available, at the national level. About 19% of transgender women globally are living with HIV. Due to the social and legal exclusion and economic vulnerability that transgender persons, especially women, face, they are at increased risk of experiencing violence, disempowerment, and low self-esteem, and are less able to negotiate condom use.

Pervasive homophobia, deep-seated stigmatization and discrimination, criminalization, and repressive laws against

human rights are major barriers that keep the HIV epidemic hidden. They also lead to decreased access to HIV services and increased vulnerabilities of MSM and other key populations in Nigeria.

Fast tracking progress toward zero new HIV infections requires the concerted efforts of government, in partnership with the key population communities, development and implementing partners, health care workers, law enforcement agencies and religious institutions, to address the structural barriers that impact negatively on KPs in Nigeria. Strategic case finding among these communities has proved a more efficient way of locating PLHIV and linking them to treatment services.

“We salute president Yar’Adua for his role in resource mobilization for the HIV response by extending the World bank credit for HIV, and for the nationwide mobilization, education, and organization of women, through the First Lady, Hajiya Turai Yar’Adua and the National Women Coalition on HIV/AIDS”.

*-Dr. Erasmus Morah
Country Director UNAIDS, Nigeria*

*-Mr. Edward Kallon
Former Resident and
Humanitarian Coordinator,
United Nations, Nigeria*



His Excellency,
Alhaji Umaru Musa Yar'Adua, GCFR
President Federal Republic of Nigeria
(2007 - 2010)

2019 National Assessment of HIV and AIDS and Health Services Situation in Nigerian Prisons

Globally, prison environments are known to have higher transmission rates of HIV, Hepatitis B and C, Tuberculosis, and sexually transmitted infections. Prisoners are one of the five key populations most vulnerable to HIV infections, due to unsafe sexual practices, limited access to health care services, factors related to prison management and the criminal justice system, as well as substandard living and working conditions.

In 2019, there was a national assessment of the epidemiological situation of HIV and TB among prisoners in Nigeria, under the leadership of NACA, USAID and the United Nations Office on Drugs and Crime, including a survey of a representative sample of people in 12 prisons across six geopolitical zones of Nigeria. In all, 2,511 people participated, 92% of whom were men.

HIV prevalence

Overall, HIV prevalence was 2.8% among people in prison, and was higher among women (6.9%) than men (2.7%). It was highest among those with no formal education and among those older than 45 years.

Sex in prison

While only 4% reported to have engaged in consensual sex with other people in prison, over 70% reported that consensual sex between people in prisons occurred and this was higher among men (76%) than women (28%). Also, 60% of respondents indicated that sex was being offered as goods and services.

TB screening

Positive results for TB symptoms screening were 46%. This was similar for both men and women. Positive TB screening was higher among older people.

Drug use

Both injecting and non-injecting drug use were reported by people in prisons. The most common drugs used in prison were cannabis and opioids. About half had a lifetime history of cannabis use compared to 11% in the general population. In addition, 1 in 20 people had a lifetime history of non-medical use of opioids. The estimated population of people who injected drugs in prison was about 3%, and about 2% of respondents reported beginning to inject drugs while in prison.

Conclusion

HIV prevalence among people in prison was double that of the general population. There is a need for comprehensive prevention, care and treatment interventions including harm-reduction services among people in prisons in Nigeria. Effective TB screening programs must also be implemented to enhance early detection and treatment.

Championing the Elimination of Mother-to-Child Transmission of HIV

In 2011, despite two decades of response to the HIV and AIDS epidemic, Nigeria still had the second-largest global burden of HIV and AIDS and contributed the largest percentage of new vertical HIV transmission—30% of the global burden—with an estimated 60,000 infants acquiring HIV from their mothers annually. Although Nigeria's HIV prevalence at that time had

declined to 4.1% among pregnant women from a peak of 5.8% in 2001, the number of new infections among adults and children remained unacceptably high.

The world came together in June 2011 at the United Nations in New York for the UN General Assembly High-Level Meeting on AIDS to take stock of the progress and challenges of the previous 30 years and to shape the future AIDS response. The meeting took place 10 years after the historic United Nations Special Session on HIV/AIDS.





His Excellency,
Dr. Goodluck Ebele Jonathan, GCFR
President Federal Republic of Nigeria
(2009 - 2015)



President of Nigeria Goodluck Jonathan addresses the UN General Assembly during the launch of the Global Plan towards the Elimination of New HIV Infections among Children—New York, 2011



Ebube Taylor, a young HIV advocate (with her mother Florence) and keynote speaker at the 2016 High Level Meeting on HIV/AIDS. Ebube also spoke at the 2011 High Level Meeting along with President Jonathan in 2011

There were three key activities by Nigeria at the 2011 UN High-Level Meeting. These included a statement on the floor of the Security Council by President Goodluck Jonathan, entitled *Impact of HIV and AIDS on International Peace and Security*. He emphasized the negative impacts of civil crises and wars on the spread of HIV and AIDS among vulnerable populations, particularly women, young girls, and children, and said that Nigeria was determined to provide a new impetus and direction to its HIV and AIDS response by integrating the health sector into the country's human development agenda. He promised to increase domestic funding of HIV and AIDS from 7% to 50% by 2015 in line with the Nigeria–U.S. partnership agreement and that his government would work with the National Assembly to ensure an allocation of 15% of the federal budget to health in line with the Abuja Declaration of 2001. He also promised to increase investment in procurement and supply chain management systems to ensure the availability of quality HIV and AIDS commodities at all levels of care.

At an earlier event, President Jonathan, in the company of U.S. President Bill Clinton and other world leaders, UNAIDS Executive Director Michel Sidibé and UN Secretary-General Ban Ki-Moon, launched the Global Plan for “the elimination of new HIV



infections among children and to keep their mothers alive.”

At another side event on EMTCT organized for African First Ladies, Nigeria’s First Lady, Patience Jonathan, made a presentation on the EMTCT program in Nigeria with an emphasis on PMTCT activities in the public sector and at the community level, drawing examples from several community interventions by civil society organizations.

In a paper entitled *The Nigerian National Response to HIV*, NACA Director General Prof. John Idoko highlighted the efforts, achievements, and challenges of the national multi-sectoral response to HIV in Nigeria.

The year 2010/2011 marked a major policy shift in the Nigerian HIV and AIDS response, resulting in the decline of HIV prevalence over the succeeding four years. This was due to high-level political commitment, the use of strategic information in decision-making, a targeted focus on high-burden states, decentralization of services to primary health care centers, the integration of HIV services with other services (TB, hepatitis, malaria, MNCH/SRH and NCDs) and better coordination among stakeholders, led by NACA.

The President's Comprehensive Response Plan (PCRP)

By 2013, there had been significant progress in Nigeria's HIV response as compared to the preceding years. The HIV prevalence had stabilized, incidence rate had also stabilized and there was a significant increase in access to ARVs by PLHIV. Despite these advancements, huge challenges remained. Nigeria had the second highest burden of HIV globally and treatment gaps were still at an unacceptable high. Other systemic challenges were identified such as weak coordination at national and state levels, inadequate state government contribution to resourcing the response; challenges with human resources for health, weak supply chain management systems; limited-service delivery capacity and limited access to HIV services by the people who needed them most.

As part of the centenary anniversary of the nation, which was to be held in 2014, there was a renewed commitment by the administration of President Goodluck Ebele Jonathan to address these challenges and put Nigeria on track to halt the spread of the HIV epidemic.

President Jonathan convened an HIV/AIDS stakeholder consultation where he challenged the leadership of the AIDS response led by the National Agency for the Control of AIDS (NACA) to articulate the bottlenecks and accelerate efforts to achieve the relevant 2015 MDG targets (MDG 4, 5 and 6) as well as the targets in the National Strategic plan 2010-2015. This gave birth to the President's Comprehensive Response Plan (PCRP). The purpose of the PCRP was to galvanize political commitment at all levels for the HIV response. Specifically, the objectives of the plan were to:


- Provide HIV testing services for 80 million individuals aged 15 and older
- Enroll an additional 600,000 eligible adults and children on ART
- Provide ART for 244,000 HIV positive pregnant women to prevent MTCT
- Provide access to combination prevention services for 500,000 Key Populations (then called Most at Risk Populations) and 4 million young people
- Activate 2,000 new PMTCT and 2000 ART service delivery points across the country.

The PCRP presented an opportunity to achieve increased ownership and sustainability of the response even at subnational levels. With technical and financial support from UNAIDS, NACA led the development of this plan through an extensive, participatory and inclusive process.

The plan was organized into 2 broad pillars. One on Coordination and Systems Strengthening and the other on the HIV thematic areas of Prevention, Treatment, Care and Support. The 2 pillars were further divided into 13 priority areas with specific objectives.

An associated performance framework to track progress of the PCRP implementation followed. To promote accountability and comparability, targets were allocated to states. The plan was costed to the tune of N 262.7 billion (USD 1.7 billion) over the two-year period. 3.7% was allocated to the first pillar (Coordination and systems Strengthening) while the remaining 96.3% was earmarked for the second pillar (Accelerating the implementation of HIV prevention, care and treatment services).





Full resourcing of the PCRPP by the Government as conceived by the plan would have significantly increased the contribution of domestic funds in the HIV response to 60% of total required funding by 2015. Although the PCRPP was not resourced and implemented as planned, the Government of Nigeria made available funds through the Subsidy Re-investment Program (SURE-P) to address some of the identified gaps in the plan. SURE P

implementation focused primarily on prevention programs and this later transitioned in 2015 into a new sustainable and resource appropriate model of HIV management called the NACA Comprehensive AIDS Program (NCAPS) program which was rolled out in Abia and Taraba states as models for HIV implementation in the country for future scale up.

HE Olusegun Obasanjo, Former President of Nigeria Joins the Champions for an AIDS-Free Generation

The Champions for an AIDS-Free Generation is a distinguished group of former presidents and influential African leaders committed to achieving an AIDS-free generation in Africa. The initiative was founded in 2008 by His Excellency Festus Mogae, the Former President of the Republic of Botswana, and launched at the 2008 International AIDS Conference in Mexico. The Champions transcend political partisanship to speak freely and independently about the issues relating to HIV that need urgent solutions at the highest level. Specifically, this high-level group was established to target sitting heads of state and relevant organizations to advocate for the development of evidence-informed national AIDS strategies; the enactment of policies and legislation to create enabling environments; the mobilization of resources to support the plans; expanded multi-sectoral partnerships to garner necessary support and provide peer support for stronger, visionary and outspoken leadership at all national, regional and international forums. Together, their decades of commitment and hard-won accomplishments have saved millions of lives and altered the course of the HIV epidemic around the world.

Monitoring and Pushing Back on Rights Violations

The early days of the HIV epidemic were dominated by significant stigma and discrimination faced by people living with or affected by HIV and AIDS. This, in turn, led to violations of their rights to treatment and related services, freedom of movement and association. Many PLHIV were ostracized from their homes, communities, and places of work, and denied the right to care for themselves and their children. Some were even denied access to basic amenities and services such as water and healthcare. The disclosure of a PLHIV's status in some instances was not professionally or ethically done, sometimes to the extent that it became public knowledge and formed the basis for profiling, ridicule, stigma, and discrimination.

In cases where both partners were infected, women were assumed—often incorrectly—to have infected their male partners and were denied the right to inheritance of their partner's properties when they died. It was not uncommon for women in some communities to be labeled “witches” and thought to have brought misfortune and bad luck.

The rights guaranteed by Article 23 of the United Nations Declaration of Human Rights of 1948 were violated with impunity by employers, including government ministries, departments and agencies. These universal rights, most of which are also guaranteed under the Nigerian constitution, include the right to work, to free choice of employment, and protection against unemployment. Community-based organizations, PLHIV networks and activists, and other human rights organizations took up the responsibility to monitor violations of these rights at the community level. This helped give visibility to rights violations and generated a vast and reliable pool of data. This provided evidence for advocacy for the National Agency for the Control of AIDS, culminating in the enactment of the 2014 National HIV and AIDS (Anti-Discrimination) Act to protect PLHIV.

The Child's Right Act of 2003 had provisions that further helped children of PLHIV, ensuring they were eligible for inheritance within the states that had passed the law in line with the Federal Government's enactment. Other relevant strategic plans, policies and regulations include:

- 2014 HIV and AIDS (Anti-Discrimination) Act
- Patient Bill of Rights
- Violence Against Persons Prohibition Act 2015



- Stigma Reduction Strategy
- Child Rights Act 2003
- National Human Rights Act 1995
- The National HIV Policy
- The HIV/AIDS National Strategic Framework
- National Workplace Policy on HIV and AIDS (2013)

Periodic surveys and research have been conducted to inform policy and programming, including the PLHIV Stigma Index and the Legal Environment Assessment for HIV/AIDS response, which demanded improved equity in access to services among key populations. The Legal Environmental Assessment drives international and regional levels to use the law as a tool to end AIDS, especially to improve equity in access to services among key populations.

Access to justice has also improved, with more human rights activists and organizations engaging with PLHIV networks and organizations. The Network of PLHIV in Nigeria (NEPWHAN) has been outstanding in driving evidence-based advocacy and documenting reports of violations. Another key stakeholder has been the Coalition of Lawyers for Human Rights, which provides pro bono legal services to people living with, most-at-risk of, or affected by HIV in cases of violation

of their human rights. It was set up in 2015 by UNAIDS, in conjunction with Lawyers Alert, NACA, the Nigerian Bar Association and the National Human Rights Commission.



World AIDS Day Rally

Monitoring and responding to rights violations has faced some challenges. Each entity, agency or organization has its own deep-rooted value system, which is sometimes not aligned with global human rights principles. It is also challenging to confront the attitudes and entrenched values of lawmakers, health care workers, law enforcement agencies, and religious leaders. These stakeholders sometimes uphold and manifest deep-rooted values and beliefs on HIV infection, PLHIV and key populations, viewed largely from religious and cultural perspectives. This, of course, has informed the evolution of

more strategic approaches in dealing with and guaranteeing the cooperation of these stakeholders.

Data from the Nigeria Demographic and Health Survey (2013) showed that about half of Nigerians exhibited a stigmatizing attitude against PLHIV. The more recent PLHIV Stigma Index indicated that it remains an issue in the country today.

The country needs to develop and adopt a standardized and accessible monitoring and surveillance mechanism that ensures a quick response at the community and state levels, taking into consideration the dynamics of each location and the state.

Critical analysis of the reports and data on human rights violations should be carried out for a more in-depth understanding of the trends and the extent of the violations, to develop advocacy and a proactive response.

A rights-based approach must be the foundation on which all programs are developed and implemented. An opportunity exists in making this a reality through the March 2021 memorandum of partnership signed between NACA and NHRC to incorporate a rights-based approach in HIV programs.

Building Robust Legal Protection through an HIV Anti-discrimination Law

People living with HIV faced stigmatization and ostracization from the late 1980s to the early 2000s. Many were treated as outcasts and disowned by their families and friends. Some were given separate rooms and crockery. Employers terminated the appointment of employees who tested positive.

At the time, while many believed HIV could only be transmitted through sexual intercourse, some believed that the virus was punishment from God for immoral acts. These views denied basic empathy, so ingrained in African cultures, to people living with the virus. They were understood to be responsible for their own misfortune and were treated with denigration and scorn. Unable to cope with the stigma, many PLHIV took their own lives.

The Federal Government's initial efforts at drawing attention to the disease did not help matters. Billboards erected in large cities displayed pictures of skulls and cross bones, with messages such as "AIDS Kills" and "Abstain from Sex", which further reinforced the stigmatization and



discrimination of PLHIV. Testing positive to HIV was generally understood to be a death sentence.

The turnaround of the government's response to HIV and AIDS, including mitigating the impact of stigmatization and discrimination of PLHIV, occurred when Olusegun Obasanjo became President of Nigeria in 1999. In early 2000, he established the National Action Committee on AIDS, later the National Agency for the Control of AIDS. It was composed of a broad-based membership, including PLHIV, and state and local action committees on AIDS were established to support it. To reduce the stigma around HIV and AIDS, Obasanjo ensured he was photographed with people living with HIV. He also took an HIV test publicly to encourage Nigerians to discover their HIV status. The increasing availability of ARV drugs also helped improve the lives of PLHIV.

One of the first things NACA did was identify key partners and bring PLHIV together to form a network. An example of this partnership is the Network of People Living with HIV in Nigeria (NEPWHAN), which had met in Kaduna in 1998 and elected its first president, John Ibekwe. In 2000, a more encompassing meeting was held in Abuja and Dr. Pat Matemilola was elected as the Network's national



Director General, NACA, Prof. John Idoko (3rd L), UNAIDS Country Director, Dr. Bilali Camara, (2nd L), NEPWHAN Coordinator, Abdulkadir Ibrahim (L), and AHF Country Director Dr Tayo Towolawi (R), present Anti-Discrimination Law—Abuja, 2014

coordinator, a position he held until 2009 when Edward Ogenyi took over, leading NEPWHAN until October 2015. As the national response to HIV/AIDS gathered momentum, NEPWHAN and NACA, with support from civil society and UNAIDS, intensified the clamor for an anti-HIV/AIDS discrimination law.

A major role played by PLHIV in Nigeria, guided by these key organizations, was in collating reliable data on all aspects of the impact of HIV/AIDS. The earliest iterations of this data predate NACA. The coming into existence of a central coordinating mechanism made it easier to gather this

data into a database that could be useful in shifting government policy. Engagement soon coalesced around the need for legislation to protect PLHIV as well as to change the attitudes of members of society toward them.

Further, an immense amount of work by academic researchers highlighted the psychosocial impact of HIV and AIDS, making a compelling social argument against stigmatization. This research base was developed through close cooperation with PLHIV and advocacy organizations.

After a long period of advocacy and campaigning, the HIV and AIDS (Anti-Discrimination) Bill was enacted by the National Assembly and signed into law in 2014 by President Goodluck Jonathan.

It radically changed the legal regime surrounding PLHIV, creating a protected status against discrimination for every person on account of their HIV status. Practically, employers are prohibited from demanding HIV test results during recruitment. These provisions are aimed at giving PLHIV full inclusion in civic and economic life and reducing stigma within a coordinated national response. To date, 17 state governments have domesticated this federal law.

Even more importantly, measures were immediately put in place to ensure the enforcement of the Act. These included a massive awareness creation campaign on the existence of the Act, as well as the development of a National HIV/AIDS Workplace Policy, and training of judicial officials. Existing platforms such as state and local action committees on AIDS, support groups, and state networks of people living with HIV/AIDS were used to document and report rights violations experienced by PLHIV.

As good as these measures are, the slow pace of justice administration in Nigeria has frustrated attempts by PLHIV to test the new law when discriminated against by private employers. Stigma continues to be an issue, often couched in cultural terms. This can be seen in the pushback against the rights of the LGBTQ+ community in Nigeria, which saw the enactment of a punitive Same-sex Marriage (Prohibition) Act in 2014.

While the Federal Government wields a lot of influence, several states are yet to domesticate the Anti-Discrimination Act, making implementation patchy at best. The Act is nonetheless an important signpost and should be applauded, tested, and widely domesticated at the state levels.



Workplace Policy

The negative effects of stigmatizing and discriminating against people with HIV can be substantial, both to employers and to the workers themselves. First developed by the Federal Ministry of Labour and Productivity in 2005 and reviewed in 2013, the National Workplace Policy on HIV and AIDS addressed HIV stigma and discrimination in the workplace. It covers all workers working under all forms of arrangements and at all workplaces; and all economic activity including the private, public and informal sectors, as well as the armed forces and other uniformed services. The policy—based on the principles of social justice, human rights and equity—aims to guide employers on how to manage people living with HIV and AIDS, offering guidelines for government, employers, workers and other stakeholders, and identifying strategies and programs based on the International Labour Organization Recommendation Concerning HIV and AIDS.

Lagos as a Fast-Track City and Pilot for Decentralized Funding

Due to Lagos' high population density and HIV disease burden, it was selected to participate in the Fast-Track Cities maiden meeting on 1 December 2014. The overall goal of Fast-Track Cities is to end new HIV infections by 2030. Selected cities partnered with UNAIDS, the International Association of Providers of AIDS Care (IAPAC), UN-Habitat and other international agencies, and were assigned ambitious targets which must be met. Fast-Track Cities are expected to increase their HIV funding considerably while development partners make counterpart funding available.



His Excellency, the Executive Governor of Lagos State, Mr. Babajide Sanwo-Olu, Commissioner of Health Lagos State, Prof. Akin Abayomi and CEO Lagos SACA, Dr. Monsurat Adeleke at the launch of the "#isabiHIV" campaign

In June 2016, Lagos signed the global 90-90-90 initiative which aimed, by 2020, to ensure that 90% of people know their HIV status; 90% of those who know their status are on treatment, and 90% of those on treatment have a suppressed viral load, which means that they cannot infect anyone.

Lagos is working, in collaboration with multilateral and bilateral agencies, to ensure that it achieves the Fast-Track Cities targets. While the initiative initially focused on the 90-90-90 targets, the new goal is the more ambitious 95-95-95 targets. According to the Lagos State AIDS Spending Assessment in 2017, 70% of HIV response programs were supported by external agencies, while the State government's contribution was 22.8%. This commitment is higher than that of the Federal Government of Nigeria and is part of a growing trend. In recent years, there has been an over 400% increment in the budgetary allocation to the Lagos State Agency for Control of AIDS budget, with 85% release. In the 2020 budget, there was an increase of 28.8%.

However, Lagos is aware that international funding will eventually cease and is therefore creating a domestic resource mobilization plan for the State HIV and AIDS response through the active engagement of the private sector and the Nigerian Business Coalition Against AIDS (NiBUCAA). Lagos

State is also mobilizing resources through the State HIV/AIDS Consortium to support its efforts to achieve the surge target of 60,000 new clients to be initiated on ART treatment and to conduct advocacy visits to key government stakeholders to gain their support for an increased budgetary allocation for HIV/AIDS-related research.

Lagos State, through its AIDS agency, also collaborates with its federal counterpart, especially on the implementation of the National HIV Policy and the State Strategic Plan (2017-2021). The State has disseminated the Local Government Area-disaggregated NAHIS HIV prevalence data which empowers planning and response actions at the lowest level of governance.

The 2018 Nigeria HIV/AIDS Indicator and Impact Survey (NAHIS) found that Lagos State had a prevalence rate of 1.3% and estimated that 120,000 people in the state had HIV. This showed that Lagos accounted for 6.3% of the country's total HIV cases. The data also showed that 64% of people living in Lagos knew their HIV status. About 80% of those infected were on ART and 38% had attained viral load suppression.

Although Lagos State fell short of achieving its Fast-Track targets in 2020, efforts are continuing to achieve epidemic control in the state and will spur other states to meet their



own targets, improving Nigeria's chances of meeting its target of ending AIDS as a public health threat by 2030.

Abia and Taraba Treatment Program: What Viable ARV Model for Nigeria?

For well over a decade, the response to the HIV epidemic has been primarily driven by international donors. But, in 2011, donors and the government agreed that the country itself could and should assume greater leadership of the response.

As a result, in early 2014, the National Agency for the Control of AIDS and PEPFAR agreed that the transition to a country-led, sustainable, and resource-appropriate model of HIV intervention would begin in two states to determine how best to further transfer ownership of the nationwide HIV response to the government. On 1 April 2015, Abia and Taraba states were transitioned fully from PEPFAR, implemented through Family Health International (FHI 360), to NACA, implemented through State Project Implementation Units (SPIU) embedded in the State Ministry of Health.



C-R: President Goodluck Jonathan, represented by Vice President Mohammed Namadi Sambo; Senate President, Sen. Ayim Pius Ayim and Director General, NACA, Prof. John Idoko, at the launch of Nigeria Subsidy Reinvestment and Empowerment Programme (SURE-P) for eMTCT—State House Abuja, 2012

In the first 18 months, the transition ran smoothly, with technical assistance provided to the SPIUs by NACA/FHI 360 consultants.

Adequate funding came from the Subsidy Reinvestment and Empowerment Programme (SURE-P) scheme established by the Federal Government to reinvest savings from fuel subsidy removal to support critical infrastructure projects and social safety net programs.

Since April 2015, both Abia and Taraba have continued to have robust structures, systems and staffing for program implementation, management, monitoring

and evaluation. By March 2017, the states exceeded the earmarked targets. But the major deficit noted was that neither state had begun implementation of the Test and Treat HIV policy adopted in late 2016 due to a funding shortage which had begun to hamper all program activities by early 2017.

SURE-P funding ended in 2016, and the HIV budget for the two states was rolled into the national budget appropriation process. This placed a strain on the HIV response as neither state received operating funds until November 2017 and, when they did, the funds were less than 10% of the 2017 request.

Despite the commitment of state-level personnel, there is great apprehension among officials and PLHIV about the feasibility of transitioning to local control.


The greatest threat to the successful transition to full Nigerian ownership of HIV prevention and treatment efforts nationwide is the lack of sufficient, consistent, and predictable funding, particularly from government to the subnational levels.

Ensuring the financial viability of the HIV response will require sustained political will at all levels of government and sustained advocacy on multiple fronts, including from PLHIV, civil society, SMOH staff, governors, members of the National Assembly, the private sector and the international community. Nigeria has the resources to sustain these programs at a high level of effectiveness and efficiency, but this requires that leaders manage the epidemic with the urgency it deserves, otherwise the costs to the country, in both human lives and finances, will be much greater.

AIDS Healthcare Foundation in Nigeria

In 2011, in Gbajimba, a town on the outskirts of Makurdi, Benue state, and in remote Isanlu, Kogi state, the AIDS Healthcare Foundation (AHF) officially commenced HIV/AIDS service provision. In 2012, AHF's model stand-alone clinic opened in Abuja, FCT, and later expanded to Panda in Nasarawa, Cross River, Anambra and, last Akwa Ibom state. From a zero-client base in 2011, AHF now supports over 24,000 PLHIV with free comprehensive antiretroviral therapy, antibiotics for the treatment of opportunistic infections, and drugs for non-communicable diseases in these seven states.





With operations largely localized to remote, hard-to-reach locations, AHF undertakes infrastructural revitalization (new buildings and renovations); procurement of ARV buffer stocks, rapid test kits and laboratory equipment; and support to the National Integrated Sample Referral Network (NiSRN), as well as printing of M&E tools. AHF is also the technical partner for the Government of Nigeria Fast-Track Initiative (FTI) in FCT, Nasarawa, Benue and Cross River.

The AHF grant, which supports local CBOs and CSOs, has disbursed over US\$375, 000 to partners in Nigeria since 2013. This grant is distinct from the Emergency COVID-19 grant which benefited hundreds of vulnerable households at the height of the COVID-19 epidemic in Nigeria.

The International Condom Day commemoration in Nigeria is driven by AHF, as part of its condoms advocacy and promotion policy and, in 2019, AHF conducted a nationwide survey on condom consumption attitudes in collaboration with NACA and NOI polls.

AHF remains a pillar of support to young women and girls on menstrual hygiene management, with free sanitary pads in schools and communities, as well as scholarships and skills building under its Girls Act Initiative.

The organization has continuous collaboration with the Federal Ministry of Health (FMOH-NASCP), State MOH, NAC and UNAIDS, and, in discharging its mandate, has trained 555 government health care workers on Modified Nurse-Initiated Management of ART (NiMART), HIV self testing, equipment maintenance, 2020 Prevention and Treatment Guidelines, and safety and security, in addition to testing 2.27 million individuals for HIV and distributing over 20 million free condoms.

AHF-Nigeria has invested approximately 7.6 billion Naira (US\$19.14 million) in the National HIV/AIDS response in Nigeria from inception to date, and positively impacted the lives of over 24,000 PLHIV since its commencement, clearly demonstrating that it is a willing and significant partner in the fight against HIV/AIDS in Nigeria.



Top left: R-L: Executive Director UNAIDS, Dr Peter Piot; President of Niger Republic, Mamadou Tandja and President Council of Senate Senegal, Mbaye-Jacques Diop arriving for the opening session of the meeting of Heads of State and Government at the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria—Abuja, 200;

Top right: Health care workers conducting HIV tests at the Flag off of the HCT campaign, World AIDS Day Mambilla Barracks – Abuja, 2014.

Bottom left: L-R: President of Nigeria, Olusegun Obasanjo; ICASA 2005 President, Prof. Femi Soyinka and UNAIDS Executive Director, Dr Peter Piot, at the plenary session of ICASA 2005 held at the International Conference Center—Abuja, Nigeria, 2005.

Bottom right: Director General, NACA, Prof. Babatunde Oshotimehin (2007–2008) with Director General, NACA Prof. John Idoko (2009–2016) during the—Abuja, 2013





PRESIDENT:
GENERAL IBRAHIM
BADAMASI BABANGIDA



AUGUST 1985 – AUGUST 1993

PRESIDENT:
ERNEST ADEGUNLE OLADEINDE
SHONEKAN



AUGUST 1993 – NOVEMBER 1993

MINISTER:
OLIKOYE RANSOME-KUTI



1983–1992

1985/1986

First two AIDS cases in Nigeria were diagnosed and reported at the 2nd International AIDS Conference in Paris

1988

First World AIDS Day in Nigeria

1991

NACP expands to become National AIDS and STI control Program (NASCP) National AIDS Control Programme (NACP)

1994

UNAIDS Secretariat established globally in Geneva

PRESIDENT:

GENERAL SANI ABACHA



NOVEMBER 1993 – JUNE 1998

PRESIDENT:

OLUSEGUN OBASANJO



MAY 1999 – MAY 2007

UNAIDS COUNTRY DIRECTOR:



DR CONSTANTINOS BERHE TESFU

(2000–2004)

1997

AIDS activist and former health minister Olikoye Ransome-Kuti announces that his brother Fela Kuti has died of AIDS

1998

Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) established

1999

National Action Committee on AIDS (NACA) established

2000

UNAIDS Nigeria Country Office established with Costa Berhe as the first Country Programme Adviser and Head of Office

NACA DG:



PROF. BABATUNDE OSOTIMEHIN

JULY 2002 – DECEMBER 2008

UNAIDS COUNTRY DIRECTOR:



DR PIERRE MPELE

(2004–2007)

2001

First African Heads of State Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases.

Establishment of AIDS Watch Africa with President Obasanjo as the first chairman

2002

National ART program begins in 25 tertiary hospitals targeting 10,000 adults and 5,000 children

2003

The first Global Fund grant received in Nigeria in the form of three grants awarded to the value of US\$2.5 million

2004

PEPFAR is inaugurated in Nigeria and begins operations

Association of Women Living with HIV/AIDS established

PRESIDENT:

UMARU MUSA YAR'ADUA



MAY 2007 – MAY 2010

MINISTER:
PROF. EYITAYO LAMBO



JULY 2003 – MAY 2007

MINISTER:
PROF. ADENIKE GRANGE



JULY 2007 – MARCH 2008

NACA DG:



PROF. JOHN IDOKO

APRIL 2009 – AUGUST 2016

UNAIDS COUNTRY DIRECTOR:



DR WARREN NAMARA

2007 – 2010

2005

Nigeria host 14th International Conference on AIDS and STIs in Africa - Abuja, Nigeria

2006

2006 UN General Assembly Political Declaration on HIV/AIDS

2007

National Action Committee on AIDS becomes full government agency: National Agency for the Control of AIDS (NACA)

2008

Launch of the 'Champions for an AIDS-Free Generation' with President Olusegun Obasanjo as a founding member

PRESIDENT:
GOODLUCK JONATHAN



MAY 2010 – MAY 2015

MINISTER:
PROF. DR KHALIRU ALHASSAN



OCTOBER 2014 – MARCH 2015

UNAIDS COUNTRY DIRECTOR:



DR KWAME AMPOMAH
SEPTEMBER 2010 – FEBRUARY 2013

PRESIDENT:
MUHAMMADU BUHARI



MAY 2015 – TILL DATE

MINISTER:
PROF. ONYEBUCHI CHUKWU



APRIL 2010 – OCTOBER 2014

UNAIDS COUNTRY DIRECTOR:



DR BILALI CAMARA
2013 – 2017

2011

UNGA High-Level Meeting on AIDS. President Goodluck Jonathan and Nigerian HIV activist, Ebube Taylor address the Assembly and provide leading voice for advocating EMTCT

2014

Same-sex prohibited Act enacted
HIV/AIDS Anti-Discrimination Act enacted

2015

EMTCT initiative launched by President Buhari at a sideline event of UNGA

2016

KP Secretariat established following its registration with Corporate Affairs Commission in 2014 with Mr. Ifeanyi Orazurike as the first Chair

MINISTER:
PROF ISAAC ADEWOLE



NOVEMBER 2015 – 28 MAY 2019

NACA DG:



DR SANI ALIYU

JULY 2016 – JULY 2019

NACA DG:



DR GAMBO ALIYU

JULY 2019 – DATE

2017

UNGA HLM in New York. President Buhari commits Nigeria to shared responsibility and ownership of the response by making government resources available to maintain 60,000 PLHIV on treatment and treat a further 50,000 PLHIV annually

Nigeria crosses the milestone of 1 million people on ART

2018

Re-establishment of the National Treatment and PMTCT Program

FMOH launches National Data Repository

2019

Game-changing results of NAIIS, together with revised NSF launched by President Buhari joined by UNAIDS EXD Michel Sidibe

BHCPF launched

National Surge Strategy initiated by PEPFAR and government

MINISTER:
DR OSAGIE EHANIRE



AUGUST 2021 – DATE

UNAIDS COUNTRY DIRECTOR:



DR ERASMUS MORAH
JULY 2017 - JULY 2022

UNAIDS COUNTRY DIRECTOR:



DR LEOPOLD ZEKENG
INCOMING JULY 2022

2020

UNCT and bilateral donors adopt the Four Ones principle of HIV for the management of COVID-19 in Nigeria

One UN Basket Fund for COVID-19 in Nigeria established in June and mobilizes US\$73 million.

2021

Nigeria leads the 3rd Committee of the UNGA that coordinated the common HIV Africa position. President Buhari addresses the UNGA

2022

62 Billion Naira HIV Trust Fund Launched on Feb 1 by President Buhari together with Mr. Aliko Dangote and Dr Herbert Wigwe



CHAPTER 3

**NIGERIA'S DOMESTIC RESPONSE
RENAISSANCE (2015–2020)**



His Excellency,
Muhammadu Buhari, GCFR
President Federal Republic of Nigeria
(2015—To-date)

With the likelihood of increased competition for external donor funding for the AIDS response, Nigeria developed its domestic resource mobilization strategy in 2012 guided by UNAIDS' Investment Framework on allocative efficiency of the AIDS response. The strategy had four key pillars: increase government revenue for HIV programming; increase private sector contributions; increase the efficiency of the response; and improve governance of the response. The country took a new approach to achieving treatment saturation in the 12 selected states and the Federal Capital Territory that accounted for 70% of the country's HIV burden, known as the 12+1 Strategy.

In 2015, at the United Nations General Assembly, the country also launched a strategy to eliminate mother-to-child transmission, followed by the adoption of WHO's Test and Start strategy to promote early access to treatment and harness the preventive benefits of ART in pregnancy. This saw treatment decentralized to the lower tiers of service delivery, same-day initiation of treatment, and the new service delivery models of differentiated care, which facilitated improvement in treatment coverage.



H.E. President of Nigeria, Muhammadu Buhari (C), Prof. John Idoko Director-General NACA (L), Mr. Michel Sidibé (R), at the 70th UN General Assembly, New York, 2015

In 2017, at the UN General Assembly High-Level Meeting in New York, President Buhari of Nigeria committed to shared responsibility and ownership of the AIDS response, backed by a commitment to fund treatment for a further 50,000 patients annually.

This period of increasing domestic responsibility was about more than just funding. In 2013, Nigeria had enacted a national workplace policy on HIV and AIDS, providing a framework for development of a comprehensive and gender-sensitive HIV and AIDS response in the workplace, and a year later enacted the HIV/AIDS (Anti-Discrimination) Act. The 2014 National Plan of Action: Addressing Gender-based Violence and HIV/AIDS Intersections (2015–

2017)—launched by NACA, with the Federal Ministry of Women Affairs and Social Development, UNDP, and UN Women—aimed to reduce HIV by addressing GBV using a multi-level, multi-sectoral approach. In 2016 came the National HIV/AIDS stigma-reduction strategy.

Still, by this time, Nigeria had an estimated 3 million PLHIV, 70% of whom did not know their status, and there were approximately 190,000 new HIV infections annually.


To address this, Nigeria launched its Fast-Track Plan, derived from the UNAIDS West and Central Africa region Catch-up Plan to address bottlenecks, and accelerate national responses, together with adoption of the WHO “Treat All” guidelines, which committed the government to providing ART for life to all PLHIV.

These concerted efforts were starting to pay off: by 2017, the number of people on treatment had tripled since 2010 to 1 million and PMTCT programs were in operation across 6,363 facilities. A landmark study, the National HIV/AIDS Indicator and Impact Survey, supported by PEPFAR and the Global Fund, gave a more accurate picture of HIV prevalence than existing data sources. When the data came in, the news was good: 1.4%, a far cry from the peak of 5.8% in 2001. But this was no time to take

the foot off the pedal.

The National HIV/AIDS Strategic Plan 2017–2021 was revisited in 2018 and, in October of that year, the Federal Ministry of Health launched the National Treatment and PMTCT Programme (NTPP). This laid the foundation for country leadership and ownership, and for greater mobilization of domestic resources to be in line with the country’s HIV burden. This would become the bedrock of the sustainability of the HIV response in a country with, by that time, over 1 million PLHIV on ART. This re-establishment of the National Treatment and PMTCT program retraced the path forged 14 years earlier when the Government of Nigeria was the sole owner of the HIV treatment program in which 10,000 PLHIV were put on treatment, but the new program was more robustly designed. The program contained vital strategies with a clear one-year costed roadmap. By 2019, when the government launched the Revised National HIV and AIDS Strategic Framework 2019–2021, UNAIDS’ data showed that in Nigeria, 67% of PLHIV were aware of their HIV status, 53% were on HIV treatment, and 80% virally suppressed. As such, the Nigerian journey is one of the most important turnaround stories of the AIDS pandemic, and second only to South Africa’s on the African continent.





This period marks a renaissance of the AIDS response in Nigeria. It is both a return to the early days, when Nigeria was at the forefront of efforts to grapple with the new disease, and marks a new dawn, with hope for the day ahead, when Nigeria will also be a leader, but this time in a world free from AIDS.

The Stars are Aligned: President Buhari Appoints Prof. Isaac Adewole as Health Minister and Dr. Sani Aliyu as NACA Director General

Before 2004, Nigeria took full responsibility for funding HIV treatment. At least 10,000 people were being treated directly by the government at a time when most African countries did not invest in HIV treatment.

However, when U.S. President George W. Bush launched PEPFAR, Nigeria decreased its funding significantly in the fight against HIV and left the task to donors. PEPFAR displaced and absorbed the poorly funded Nigerian government initiative.

It was around this time that Prof. Isaac Adewole became Chairman of the University of Ibadan's Campus Committee

on AIDS and Principal Investigator of the AIDS Prevention Initiative, where he managed prevention of mother-to-child transmission (PMTCT) and subsequently the antiretroviral therapy programs. Later, he became a member of the National Task Team on PMTCT and then chairman of the team.

Adewole, a professor of obstetrics and gynecology, noticed the gaps in the health sector and antenatal care that had caused thousands of babies to be born with HIV.

In 2015, President Muhammadu Buhari appointed Adewole as health minister. Upon his inauguration, Adewole was determined to ensure that the government played a more active role in HIV treatment and funding as well as in the coordination of the fight against the disease.

Prof. Adewole's appointment also came as the leadership of the National Agency for the Control of AIDS (NACA) was due for a change. The Chief of Staff to the President, Mr. Abba Kyari, convinced Cambridge-based epidemiologist Dr. Sani Aliyu to return to Nigeria to lead NACA. Dr. Aliyu, who managed the health of about 500 HIV patients in the United Kingdom, was subsequently appointed to head NACA.

Prior to these appointments, there had been growing friction between NACA and the Federal Ministry of Health's National AIDS and STIs Control Programme, the division in the ministry responsible for the health sector response to HIV. This rivalry impacted negatively on the battle against HIV. Aliyu investigated the issues and forged special cooperation with the ministry to resolve this impasse.

Furthermore, Aliyu was able to ensure that Nigeria played a more active role in HIV treatment. He secured a commitment from the president to put an additional 50,000 Nigerians on treatment annually. That translated into an increase in funding of N2.5 billion to N3 billion a year. For the first time, the president doubled the budget of NACA to help it meet this commitment.


The launch in 2019 of the results of the Nigeria AIDS Indicator and Impact Survey (NAIIS), the largest-ever population-based HIV survey, providing more accurate and differentiated data, further improved the foundations on which Nigeria's HIV and AIDS response must now continue to build.

In the alignment of stars UNAIDS was a critical part, especially with regards to the harmonization of partners' efforts and programs. A key role was played by Dr. Bilali Camara in his capacity as UNAIDS Country Director



Minister of Health, Prof. Isaac Adewole (seated) with Director General NACA, Dr. Sani Aliyu and UNAIDS Country Director, Dr Bilali Camara during a familiarization visit

in Nigeria from 2013 to 2017. Camara supervised the agency's national HIV response and mobilized key groups and sectors of the country effectively. He championed advocacy to transform national HIV efforts into an impactful response by enabling every decision-making level to fully play its role. The Presidency, the National Assembly, the Governors' Forum, civil society, non-governmental organizations and PLHIV were all welcomed and motivated to play meaningful roles in the fight against the HIV epidemic in the country.



Camara undertook the strengthening of the Joint United Nations Team on AIDS (JUNTA) with each agency playing key roles as defined by the UNAIDS Division of Labour. With that united UN front, Camara reached out to major partners—such as PEPFAR, DFID and the Global Fund—to support the fight against the epidemic in Nigeria, avoid duplications and prevent the use of resources on strategies that had not worked. He ensured these partners worked closely with NACA, the Ministry of Health, the states’ AIDS agencies, civil society and PLHIV in an open, harmonious, and results-driven manner.

Realizing that the HIV epidemic was not equally spread between states and within states and that most PLHIV were dying of

tuberculosis, Camara created a convergence between NACA, the National Primary Health Care Development Agency and the National TB Control Programme. The convergence fast tracked activities toward achieving the 90-90-90 goals.

These collaborative partnerships also led to the passing of the National HIV and AIDS (Anti-Discrimination) Act 2014 by the National Assembly to protect people living with or affected by HIV.

These three key figures - Prof. Adewole, Dr Aliyu and Dr Camara were instrumental in significantly influencing policy, programs and funding of HIV and AIDS in Nigeria. Their contributions are most noteworthy.

Joint UN Team on AIDS in Action

The United Nations Joint Programme on HIV/AIDS (UNAIDS) unites the efforts of 11 cosponsor UN organizations—WHO, UNICEF, UNFPA, UNODC, ILO, UNDP, UNESCO, UN Women, WFP, UNHCR and the World Bank to end AIDS as a public health threat by 2030 as part of the Sustainable Development Goals. The Joint Program driven by cosponsors and coordinated by the UNAIDS Secretariat is guided by the Division of Labour which sets out the HIV related thematic area of each agency based on its overall mandate. The programme contributes to the national HIV response based on country priorities and within the context of the UN Sustainable Development Cooperation Framework (UNSDCF) signed with government.

The Joint Programme secures political commitment, provides strategic information, normative guidance and standards for the development of country and sector strategic plans/frameworks and guidelines as well as statutory reporting for the HIV response, in humanitarian setting, based on robust data analysis, investment cases, surveys, estimates and projections and the compilation and sharing of best practices. Examples of products supported are: Integrated Bio-Behavioural Surveillance Surveys, National AIDS Indicator and Impact Survey, investment case for adolescent and young people, Modes of Transmission studies, National AIDS Spending Assessments, studies reflecting the link between COVID-19 and HIV and Stigma Index Surveys.

Sustainability planning and resource mobilization, a priority for the NSF, have been key focus for the Joint Programme. The Programme supports frameworks for innovative financing and agitates for the alignment of these resources around country priorities. The Domestic Resource Mobilization Strategy, National Sustainability Framework and 2021 Sustainability Plan for HIV, TB and Malaria and the launch of the HIV Trust Fund are just some of the products and processes that have informed this area of work. Main donor engagement such as Global Fund grant mobilization and oversight, PEPFAR COP, EU and German contributions for HIV and COVID-19 have benefited from the Joint Team's political advocacy, normative guidance and technical inputs.

The Joint Programme championed and provided technical guidance in the re-establishment of the National Treatment and Prevention of Mother to Child Transmission Programme (NTPP) and provides political and technical guidance as well as strategic information to the National AIDS and STI Control Programme (NASCP) in the implementation of its workplans including guidelines on treatment, differentiated service delivery, EMTCT and Key Population guidelines. Towards Universal Health Coverage, the team supports health systems strengthening and leverages agency mandates in multisectoral initiatives to address intersecting inequalities that drive HIV and health outcomes. Examples are the Spotlight Initiative which aims to eliminate all forms of violence against women and girls, with strong partnership from the European Union; education initiatives with youths in and out of schools addressing human rights breaches

through its work with the National Human Rights Commission and supporting the enactment of policies and guidelines in workplaces, prisons and other close settings. Such policies and guidelines have proven effective in discrimination suits brought against duty bearers over the years.

Addressing structural and social inequalities is high on the priorities of the Joint Programme which strengthens community

structures such as NEPWHAN and ASHWAN, Key Population Secretariat and other government and non-government structures and Faith Based Institutions to enable the establishment of strategic plans, internal policies and guidelines for community (PLHIV, youth, young women, MSM, FSW, Transgender persons, persons who inject and use drugs, persons in closed settings) participation and leadership in resource mobilization and programme implementation. The National Social Protection Strategy was revised with the support of the Joint Team, ensuring an HIV sensitive policy, along with a fiscal space analysis to identify innovative financing mechanisms to fund social protection in Nigeria. An actuarial valuation of the National Health Insurance Scheme, and the Sokoto state health insurance operationalization through the Basic Healthcare Provision Fund (BHCPF) were also supported.



UN Joint Team on AIDS retreat with partners to reflect and determine investment priorities for 2022—Akwa Ibom, 2021

To help combat the impact of the dual pandemic on service uptake, the Joint Programme in 2021, mobilized resources through the One UN Basket Fund, to generate evidence to support PLHIV to navigate the COVID 19 pandemic, resulting in successful community-led monitoring initiatives, distribution of care packages in a time of need and a sensitization and vaccination drive for PLHIV led by NEPWHAN.

The programme's contribution has not gone unnoticed by the political and community machineries and a 2019 evaluation of Joint Programs in 14 countries across different regions solidifies the value-added relevance of the Joint Programme and the UNJT to the AIDS response in Nigeria. The findings of the evaluation led to the UN Joint Programme in Nigeria being pegged a best practice by the UNAIDS Programme Coordinating Board. For successive years, the UN Resident Coordinator considered the Joint Programme to be the best performing Joint Programme of the UN system, spearheading and demonstrating efforts of delivering as one.

The following logos represent cosponsors and secretariat of the Joint UN Programme + team on AIDS and Cosponsors:





90-90-90: The West and Central Africa Catchup Plan and Presidential Fast-Track Initiative

While 21% of the world's new HIV infections and 30% of global deaths occurred in West and Central Africa in 2016, HIV response in these WCA countries lagged other sub-Saharan countries. This prompted the initiation of a plan for the region to address bottlenecks and accelerate national responses by 2020 to meet the goals of the 2014 UNAIDS 90-90-90 initiative:

- 90% of all people living with HIV would know their HIV status
- 90% of all people diagnosed with HIV would receive sustained ART
- 90% of all people receiving ART would have an undetectable HIV viral load

Country and state plans were then derived from this overarching regional plan.

The first phase of the plan focused on eight countries: Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo, Nigeria, Guinea, Liberia, Sierra Leone, and the Central African Republic. Four of these—Cameroon, Côte d'Ivoire, the Democratic Republic of the Congo, and Nigeria—comprised more than 75% of the burden of HIV infection in WCA and had treatment coverage of less than 36%.

THE WESTERN AND CENTRAL AFRICA CATCH-UP PLAN

PUTTING HIV TREATMENT ON THE FAST-TRACK BY 2018

The Nigerian part of the WCA plan was launched by President Muhammadu Buhari on 1 December 2016. Nigeria, being the largest country in the WCA region, was central to the objective of meeting the targets by 2020. Achieving these would have put the world on track to ending AIDS as a public health problem by 2030.

Nigeria has the largest HIV burden in WCA. With a prevalence of 3.1% in 2016, Nigeria had an estimated 3 million PLHIV—70% of whom did not know their HIV status—and about 190,000 new HIV infections annually, according to reports by UNAIDS.

But the plan faced serious challenges, including poor government ownership;

leadership and funding deficits, particularly at the state level; weak health and service delivery systems; a low level of case finding of HIV-positive persons; and low pediatric ART, PMTCT and EID coverage rates.

The plan was to adopt the global 90-90-90 targets, institute lifelong ARV treatment for HIV-positive pregnant mothers to improve their own health outcomes, reduce the transmission of HIV to their babies and adopt the Test and Treat approach, i.e., begin ARV treatment immediately when HIV infection is confirmed.

Based on these policy changes, Nigeria was expected to quickly put an additional 500,000 people on treatment, test 3 million more pregnant women, and put a further 75,000 pregnant women on lifelong ART. These measures were geared toward putting Nigeria back on track to eliminate mother-to-child HIV transmission and achieve the 90-90-90 target by 2020. While the plan did not replace various interventions by PEPFAR and the Global Fund, it complemented them by identifying and providing services at sites not covered by donor support.

One of the underlying strategies of the plan was to give government (through the FMOH/NASCP) the leadership role in direct

support and supervision of unsupported sites in four Fast-Track states: Benue, Cross River, Nasarawa and Kaduna, and in the Federal Capital Territory. Advocacy and orientation visits were conducted to the five areas and high-level discussions were held with commissioners of health, permanent secretaries, directors of public health, State Management Teams on HIV/AIDS (SMT), State AIDS/STI program coordinators, state primary health care development agencies and many HIV and AIDS stakeholders in each state. Site assessments were made to tailor plans to the specific needs of the states, focusing on viable sites that had no support from development partners.

The initial phase was aided by the AIDS Healthcare Foundation (AHF), which provided much-needed technical support and training for health care workers in the identified sites.

The initiative was implemented in the five states for 18 months before it metamorphosed into a more comprehensive program now known as the National Treatment and PMTCT Programme (NTPP), with the same objectives of ensuring government leadership, coordination and increased domestic funding of the country's treatment program, to reduce dependence

on donor funding that provides over 80% of the resources for HIV treatment and prevention.

While it did not achieve the ambitious treatment and PMTCT targets, the NTPP successfully motivated the government to take responsibility and provide domestic resources for the purchase of commodities, and HIV testing and treatment in a few states. The main implementing partner,

AIDS Healthcare Foundation (AHF), provided rapid test kits and antiretroviral drugs through government funding to the national commodity pools. This project, along with government funding of Abia and Taraba states, is the only example of direct government funding of ART programs without donor support, a strategy the NTPP now seeks to expand throughout the country using a phased approach.

Technology Lends a Helping Hand

To support the data monitoring and reporting role of the NTPP, Nigeria now has a National Data Repository which is a partnership between the Federal Ministry of Health and PEPFAR. The repository receives identified patient data from health facilities providing HIV testing and treatment services across the country.

There is also the HIV PACE ECHO project which leverages video conferencing technology to provide case-based clinical mentorship to health care providers rendering HIV care and treatment services, especially those in primary health care centers. These initiatives were aimed at improving the quality of care provided by health workers and monitoring Nigeria's achievement toward meeting the UNAIDS 90-90-90 targets.

Harnessing the Power of the Media

In a country of over 200 million people, communicating messages around HIV and AIDS is no easy task and requires concerted efforts by all stakeholders. Partnerships and synergies with the media are a significant part of communications strategies in HIV and AIDS response programming.

The lifespan of any public health crisis is largely tied to the availability of the right sets of messages and how receptive people are to them. In the years following the outbreak, the public either lived in denial or had strong doubts about the disease. The spread of disease is inextricably linked to the spread of disinformation and thus the media is key in the HIV response.

Entrenched cultural sentiments strongly discouraged sex education in public or promoting the use of contraceptives. And because the major medium through which HIV is transmitted is unprotected sex, it became a battle between convention and safety. Naturally, journalists were positioned at the frontlines of this battle and rose to the challenge of shaping the narrative. “HIV/AIDS is real” became the mantra of the press, and health correspondents


strove to understand the virus and enlighten the public on how to avoid contracting or transmitting it.

Besides regular reportage by health correspondents, the Shuga television series initiative on MTV, the first-ever *Media Handbook on HIV/AIDS in Nigeria* (2003), the USAID Vision project, and Journalists Against AIDS (JAAIDS) in Nigeria were worthy media efforts toward curbing the disease. The *Media Handbook on HIV/AIDS in Nigeria* was the result of a collaboration between three organizations: JAAIDS Nigeria, the Development Communications Network, (DevComs) and the United Nations Information Center. This immense work informed public discussion about HIV and AIDS.

Through media efforts, Nigerians were constantly reminded that it was possible to be HIV positive and live a healthy life, and more and more people submitted themselves for testing and learned preventive measures.

Over the years, however, media engagement in the epidemic has diminished. Some associations of journalists built around the virus appear to only become active during the celebration of World AIDS Day on December 1. There seems to be a decline in collaboration between the media and other





stakeholders in the national HIV response. Fewer newspaper pages and less airtime are dedicated to enlightening people about the virus.

Other health challenges, such as COVID-19, have drawn media attention away from HIV/AIDS but simultaneously highlight the vulnerability of Nigerians living with HIV to COVID-19 because of their weak immune systems. The COVID-19 pandemic has also meant they have experienced greater difficulty accessing antiretroviral drugs and healthcare, as hospitals and clinics are overstretched.

Nigeria still has a long way to go to achieve the 90-90-90 target of ensuring that most people across populations know their status, are being treated and are virally suppressed. In a country that has the fourth-largest number of people living with HIV and AIDS globally, it is vital that the mass media plays a more active role in the fight against HIV and AIDS by engaging in in-depth contextual discourse. There is a need for a media reawakening as far as the country's HIV response is concerned. Relevant associations should be resuscitated, and journalists trained to harness modern communication tools to battle the virus.

Media executives and editors should encourage in-depth analyses of issues and

long-term specialization in health reporting because those who remain on the health beat longer become more knowledgeable and can shape public opinion. News organizations need to build the capacity of their reporters regularly through workshops and the provision of cutting-edge equipment.

To enhance the media's role in responding to the epidemic, government agencies involved in the response should also foster robust relationships with the media beyond press conferences. The role of the media in the HIV response in Nigeria needs to be retooled following the issuance of the first set of community radio licenses in 2015 by the Federal Government. Thus, cultural and social norms that fuel misinformation about HIV prevention can be adequately countered and clarified by community radio stations, where available.

The media landscape is no longer what it was when HIV/AIDS emerged as a public health crisis and then became an epidemic. Social media have become potent and widely acknowledged as exerting great influence on knowledge and behaviors. There is also greater use of virtual and online communication even by traditional media organizations. Social media and online services should become increasingly part of the core response to HIV and AIDS.

Without the active involvement of the media in the HIV response, preventable tragedies will still be recorded. So,

the timely dissemination of accurate information to the people cannot be overemphasized.


Courageous Journalism Fosters Understanding

Journalists have often stepped up in support of the HIV and AIDS response by researching and reporting on challenges around the epidemic. In August 2018, “How Nigeria ‘Kills’ Children Living With HIV”, a five-part investigative report written by Tobore Ovuorie, was published in The Nation newspaper. As an undercover journalist presenting herself as someone who was either HIV positive or needed to enroll children living with HIV in school, Ovuorie gathered first-hand evidence of what Nigerians living with HIV experienced daily. The report, which spanned seven states, including the Federal Capital Territory, revealed how deep-rooted stigmatization and discrimination against PLHIV was. It also showed that what fuels stigma is often ignorance, business interests and self-preservation.

Ovuorie’s report documented how children were turned away from schools once their status was disclosed, usually because the school management feared they would infect their playmates or that parents would withdraw their children once they found out. It did not matter that the aspiring students were on a strict antiretroviral drug regimen and were virally suppressed and therefore incapable of passing on the virus. It also did not matter to these school officials that, in 2014, Nigeria signed the National HIV and AIDS (Anti-Discrimination) Act to



Director General, NACA, Dr. Sani Aliyu, presents an award to Health Correspondent, Tobore Ovuorie during a Health Correspondent and Editors Dinner—Abuja, 2019



eliminate all forms of discrimination and create a supportive environment for everyone living with HIV.

In one incident at a school in Lagos, a head teacher abruptly changed her mind on admitting the children. On several occasions, the undercover journalist was requested to keep the status of the presumed children a secret for various reasons. The report was a compelling and saddening take on the state of HIV and AIDS stigma in the country, especially as it related to young people and access to education. Rather than create a safe working and learning environment as instructed by the law, institutions, including public regulatory bodies, prefer to deprive HIV-positive Nigerians of their right to live meaningful lives. Children and their parents must either keep their status a secret and be exceedingly careful when taking their medication, or they automatically settle for second-rate schools after a long and depressing search.

Ovuorie's report brought to light not only the limited opportunities for children living with HIV in schools but also the general prejudice Nigerians have against employees who are HIV positive. Many who spoke to the journalist confidently said they would not hesitate to lay off a domestic worker found to have the virus so as to protect family members.

Another report, by senior investigative journalist Chikezie Omeje and published in Sahara Reporters in 2018, unveiled irregularities in contracts for HIV campaigns, and counseling and testing services implemented in some parts of the country.

Thus, the events of the past few years within the media space have shown that the job of journalists is not only to disseminate information to the public on how they can protect and treat themselves, but also to feel the pulse of the people and share this information with NACA.

This cutting edge, socially responsible journalism enables all stakeholders to better understand the nuances and extent of the HIV problem, and the findings can help both government agencies and non-governmental organizations formulate the right policies, develop programs, address the fundamental issues, and prioritize the most pronounced issues more effectively for reform.

Re-establishment of National Treatment and PMTCT Program (NTPP): A New Take on Domestic Responsibility




Minister of Health, Prof. Adewole briefs key development partners - WHO, UNAIDS, USG/PEPFAR, and GF, on the re-establishment of the National Treatment and PMTCT Programme in Nigeria—Johannesburg, 2018

On 30 October 2018, the National Treatment and PMTCT Programme (NTPP) was officially relaunched. This was not only a historic event, but also a reminder that prior to the advent of the Global Fund and PEPFAR, Nigeria was one of the first African nations to establish a national treatment program. In 2004, the Government of Nigeria was the sole owner of the HIV treatment program in which 10,000 PLHIV were put on treatment. The relaunch event of the NTPP underscored its significance, bringing together highlevel representatives of the Government of Nigeria.

including the Minister of Health Professor Isaac Adewole, State Minister of Health Dr. Osagie Ehanire, Director of Public Health Dr. Evelyn Ngige and DG NACA, Dr. Sani Aliyu.

The decision to relaunch NTPP was first announced in Johannesburg in February 2018 at an event that brought government officials together with representatives of the Global Fund, PEPFAR, UNAIDS and WHO. At the official launch in October, these international and U.S. Government agencies, as well as others—such as UNICEF, the Global Fund CCM, Network of PLHIV in Nigeria and civil society organizations—again joined hands to express their full commitment to a successful implementation of the NTPP. This event laid the foundation for country leadership and ownership, which is the bedrock for the sustainability of the HIV response in Nigeria.

“Today we welcome this move, that finally the Government of Nigeria is going to take a leading role in coordinating and ensuring a robust National HIV response for its citizens. This will sustain the response, this will ensure that domestic resources are mobilized to mirror the HIV burden in this country,” said Helen Aphan, member and coordinator of the Association of Woman Living with HIV/AIDS in Nigeria.



“The relaunch of the NTPP was a clear indication of the government’s commitment to crafting an exit strategy from donor funding for the country. It gave a central role to the NASCP to drive the NTPP’s three main prongs: a) ational program leadership, coordination, monitoring and reporting; b) capacity strengthening at the federal and state levels; and c) increased government contributions.” said WHO Country Representative, Dr. Wondi Alemu. Under the NTPP, the Ministry of Health led a Fast-Track program, which had been up and running since January, with close to 68,000 PLHIV on ART in Abia, Taraba, Benue, Cross River, Nasarawa and the FCT. This provided proof of concept for a sustainable HIV response program. The NTPP contained vital strategies with a clear one-year costed roadmap, which translates the planned health sector response reflected in the National Strategic Framework on HIV and AIDS: 2017-2021 (NSF 2017–2021) and detailed in the 2016 Catch-Up Plan.

The NSF 2017–2021 is a five-year strategic plan that guides the country’s multi-sectoral HIV/AIDS response. On 21 September 2018, the President approved a special intervention fund of almost

₦2.4 billion to NACA for antiretroviral treatment for 32,555 adults and children enrolled in treatment, and directed the Minister of Budget to make ₦4.41 billion available in the 2019 budget for procurement of antiretroviral medicines. At the NTPP launch event, the Minister reiterated that the Government of Nigeria is committed more than ever for Nigeria to take back its responsibility and take its rightful place in coordinating the national health sector response and the scale-up of HIV treatment coverage of all PLHIV.

Speaking at the launch event, Dr. Adewole said: “All Nigerians living with HIV will never be left behind and the NTPP is the entry point to ensure that they are all put on treatment and sustained for life.”

Documented Global Best Practices

Nigeria has the highest burden of HIV in the West African sub-region and continues to bear a disproportionate number of reported cases of TB and malaria in Africa. To get to the last mile, all hands must continue to be on deck to sustain the investments including the strengthening of national health systems.

The cumulative efforts of previous years are paying off, evidenced by phenomenal achievements that include documented global best practices. The National AIDS Incidence and Impact Survey (NAIIS 2018), which reported a 1.3% HIV prevalence rate; the strengthening of routine data reporting through electronic medical records (EMRs) and the DHIS platforms; and the establishment of a National Data Repository (NDR) leading to the availability of real time HIV data and case-base reporting have been additional game changers.

The early adoption of the WHO Treat All Policy and fast-tracked intensified case finding of people living with HIV has contributed to the increased treatment coverage which currently stands at 65%. The re-establishment of the National Treatment and PMTCT program (NTPP)—which aims at strengthening the capacity of NASCP to deliver on its mandate and is also the platform through which the Global Fund and PEPFAR alignment project is hinged—has been instrumental in reinvigorating efforts to increase access to national HIV testing, treatment and prevention services.

WHO is collaborating with other key stakeholders to support NASCP in addressing the urgent challenge of prevention of mother-to-child



Dr. Walter Kazadi Mulombo,
WHO Country Representative to Nigeria

transmission of HIV (PMTCT).

“WHO is committed to continue to work in synergy with the Government of Nigeria and non-state actors toward attaining set national and SDG targets while leveraging the country’s primary health care strengthening initiatives to sustain the global health initiatives,” said Dr. Walter Kazadi, WHO Representative in Nigeria, at the National dialogue on PMTCT in May 2021.



Formal launch of the National Treatment and PMTCT Program (NTPP) with highlevel representation by the Government of Nigeria (Minister of Health, State Minister of Health, Director of Public Health, Director General, NACA, Heads of Agencies of the UN (WHO, UNAIDS and UNICEF), USG-PEPFAR (CDC, DOD, USAID), CCM, Network of PLHIV in Nigeria and Civil



UN General Assembly, New York, 2017: Nigeria Commits to Shared Responsibility and Ownership of the HIV Effort

The need for a global fund to fight HIV, TB and malaria was articulated in Abuja, Nigeria, in 2001 during an African Heads of States summit and the mechanism was eventually created in 2003 with huge funding pledges and commitments. The President of the United States, George W. Bush, surprised the world in 2003 by announcing a US\$15 billion investment in HIV and AIDS. From the Nordic countries to Europe, Canada and Japan, everybody was investing in HIV and AIDS, and there was massive outpouring of funds.

Despite this, African countries were not inspired to invest their own money, perhaps because donors were channeling resources into the continent, and it was seen as largely sufficient. Such a position was tenuous at best, and fraught with many risks.

For example, in 2002, Malawi was prioritized to get over US\$220 million from the Global Fund. At the time, the amount was greater than the entire budget of the country's

health ministry and thus entailed significant management and handling capacity. The Malawi government only contributed less than 5% of the funding to the HIV response at that time. For Nigeria, this raises the question of Nigerians with a lifelong disease dependent on external support. By 2015, funding from the United States Government accounted for 80% of the cost of ARV treatment for people living with HIV in Nigeria, while up to 18% came from the Global Fund. Of its more than one million people on treatment then, the Nigerian government was taking care of about 60,000 people.

A rethink was necessary. In 2012, a paper by UNAIDS, *Shared Responsibility, Global Solidarity*, articulated a new position urging African countries and developing countries in Asia and Latin America to share the responsibility of caring for their people. Noting that developing countries alone could not bear the burden without external donors, UNAIDS emphasized the message that the responsibility was shared, and that the world would not abandon individual countries.

The new NACA leadership, alongside UNAIDS, pushed aggressively against the existing order of dependency.

At the UN General Assembly in November 2017, President Muhammadu Buhari, represented by Dr. Sani Aliyu, made an historic and groundbreaking commitment to make government funds available for the treatment of an additional 50,000 patients annually, using government resources—a major victory for people living with HIV in Nigeria. President Buhari subsequently directed for NACA's budget to be adjusted accordingly to reflect this formula of incrementally assuming financial ownership of the response.

Essentially, this shared commitment symbolized hope to people living with HIV, that their government was alert, doing the right thing and moving in the right direction. It also sends the signal that it is Nigeria's responsibility to treat its PLHIV. If any donor withdraws its support, the country has a pathway. At the time, Nigeria had no national treatment program, but with availability of core treatment funding by the government, the Minister of Health was emboldened to re-establish a National Treatment and PMTCT Programme later in 2018.



Director General NACA, Dr. Sani Aliyu, at the 72nd Session of the United Nations General Assembly - 2017

No Looking Back: Nigeria Reaches Milestone of One Million People on Treatment

In 2017, Nigeria reached the milestone of one million people on antiretroviral therapy (ART). Sixteen years earlier, the national antiretroviral (ARV) drug access program was launched with a modest initial target of reaching 15,000 children and adults. There were about 980,000 PLHIV on ART by December 2016, and this increased to 1,066,223 by the end of 2017. The number of new participants in ART treatment annually increased from 109,226 in 2010 to 185,740 in 2017, with significant additions between 2013 (148,028) and 2016 (191,591).

The journey to this milestone began at the United Nations General Assembly Special Session on HIV/AIDS in 2001, where a Declaration of Commitment was adopted by all countries. The President of Nigeria at that time, Olusegun Obasanjo, identified the control of HIV and AIDS as a priority, and was tested for HIV during a well-publicized national HIV awareness activity initiating the national ARV access program. This government-backed program provided ARVs at minimal cost to PLHIV. It also established government organs to address the need for policies, guidelines, and strategic plans.

The introduction of the national ARV access program provided much-needed hope to those living with and affected by HIV. A diagnosis of HIV was no longer regarded as a death sentence. This led to shifting perceptions in favor of greater openness in getting tested and living positively. The advent of ARTs also meant that the myriad problems caused by the HIV epidemic—such as lower life expectancy, poverty, and reduced labor productivity—were impacted since the virus and the disease could now be lived with. AIDS-related deaths in the country, which had risen to 310,000 in 2003, fell to 107,000 in 2018.

The scaling up of the national ART program required input from government, development partners, clinicians, community health workers, civil society organizations, religious organizations and, of course, people living with the virus themselves. Nigeria received crucial support from the Bill & Melinda Gates Foundation, the Clinton Health Access Initiative, the Global Fund and PEPFAR. The United Kingdom and Japan also made contributions to the control of the HIV epidemic through their respective aid agencies.

The Nigerian program has always been guided by the recommendations issued by WHO and has enjoyed significant technical guidance from local and international

experts. From its inception, there have been vibrant technical working groups and task teams made up of experienced clinicians, academics, program managers and researchers from within and outside of government.

Achieving one million persons on ART required changing strategies as the needs arose and using data to guide implementation activities. For example, while Nigeria had a population of 128 million people in 2002, this grew to 195 million in 2018. HIV prevalence also varies across the six geopolitical zones of the country and, while all 36 states have benefited from prevention and treatment strategies and activities, those with higher HIV prevalence rates and higher burdens were prioritized for scale-up of ART services.

Although the Federal Ministry of Health is responsible for coordinating the health sector response to HIV, it has worked closely with other sectors and actors, with overall coordination being provided by the National Agency for the Control of AIDS. Awareness campaigns for HIV were carried out across the country using multiple communication and social mobilization channels. Information about the availability of ARVs was also widely disseminated,



Focus group discussion with women living with HIV, 2021 Gender Assessment of HIV response Nigeria

which has greatly impacted the expanded scope and success of the program, saving lives in the process.

The journey was not without some problems. In the early years, there was a challenge of ARVs being out of stock in some facilities, which necessitated urgent redistribution of drugs from one facility to another. The introduction of the pooled system for ARVs and other commodities with a central coordination of drug supply, irrespective of the source of funding for procurement, helped solve this problem.

As of December 2018, 93.2% of diagnosed PLHIV were on ART, with 56.2% recorded to be virally suppressed. Now, more attention needs to be paid to the quality of HIV services provided as the country makes progress toward ensuring that all the 1.8 million PLHIV in Nigeria are on treatment and virally suppressed. Children and adolescents are a sub-population that has been prioritized with tailor-made strategies for identification and successful retention in care.

The 2018 Nigeria HIV/AIDS Indicator and Impact Survey provided further guidance on where the treatment gaps were in relation to age groups and geographic areas. Related studies have also highlighted the coverage among key populations, and strategies have been developed to identify and treat all PLHIV, irrespective of their social status or sexual orientation. This is as Nigeria and its partners and stakeholders press toward the goal of ending AIDS by 2030.

Addressing Gender in the HIV and AIDS Response

In 2018, the Nigeria HIV/AIDS Indicator and Impact Survey revealed that the country had moved from second to fourth in the global HIV burden ranking. As of 2019, HIV prevalence among adults aged 15 to 49 years was 1.3% (females 1.8% and males 1.0%), showing that women and girls were disproportionately affected by HIV, a vulnerability rooted in their biology and exacerbated by a complex mix of societal norms, rights, and value systems.

The recognition and understanding of the gender dimension of HIV and AIDS and its impact had already led to several actions in the national HIV and AIDS response in Nigeria, including the formation in 2007 of the National Women Coalition on AIDS, or NAWOCA, and the multi-stakeholder Gender Technical Committee, now known as the Gender and Human Rights Technical Committee, or GHRTC. These mechanisms led to better analysis and an improved response. The GHRTC facilitated the mainstreaming of gender equality, women's empowerment, and human rights into national responses.





R-L: UNAIDS Country Coordinator, Dr Bilali Camara with Director Programmes, NACA, Dr. Akudo Ikpeazu, at the launch of the national guidelines to address Gender-Based Violence—Abuja, 2014

The Gender and Human Rights Division of NACA provides leadership and coordination. It is noteworthy that NACA, with the support of the UNAIDS country office, conducted the first Gender Assessment in 2013, which identified issues to be addressed to strengthen the national HIV and AIDS response. To further achieve a more gender-responsive HIV and AIDS response, gender and human rights was made a cross-cutting theme in the National Strategic Plan (2017–2021).

On another level, Nigeria's commitment to a more gender-sensitive approach has improved through collaboration with UN Women, UNDP, ILO and UNFPA, especially in the development of a draft NACA gender policy, and the mapping of laws, policies,

and services on gender-based violence and its intersections with HIV in Nigeria. There are guidelines and relevant tools for gender mainstreaming and capacity building, including gender budgeting, conducting a legal environment assessment, and implementing a plan of action to remove barriers to legal and human rights in HIV and AIDS services.

The other areas of special attention include the awareness raising and operationalization; dissemination of the 2014 National HIV and AIDS (Anti-Discrimination) Act; development of stigma-reduction strategies; facilitation of economic empowerment projects for HIV populations, especially women and girls; networking and enhancing relationships among gender and HIV and AIDS stakeholders at various levels; and capacity building and advocacy targeting policymakers, opinion leaders, program implementers and male leaders.

As the country advances in gender issues, gender, and human rights, which are critical components of HIV and AIDS programming, will receive more attention. Inequality and discrimination based on sex, gender,



Director of Planning, Policy and Coordination, Dr Kayode Ogumgbemi and Deputy Director, Community Prevention and Care Services, NACA, Dr Yinka Falola-Anoemuah and other participants during the Economic Empowerment for HIV/AIDS Vulnerable young Women and Girls, supported by NACA—Lagos

gender identity and expression cause major vulnerability to HIV infection and increase the negative impact of living with the virus.

Efforts to mainstream gender must be deliberate and made an integral part of the HIV and AIDS response. While there has been a reduction in HIV prevalence globally, gender inequality continues to affect service delivery and uptake, highlighting the need for increased investment in addressing this inequality, paying special attention to PLHIV, persons with disabilities and all other marginalized groups.

The Global Fund's Long-standing Partnership with the Government and People of Nigeria

The Global Fund to fight AIDS, Tuberculosis and Malaria raises and invests nearly US\$4 billion annually to support programs to end HIV, TB and malaria as public health threats in countries and communities most in need, while building Resilient and Sustainable Systems for Health (RSSH). Since its inception in 2002, the Global Fund has committed over US\$3.54 billion to Nigeria for the three diseases (Table 1). With the onset of the COVID-19 pandemic, the Global Fund, through its COVID-19 Response Mechanism (C19RM), invested an additional amount of US\$246.88 million to support Nigeria's COVID-19 response, while mitigating its impact on HIV, TB, and malaria programs. This raises the Global Fund's total current investment in Nigeria to US\$1.2 billion, the largest Global Fund country investment in the world. Nigeria has contributed a total of US\$38.79 million to the Global Fund to date.

Table 1. The Global Fund signed amounts for Nigeria 2002 to 2022

Disease Component	Signed Amount (US\$)
HIV/AIDS	1,255,552,455
Tuberculosis	520,378,527
Malaria	1,669,714,737
RSSH	99,616,090
TB/HIV	20,207,233
C19RM	246,882,212
Total	3,792,144,021

Through partnership with the Global Fund under the leadership of Mr. Peter Sands, the Executive Director, and jointly with PEPFAR, Nigeria has made significant progress in the response to HIV/AIDS recording its largest growth in HIV treatment numbers in the year of the COVID-19 pandemic. Under the leadership of the Minister for Health, Dr. Osagie Ehanire, who is also the Chair of the Global Fund Country Coordinating Mechanism, Nigeria successfully mobilized the largest grants ever from the Global Fund in 2020 and 2021. With 1.8 million people estimated to be living with HIV, Nigeria has the second-highest number of people living with HIV in sub-Saharan Africa. The Global Fund investments have helped expand health services across the country, now supporting more than 1.6 million PLHIV



Director General, NACA, Dr. Gambo Aliyu (C); Country Portfolio Manager for Nigeria, Dr. Ibrahim Faria (L) and Head of Grant Management Division, Global Fund, Mark Edington (R) during a High-level Mission to Nigeria by Mark Edington

with lifes-aving HIV treatment, increasing treatment coverage from 57% in 2017 to over 85% in 2020.

The Global Fund’s latest investment in Nigeria of US\$ 1.2 billion for the period 2021-2023 is earmarked to strengthen the fight against HIV, TB, malaria, and COVID-19, while building stronger systems for health. The US\$310 million HIV grants are being implemented by NACA and FHI 360 as principal recipients. The grants will focus on reducing HIV incidence, strengthening both health and community systems, and removing human rights-related barriers to health and gender inequalities while ensuring the sustainability of the achievements, including mobilization of

increased domestic resources for health. Maintaining the direction of the Global AIDS Strategy 2021–2026 of ending inequalities to end AIDS, the new HIV grants will be critical in further accelerating the delivery of treatment and prevention services to people who need them the most, i.e., children living with HIV, young women and girls, and key populations.

Mr. Mark Edington leads the Global Fund Grant Management Division and oversees investments in more than 100 countries, including Nigeria. He led the Global Fund's transition to the new, allocation-based funding model from the previous rounds-based system starting in 2012. This New Funding Model (NFM) saw an increase in the success rate of HIV proposals, which was about 40% at the time. This move proved a turnaround moment for Nigeria's ability to successfully mobilize resources from the Global Fund.

Under the NFM mechanism, specifically, and with consistent support from Edington, Nigeria successfully submitted and defended a joint TB/HIV/HSS concept note in 2015 and signed a total of US\$276.29 million in HIV grants. Nigeria had previously unsuccessfully applied for several grants, including for PMTCT and ARVs in 2003 and 2004, respectively. As an ardent solicitor of increased domestic resources for ATM, Edington's advocacy efforts were pivotal in supporting Nigeria's release of co-financing



Multilateral Liaison Adviser, PEPFAR, Margaret Shelleng and Disease Fund Manager, HIV/TB, GFATM, Bryan Morris at GF Program Review meeting, April 2019

commitments in 2018. “The fight against TB and HIV/AIDS should no longer be business as usual,” he said, while commending the Federal Government on the prompt release of counterpart funds.

Since the inception of the Global Fund's NFM, Nigeria has successfully mobilized HIV grants for the prevention, treatment, care, and support of PLHIV i.e., US\$276.29 million, US\$154 million and US\$310 million in the 2014–2016, 2017–2019 and 2020-2022 funding cycles, respectively. As Head of the Grant Management Division, Edington also leads Global Fund efforts to promote effective implementation arrangements of Global Fund grants while ensuring an effective internal control environment for safeguarding of Global Fund resources in Nigeria since 2016, through the Additional Safeguard Policy (ASP).



Global Fund Executive Director, Mr Peter Sands, and Minister of Health Nigeria, Dr. Osagie Ehanire at the Global Fund replenishment conference in Lyon, where Nigeria pledged USD12 million— France, 2019

The National Key Population Secretariat and the Core Group as a Platform to Coordinate and Oversee Key Populations Interventions

Engagement and consultations with key populations and people living with HIV in the context of the Global Fund NFM in 2014 ensured for the first time the full and meaningful engagement of community members throughout the NFM process despite the challenging environment. At the end of the processes, a collective decision was made to retain the engagement platforms and structure for future strategic coordinated consultations and participation in the country's planning and program-implementation


processes. This ushered in the National Key Population Secretariat and the Core Group.

The National Key Population Secretariat and the Core Group were created as a platform for representation, to coordinate key populations interventions, and advocate on Kprelated issues in Nigeria. The Core Group, with equal representation of four and later six members each from the MSM, FSW and IDU communities serves as the decision-making organ, while the Secretariat provides operational and technical support. The Secretariat also facilitates capacity building, information sharing and feedback with the key population communities and relevant stakeholders.

The Key Population Secretariat has been registered with the Corporate Affairs Commission and functions as a typical network of networks with a composition premised



UNAIDS Executive Director, Ms. Winnie Byanyima listens to community members at one of Nigeria's One Stop Shops in Gwarinpa, Abuja, March, 2021



on equal representation of the three constituencies and a democratic governance architecture. The idea of having the three typologies of KP communities under one umbrella was novel and therefore required careful nurturing and network-building and strengthening. The Core Group composition was broadened and strengthened in 2018, in response to emerging issues and challenges.

The Key Population Secretariat has provided the KP community with good representation and made significant contributions to the national engagement, planning and programming processes, and ensured that critical issues affecting the communities are mainstreamed in relevant program and interventions plans. It has been a voice for the KPs and ensured effective participation of KP community members in KP size estimation, IBBSS, Stigma index survey and other relevant surveys and assessments. It has also alerted stakeholders and mobilized responses to human rights abuses and the arrest of members. The Secretariat facilitated state-level KP structures for a more coordinated response in some states and carried out capacity strengthening, including sessions in the annual CSOs Accountability forum and demand-creation activities to support uptake of services.

The KP Secretariat's functionality has come under criticism and faced challenges on governance issues, leadership, and representation, as well as effective coordination. Some of these challenges are not unexpected for such a nascent network with a diverse composition and intra-community issues. The need for distinct recognition and inclusion of transgender groups within the structure of Secretariat has been identified.

The initiative by community members and partners to reconcile, resolve the various issues and restore confidence in the governance and leadership structure for strengthened coordination, representation, and information sharing and feedback is critical for key populations community.

Second Generation of National Strategic Plan (2017–2021)

The first-generation strategic plan for HIV/AIDS in Nigeria covered only a period of five years, from 2010 to 2015. Prior to that, the guiding frameworks were the HIV Emergency Action Plan (HEAP) and the National Strategic Framework, in addition to the specific plans of donors and implementing partners.

In line with global best practice, strategic plans are developed with specific strategies and interventions for specific periods and a review is done midway into the timeframe. A successor plan is developed to serve the shifting global focus. Hence the National HIV/AIDS Strategic Plan (NSP 2017–2021) was developed for the new period of emerging international priorities.


Having achieved the HIV-focused targets of the United Nations Millennium Development Goals, it was imperative to align the country's agenda with the global post-2015 agenda and the Fast-Track targets of achieving 90-90-90. This involved identifying 90% of people living with HIV in Nigeria, putting 90% of them on antiretroviral treatment and achieving viral suppression in 90% of those on ART.

Several factors were taken into consideration in formulating the second National Strategic Plan. They included a bottom-up participatory approach to development; using the NSP in the development of the medium-term sector strategy and in applying for Global Fund grants and donor support; and facilitating the development of state-specific operational plans in individual states. In the bottom-up approach, 36 states and the Federal Capital Territory were supported to develop their state strategic plans, which were consolidated into the National Strategic Plan.

In developing the NSP, greater inclusion of donors and aligning budgets were important improvements.

Significantly, the country conducted the largest-ever HIV population-based survey in the world, the National AIDS Indicator and Impact Survey (NAIIS) in 2018, and President Muhammadu Buhari launched its preliminary results in 2019. The survey was seen as confirmation of the success of the previous planning session and provided the granular data required for further strategic planning

The NSP also saw changes to more effective HIV regimens, such as the introduction of



Dolutegravir, a single daily pill instead of two. Although Nigeria officially adopted the option B+ for PMTCT which implies lifelong ARV treatment for HIV-positive pregnant women and the Test and Treat Policy in 2016, their full implementation is domiciled within the NSP timeframe of 2021. The NSP facilitates the implementation of the full package for harm reduction in Nigeria, which includes the needle-syringe program and medication-assisted treatment for people who inject drugs.

Under Nigeria's strategic plans and frameworks, new infections declined by about 10% between 2010 and 2019, while comprehensive knowledge of HIV/AIDS rose to 46% in 2018 from 30% in 2008. Some 68.7% of PLHIV now know their status, 53% are on ARV treatment and 42% have achieved viral suppression. The Federal Government is providing resources to put more people on treatment, and the HIV Trust Fund has been established to fill the funding gap.

As Nigeria continues to learn from the NAIDS data, it is expected that future planning will be even more focused on meeting existing challenges, anticipating future problems, and the formulation of more effective HIV/AIDS strategic plans within the larger development planning of the country.

Prevention Agenda in Nigeria

In 2016, the United Nations General Assembly adopted a Political Declaration on Ending AIDS that aimed to reduce new HIV infections by 75% by 2020. This was followed by the launch of the Global HIV Prevention Coalition (GPC) in October 2017, with UNAIDS and UNFPA as co-conveners, in recognition of the need for a Fast-Track approach to achieve this target. The Coalition brought together the 25 (now 28) member states with the highest number of new HIV infections and who together accounted for 75% of new adult HIV infections, civil society organizations, implementers and donors to strengthen political commitment for primary prevention and ensure accountability for delivering prevention services at scale.

Nigeria was one of 12 countries represented at the Ministerial level by the then Minister of State for Health (now Minister of Health) Dr. Osagie Ehanire.



Minister of State for Health, Dr. Osagie Ehanire (2nd L) in company of UNAIDS Executive Director, Mr. Michel Sidibé (3rd L), NACA Director, Dr. Akudo Ikpeazu, (3rd R), Country Director UNAIDS Nigeria, Dr. Erasmus Morah (1st L), Technical Adviser of the Minister of State, Dr. Shuaib Belgore, (1st R), at the Global HIV Prevention Coalition (GPC) meeting— Geneva, 2018

Subsequently, Nigeria has continued to demonstrate its strong commitment to HIV prevention on the global stage through the annual high-level meeting of Ministers of Health as well as the annual National AIDS Council Directors' meeting which began in 2018. These meetings are part of an accountability mechanism for tracking global performance through a data-informed process in which participating Member States develop their scorecards matched against their country prevention targets. The GPC has assisted countries to better organize their HIV prevention programs by leveraging self-assessments tools to determine the strengths and

weaknesses of their country prevention programs and establish their capacity needs and technical assistance requirements.

Nigeria is also a founding and active member of another GPC initiative, the South-South Learning Network (SSLN) that was set up in 2020 to establish and strengthen shared learning of best practice among 10 African countries with a high HIV burden. In each country, there is a team of HIV champions and, in Nigeria, the team is led by NACA with other members of the UN Joint Team (UNAIDS, UNFPA, UNICEF) and civil society organizations. Nigeria has hosted learning sessions and shared its experiences on condom sustainability and IBBSS. The SSLN is supported by Genesis Analytics in partnership with the University of Manitoba.

In acknowledgment of Nigeria's commitment to HIV prevention and leadership, Dame Pauline Tallen, Minister of Women Affairs, Nigeria was one of 11 invited panelists at the side event of the UN General Assembly High-Level meeting on AIDS titled, "No Prevention, No End! How Leadership for HIV Prevention can turn an Epidemic." The event took place on 8 June 2021 and was hosted by UNAIDS and the Global HIV Prevention Coalition Working Group. The Minister's intervention on innovations in Nigeria to address gender

dimensions of both the HIV and COVID-19 pandemics through primary prevention and mitigation was very well received.

Following the High-Level Meeting on AIDS in June 2021, Nigeria updated its HIV Prevention Scorecard and begun processes to domesticate the new Global AIDS Strategy 2021-2026 and the Political

Declaration on AIDS, as well as adapt the HIV Prevention 2025 Road Map. Currently, Nigeria's focus is on strengthening four of the five pillars of combination prevention, namely, adolescents and young people (AYP), KP, condoms and pre-exposure prophylaxis (PrEP), with the goal of



Minister of Health, Dr. Osagie Ehanire (C), Deputy Nigerian Ambassador to Kenya, Martin Eze (2nd L), the Chinese delegation lead, Vice Minister Yu Xuejun (3rd L), UCD China, Amakobe Sande (2nd L), UCD Nigeria, Dr. Erasmus Morah (3rd R), UNAIDS Nigeria Prevention Adviser, Dr. Modupe Oduwole (1st R), at the Global Prevention Coalition (GPC) meeting— Nairobi, 2019

improving upon the 28% reduction in new adult HIV infections from 2010 to 2020.

Mainstreaming Gender-Based Violence Issues in HIV Prevention

The murder of 22-year-old Uwaila Omozuwa at a Benin City church in May 2020 brought the underlying issue of gender-based violence in Nigeria to a head, channeling a strong undercurrent of identification, condemnation, and social outrage. That she was killed in a place of sanctuary struck a raw nerve in the Nigerian psyche. In the wake of her killing, the media highlighted other cases of gender-based violence (GBV).

Since 2005, GBV in Nigeria had been described by the UNDP as occurring in epidemic proportions. GBV includes a range of harmful customs and behaviors targeted at girls and women, including intimate partner violence, assault, child sexual abuse and rape.

Both men and women in intimate relationships can experience physical, sexual and emotional violence. However, the majority of GBV victims are women and girls. At the heart of GBV are the patriarchal norms, beliefs and practices that shape socialization.

There is evidence of a strong link between GBV and HIV. The three mechanisms through which violence is generally posited to increase HIV risk are: violence constraining women's and girls' ability to negotiate safer sex; sexual abuse during childhood or adolescence increasing the risk of engaging in risky sexual practices; and rape increasing the biological likelihood of HIV transmission, particularly where there might be lacerations as a result of the use of force. Other factors for GBV/HIV include exposure to the risk of violence following disclosure of HIV status by women living with HIV and the fact that key populations such as men who have sex with men, transgender people and sex workers are at greater risk of gender-based violence due to the high level of stigma and discrimination they face. This clear nexus also indicates that GBV and HIV cannot be effectively addressed without the involvement of men and boys.

In 2013, there was recognition of a need to act to reduce GBV in order to enhance HIV prevention, as well as to impact mitigation in line with the principle of gender responsiveness of the national HIV program. NACA, in partnership with the Federal Ministry of Women Affairs and Social Development and UNDP, as well as the Joint UN Team on AIDS, mapped policies and laws, including a readiness assessment of available GBV services in the country.

In 2015, the Plan of Action: Addressing Gender-based Violence and HIV/AIDS Intersections (2015-2017) was developed based on the issues, challenges and needs identified in the mapping exercise and from the outputs of a national stakeholder meeting held in June 2014. This three-year plan aimed at reducing the incidence of HIV by addressing GBV using a multi-sectoral approach at the national, state, and local levels. The main achievements of the plan included strengthening human and institutional capacity; reviewing laws and policies; increasing knowledge and awareness on GBV/HIV prevention and management; and improving information management and use.

The public outrage over GBV thus presents a barometer of public mood about this issue closely related to addressing HIV/AIDS. It is vital that the results captured in the Plan of Action lead to improved outcomes of HIV prevention and impact mitigation programs. This will be a crucial strategy aimed at ending HIV and AIDS in Nigeria by 2030.

A Harmonized Analysis Toolset

Costing about US\$100 million and covering over 200,000 people, 185 survey teams collected data for the National AIDS Indicator and Impact Survey, or NAIS, the largest HIV-specific survey in the history of the global response to the epidemic. Data collection for NAIS took six months and was followed by three months of data analysis. With the introduction of NAIS, indicators used by different development and implementing partners were expanded and harmonized for better analysis. The use of electronic medical records is now more widespread, enabling more efficient data collection. Levels of data analysis and presentation also changed. From initially only presenting statistics at the national level, it was now possible to find state and local government level data. This allowed for granular evidence-driven programming.

The Nigerian Child: Start Free, Stay Free, AIDS Free

Maternal, infant, and neonatal mortality rates are high in Nigeria: in 2020, for every 100 children born, as many as 11 died before their fifth birthdays. About 75,000 new infant HIV infections are recorded every year.

In 2018, more than 47 children and adolescents died daily from AIDS-related causes, only 35% of children living with HIV had access to treatment, and less than half

of mothers had access to ART to prevent the transmission of the virus to their babies (44%, up from 22% in 2009).

Nigeria introduced the Prevention of Mother-to-Child Transmission (PMTCT) program at six tertiary health facilities in 2001. In 2003, the National PMTCT Guidelines were developed. The PMTCT program involves HIV testing services, special child delivery measures, giving pregnant and nursing mothers access to ARV therapy, and the provision of prophylaxis to prevent infection of infants.

Mother-to-Child Transmission (MTCT)

MTCT, also called “vertical transmission,” is the transfer of HIV from a mother living with HIV to her child during pregnancy, labor, delivery or while breastfeeding. Without intervention, the risk of MTCT can be as high as 45%. With antenatal screening and treatment, this can be reduced to < 2%.



First Lady of Nigeria, Dr Mrs. Aisha Buhari receives an award as Special Ambassador for EMTCT, from the UNAIDS Executive Director, Mr Michel Sidibe. Looking on are, Director General, NACA, Dr Sani Aliyu and UNAIDS Country Director, Dr Erasmus Morah—Abuja, 2019

UNAIDS data shows that between 2005 and 2017, new HIV infections for Nigerian children between the ages of 0 and 14 years fell from 43,000 to 36,000. AIDS-related deaths also fell from 28,000 to 23,000. Likewise, between 2010 and 2017, early infant diagnosis rose from 6% to 12%, while the percentage of pregnant women living with HIV who had access to ARV medicines rose from 17% to 30%.

The program found valuable support in Nigeria’s First Lady Aisha Buhari. Committed to reversing the negative narrative, Mrs. Buhari launched the Free to Shine campaign during the 20th Ordinary General Assembly of the Organisation of African First Ladies Against HIV/AIDS (OAFLA) in Addis Ababa in 2018. Her vision was to end childhood AIDS in Africa by 2030 while keeping mothers healthy. Since 2018, 21 member countries of the organization (now known as



the Organization of African First Ladies for Development or OAFLAD) have launched national campaigns.

In her speech, Mrs. Buhari noted that even as many people living with HIV remained unaware of their status, she believed the judicious use of locally available resources was an essential step in completely preventing mother-to-child transmission of HIV/AIDS in Nigeria.

Consequently, her Free to Shine campaign has supported PMTCT by uniting people and organizations at the community, local government, state and national levels in a collective effort toward ending the epidemic. Equally important, she has advocated for the removal of user fees for antenatal and childcare services, as well as increased funding for the health sector.

The PMTCT program has not been without its challenges. For instance, the number of facilities providing PMTCT services has been in a steady decline: There were 6,363 facilities in 2017 and 6,301 in 2018. This fell to 5,564 in 2019.

Over one-third of pregnant women in Nigeria do not access antenatal care, and measures should be put in place to reach out to pregnant women who cannot visit health facilities. Women on treatment should

also be monitored to ensure they are virally suppressed, and children born to HIV-positive mothers given prophylaxis.

More initiatives such as the Free to Shine campaign championed by Mrs. Buhari are needed. Eliminating mother-to-child transmission requires policy reform, resource mobilization and advocacy. Evidence indicates that it is possible to achieve universal health coverage if governments at the federal and state levels are committed. Ensuring children are HIV free is the only way Nigeria can hope for a future full of vibrant, healthy citizens.

Hearing the Voices of Young People

In the urban areas that are at the center of Africa's largest economy, a youthful population can be seen displaying their abundant energy and vibrancy. This energy, seen in the affluent areas of Abuja and the slums of Lagos alike, belies the prevalence of HIV. In 2018, some 1.3% of Nigeria's population of about 200 million was living with HIV and AIDS. This demographic largely comprises people between the ages of 15 and 49, and the incidence among this group heavily affects national data because of the country's predominantly young population.



Executive Secretary, CiSHAN, Walter Ugwuocha with adolescents and young people during the launch of the National HIV Strategy for Adolescents and Young People 2016-2020 (in collaboration with NACA and UNICEF)— Abuja, 2016

HIV does not discriminate. However, different groups of people are affected differently. This variation is based on behavioral patterns, education levels, and even where people live. HIV is a disease transmitted primarily through sexual intercourse, and those who engage in risky sexual behavior are at greater risk of infection.

Data from the 2018 National HIV/AIDS Indicator and Impact Survey (NAIIS) showed that prevalence rates, especially among

women, began to increase significantly between the ages of 20 and 24. This is compounded by viral suppression rates in young people being lower.

Yet youth have been very active and proactive in dealing with HIV. Speaking on the issue of young people and the HIV/AIDS epidemic, Michael Akanji of Heartland Alliance, an international human rights organization, said: “Young people lie at the heart of the matter and the reality is that we need more investment in prevention to

match current investments in treatment. It is important to harness the energy and reach of young people in the response to HIV/AIDS.”

Key youth population groups that should be targeted for prevention include female sex workers, men who have sex with men, the transgender community, and people who inject drugs. They tend to have the highest risk of contracting HIV and must not be neglected in the HIV response.

Young people have contributed immensely to the fight against HIV/AIDS through organizations such as the Nigeria Youth Network on HIV/AIDS (NYNETHA), the Association of Positive Youths Living with HIV/AIDS in Nigeria (APYIN), Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), Association of Women Living with HIV in Nigeria (ASHWAN), and Civil Society for HIV/AIDS in Nigeria (CiSHAN). Youth are also represented at the board level of the National Agency for the Control of AIDS and have received various forms of support from the government and international partners.

In trying to turn the tide against HIV and AIDS, Nigeria’s youth have embraced and are actively engaged in national response platforms such as the Country Coordinating Mechanism and various national technical



President of Nigeria, Goodluck Jonathan demonstrating his commitment to the HIV response during the Flag-off of the “Protect the Goal Campaign” to promote Zero New HIV Infections, Zero Discrimination, and Zero AIDS-related deaths—State House, Abuja, 2014

working groups, steering committees, and sub-committees at the federal and state levels. Young people have raised their voices to promote access to universal prevention, treatment, care and support services across the country.

Reflecting on this dynamic, Moses Okpara, National Secretary of the Youth Network on HIV/AIDS in Nigeria, said in 2015: “Our youth and networks are better positioned to scale up advocacy for inclusion of youth-friendly services in the post-2015 agenda.”

However, the effect of steadily decreasing funding from external donor organizations to youth-led non-governmental associations has seen these engagements increasingly face financial difficulties. Many programs have had to be discontinued and this affects the overall effectiveness of youth participation in stemming the tide of HIV. Minimal resources are having to be stretched to cover the basic community engagement, advocacy, youth coordination and grassroots campaigns needed to get more people tested and included in treatment programs.

Despite this, youth need to be more active than ever to eliminate all barriers to HIV diagnosis and treatment. These range from affordability, availability and accountability of prevention and treatment, to care and support services. It is crucial for young people to have a hand in policy formulation in the country, as well as representing the country at international platforms and events.

The government should partner with other stakeholders to create more youth-friendly centers that provide sexual and reproductive health services. Equally practical is considering the review of the age limit for access to HIV counseling and testing to cover people between the ages of 15 and 17. It is important that they are


not discouraged by the need for parental consent.

Government agencies also need to help youth networks achieve financial sustainability because of the key role they play. Young people, arising from their natural tendency to travel, have expressed the need for an automated online drug administration system that allows them to access ARV drugs anywhere in the country. Innovations such as these call for reimagining aspects of health care delivery to address the needs of this key demographic.

It is important that support groups for young people should be encouraged across Nigeria as these help people living with HIV/AIDS better manage their status, allowing them to learn from the experiences of both older people and their peers.

It is crucial that youth are seen as part of the solution. Strategic support to young people should continue to be granted to allow them to contribute to the conversation and action on HIV/AIDS and ensure that their voices are heard in decision-making forums. When young people are empowered to take the message of the response to their various communities, they will share methods and success stories far more effectively.





There is no doubt that the best person to talk to a young person about any issue is someone who both reflects their youth and understands their struggles.

Promising Models to Reach Adolescent Girls and Young Women

Adolescent girls and young women (AGYW) have borne a greater share of the burden of Nigeria's HIV epidemic. The 2018 Nigeria HIV/AIDS Indicator and Impact Survey showed that young women aged 20 to 24 years had HIV prevalence rates four times higher than their male peers. In 2018, new HIV infections among young women aged 15 to 24 years was 1.7 times higher than that among young men.

Various research findings indicate that adolescent girls face numerous vulnerabilities such as gender inequalities, sexual abuse, early and forced marriage, marital rape, teenage pregnancy, low educational attainment, poverty, intergenerational sex, gender-based violence, female genital mutilation, sexual exploitation and trafficking, and limited access to sexual and reproductive health services. They also have low comprehensive

HIV knowledge and low utilization of condoms. In addition, adolescent girls and young women living with HIV are the farthest behind in terms of achieving viral suppression.

A lot is known about effectively managing HIV among adolescent girls and young women in many developed and developing countries, but there is very little evidence on how to manage the incidence of HIV among them in resource-constrained settings. Funded by the Global Fund, the Society for Family Health implements two innovative HIV prevention intervention models for this age group in the Federal Capital Territory, and Oyo and Akwa Ibom states.

The design of the intervention models was informed by evidence generated from novel action research that aimed to identify and define the vulnerabilities of young women aged 15 to 24 years. The research found that the three key factors increasing the vulnerability of this group to HIV infection were inadequate knowledge of HIV transmission, prevention and treatment; low uptake of HIV testing services; and low access to condoms. Six models of service delivery and access interventions were then designed in collaboration with young women and tested to identify the models that best addressed these three areas.

Two models were developed in 2018, each targeting a distinct sub-population of young women. One of these was the Change Influencer (CI) model for reaching sexually active young women. The other, the Place Value Agent (PVA) model, was for reaching adolescent girls and young women at higher risk of HIV infection due to their lifestyle, work-related activities, and/or socioeconomic status.

The CI model was based on peer sessions and the provision of mobile HIV testing and condoms. It also used mother-to-daughter (parent/child) communications and was aimed at the acquisition of social skills by the respondents. The emphasis of the PVA model lay in interpersonal communications and the use of “girlfriend networking,” while giving access to mobile HIV testing and condoms as in the CI model.


The models were piloted for 12 months. The CI model included structural interventions that supported the creation of an enabling environment to facilitate access to services as well as building the agency of this group. Regular contact through peer sessions enabled the delivery of HIV prevention information and condoms.

The PVA model adapted the Priorities for Local AIDS Control Efforts (PLACE) method, which was designed to increase local

capacity to understand the drivers of local HIV epidemics and identify gaps in services among those most likely to acquire and transmit HIV. Hotspots and venues where adolescent girls and young women were most likely to acquire and transmit HIV were identified. AGYW were trained to provide HIV/STI prevention information and became Place Value Agents. These agents reached out to their peers to transfer HIV knowledge and mobilized them to access HIV testing services provided at the identified hotspots.

A key element of both models was the engagement of young persons as auxiliary service providers to provide HIV testing services in the community and referral facilities. Young health care workers at referral facilities were trained to provide youth-friendly services to HIV-positive AGYW identified during HIV testing, to promote uptake of ART and ensure retention in care.

In 2019, both models were found to be effective in identifying AGYW who needed HIV treatment: the yield rate for testing HIV positivity in both models (3.1%) was higher than the national prevalence for the target population (2%). The unit cost of reaching AGYW with prevention messages ranged from US\$2.78 to US\$5.64 using the PVA model and US\$5.01 to US\$29.59 using the CI model. Reaching AGYW with HIV testing



services cost US\$3.36 to US\$5.54 and US\$15.15 to US\$54.30 per person using the PVA and the CI models, respectively. The unit cost for linking HIV-positive AGYW to treatment was US\$136 to US\$247 for the PVA model and US\$2,002 to US\$2,407 for the CI model.

The PVA model was more cost-efficient for increasing the uptake of HIV testing services, although its effectiveness for improving condom use and adoption of other positive prevention practices is yet to be established. Targeted interventions are key but they need to be planned with the understanding that adolescent girls and young women are not a homogenous group. Interventions need to be designed to reach specific sub-populations of larger groups, as demonstrated in this intervention model.

In patriarchal societies like Nigeria's, programs that target the sexual partners of AGYW, as well as adolescent boys and young men, are also needed to enhance programming for AGYW. The country needs to learn more about targeted interventions for this critical sub-population to enhance its HIV response for them. Addressing these challenges requires working with both women and men to reconsider not only unequal power dynamics, but also underlying social and gender norms. The response should also cover greater access to sexual and reproductive health services, ensuring girls can stay in school, and providing them with economic opportunities.

Policies and Lack of Sex Education Hinder Response

The age of consent to obtain reproductive health services by adolescents remains an issue. Under the law, there is no guarantee that a health worker or service provider who provides services to a minor will not face prosecution. Parents are also quick to reject sex education in schools. Yet, minors do engage in sexual intercourse, which may expose them to risks, irrespective of their parents' position. Sex education as part of the education curriculum has a lot of gaps. The teachers are not well trained and there is no strategy to monitor quality.

The Journey to NAIS and Rebasing the Epidemic: The Role of UNAIDS



His Excellency, President Muhammadu Buhari (4th L); Minister of Health, Prof. Isaac Adewole (5th L); Minister of FCT, Muhammad Musa Bello (L); Minister of Women Affairs, Dame Pauline Tallen (5th R); Secretary to the Government of Federation, Mr. Boss Mustapha; Director General, NACA, Dr. Sani Aliyu, with the UNAIDS Executive Director, Mr Michel Sidibe and US Deputy Chief of Mission, David Young, during the launch of the NAIS results—Abuja, 2019


Stratified surveys

In Nigeria, three types of surveys have been used by the Federal Ministry of Health HIV/AIDS Division to determine HIV prevalence and to monitor the trends of the HIV epidemic in the country:

- The HIV Sentinel Survey (HSS), which should be conducted every two years

among women attending antenatal clinics, determines HIV prevalence among pregnant women.

- The National HIV & AIDS and Reproductive Health Survey (NARHS) should be conducted every five years and covers the general population.
- The Integrated Biological and Behavioural Surveillance Survey



(IBBSS), which is mostly used to monitor prevalence and behavioral trends among key populations.

The last HSS and IBBSS surveys took place in 2014 while the last NARHS was conducted in 2012. Until recently, these were the main survey data sources for the country's AIDS response.

Between 2012 and 2014, significant progress was made in the AIDS response in Nigeria. The number of ART sites doubled, prevention of mother-to-child transmission sites increased eightfold, and HIV counseling and testing sites increased fourfold. According to government data, 6.7 million adults were counseled and tested for HIV in 2014, a 65% increase on the previous year. Testing among pregnant women also doubled in 2014 compared to 2013. Similarly, the number of PLHIV on ART increased significantly.

However, despite this progress, there was no commensurate improvement in the statistics on coverage of antiretroviral therapy among PLHIV. National achievements in the AIDS response were poor compared to the targets, and program implementers reported difficulties in identifying people living with HIV in need

of services. It was therefore suggested that the HIV burden was not as high as was estimated using the available data.

Former UNAIDS Country Director Dr. Bilali Camara was a long-standing advocate of the expansion of the surveillance of the country's epidemic. "I realized early on that we did not have the full picture of the country's AIDS epidemic," he said. "For a long time, I was pushing for surveillance to be expanded."

New approach

In July 2015, the National Agency for the Control of AIDS (NACA), under the leadership of its Director General, John Idoko, decided that it was imperative to better understand Nigeria's HIV epidemic. NACA set up a National Stakeholder Committee—comprising the head of the National AIDS and STIs Control Programme, the UNAIDS country director, a WHO representative, the PEPFAR country coordinator and civil society representatives—which decided to conduct a triangulation of data from various sources.

Prof. Idoko, the former director general of NACA, said: "The need for the survey was first initiated under my leadership, but we

had overwhelming support from UNAIDS Country Director Dr. Camara.”

Many countries have moved to a location–population approach, which helps to ensure that HIV services reach the people and geographic areas with the greatest need. Location–population approaches require granular-level data, which was not available in Nigeria. In 2016, the UNAIDS Nigeria Strategic Information Team was tasked with developing an evidence-informed methodology to estimate the HIV burden at the local level. During this process, a closer analysis of the results of the various surveys highlighted a series of issues with the HSS surveys:

- The Sentinel sites were too limited in number to ensure nationally representative geographic coverage based on the demographics of the country.
- Urban sites were oversampled.
- Rural sites were under-sampled.

The conclusion of the UNAIDS Nigeria epidemiological analysis was that the HSS and NARHS were no longer giving sufficiently precise epidemiological information. It was recommended that a comprehensive review of the HIV surveys being conducted in Nigeria should be carried out to address the shortcomings of the existing survey


approaches and methodology.

Thereafter, the UNAIDS country office met with various stakeholders, including the Development Partners’ Group on HIV, and presented these observations and recommendations. In so doing, it effectively utilized the Development Partners’ Group on HIV to galvanize support from PEPFAR and the Global Fund in particular.

In June 2016, the director general of NACA raised concerns that the latest estimate of 3.5 million Nigerians living with HIV was an overestimation. He shared his concerns with UNAIDS Country Director for South Africa, Dr. Erasmus Morah, and his colleague Dr. Alti Zwandor, at the 21st International AIDS Conference in Durban in 2016. In July 2016, after advocacy from the UNAIDS country office, the new Minister for Health, Isaac Adewole, and the new Director General of NACA, Sani Aliyu, agreed on the need for an epidemiologically robust population based HIV survey in Nigeria. They approved the recommendations for such a survey and committed to mobilize resources for it.

“When I resumed as Director General of the National Agency for the Control of AIDS, a recurring issue that came up at every introductory meeting with partners was the





difficulty in finding new cases,” said Dr. Aliyu. “It was obvious that there was a problem with case-finding. Was this because we were looking in the wrong places? I had doubts on the quality of data we had ... and we could not achieve epidemic control if we did not even know where we were. Hence, the number one priority of my administration was born: establishing the true prevalence of HIV in Nigeria by employing the best scientific and technical survey tools available in the shortest possible time.”

In November 2016, a review and triangulation of HIV data in Nigeria was commissioned by NACA in collaboration with, and with funding from, UNAIDS, the findings of which gave further support for a national survey to develop more precise estimates of HIV prevalence. Firm support for the survey came from PEPFAR and the Global Fund, which committed to funding what would become the NAIS.

“Getting the data situation in Nigeria right was not only the right thing to do but also the dream of so many people. Fortunately, Nigeria had great partners to help turn this dream into reality. Programming and

accounting for HIV results in the country will never be the same,” said current UNAIDS Country Director for Nigeria Dr. Erasmus Morah.

Before the results of the survey were announced, a UNAIDS technical mission led by UNAIDS Director of Strategic Information Dr. Peter Ghys visited Nigeria. His team gave advice on the use of the survey results, and the trends and geographic location of the epidemic at the national and subnational levels. It also gave technical guidance to national partners on data management and governance, including on a strategy for country ownership and leadership of the survey results, and support on how to communicate the changes in the epidemiological profile of HIV in the country.

“I am very happy that, with this new survey, we now have a better understanding of the AIDS epidemic in Nigeria and that will allow us to better respond to areas and people most in need,” said Dr. Camara.

Sidibé Commends Government


Former UNAIDS Executive Director Michel Sidibé visited Nigeria in March 2019 primarily to participate in the highly anticipated and historical presidential release of the results of the 2018 Nigeria AIDS Indicator and Impact Survey (NAIIS). Undoubtedly, this step to set the country's HIV epidemic record straight would be a turning point, not only for the future of the Nigerian HIV response but also for the entire west and central Africa. UNAIDS leadership wanted to convey its continued support for Nigeria, the HIV response and getting it right.

At the unveiling of the survey results by President Muhammadu Buhari, Sidibé was invited as a special guest. He welcomed the new data from the study and said the improved understanding of the country's HIV epidemic would allow Nigeria to better reach people living with HIV and people at higher risk of acquiring HIV.

"I commend the Government of Nigeria and its partners for conducting this ambitious survey, which provides us with a much better understanding of the country's HIV epidemic," he said. "While it is fantastic news that there are fewer people living with HIV in Nigeria than previously thought, we must not let down our guard. Let us use the results of this survey to better focus our delivery of HIV prevention, treatment and care services to the people in the greatest need and ensure that Nigeria gets on track to end the AIDS epidemic by 2030."

He used the opportunity of his country visit to have strategic discussions with government, bilateral partners, civil society, and the UN System. The engagement with the political leadership included the President, the First Lady, the Minister of Foreign Affairs, the Minister of Health, and the Director General of NACA.

Key takeaways included commendations to His Excellency for prioritizing the HIV response at the political level and the consideration of local production of HIV



“I commend the Government of Nigeria and its partners for conducting this ambitious survey, which provides us with a much better understanding of the country’s HIV epidemic. While it is fantastic news that there are fewer people living with HIV in Nigeria than previously thought, we must not let down our guard.”

- Mr. Michel Sidibé

commodities toward a sustainable response. The message of greater political focus on the elimination of vertical transmission of HIV and the promotion of treatment for all children living with HIV was cemented in the formalization of the appointment of the wife of the President, Aisha Buhari, as Special Ambassador for this cause. Sidibé said he appreciated the U.S. Government for its significant investment in Nigeria since 2004. He heard from PLHIV networks and CSOs on gaps and challenges in the country’s AIDS response and agreed to provide support to the network to develop its own strategic document to accompany the National HIV and AIDS Strategic Framework, a promise that was kept by UNAIDS.


Getting the Data Right: Largest HIV Survey and Revised Strategic Framework



UNAIDS Executive Director, Mr Michel Sidibé, delivers remarks at the launch of the NAIIS results — Abuja, 2019

Without accurate data, proper planning is impossible. For many years, the overall HIV response lacked accurate information and data to assess the situation and strike with precision.

Like many other countries, Nigeria had relied on triangulation of information from periodic epidemiological surveys such as the antenatal clinic Sentinel Surveys, National HIV and AIDS and Reproductive



Health Surveys (NARHS), Nigeria Demographic Health Surveys (NDHS), and Integrated Biological and Behavioural Surveillance Surveys (IBBSS) to inform its response.

This information was combined with routinely collected program data to monitor, estimate and project the population-level HIV epidemic trends in the country, and it formed the fulcrum of the National HIV and AIDS Strategic Framework, which was Nigeria's roadmap to defeating the epidemic. The data and information gathered were of limited accuracy and could not be fully reliably applied.

As these shortcomings became evident in the persistently low coverage of high impact interventions despite massive investments, the Government of Nigeria decided to get the data right. In 2018, along with its key partners, Nigeria conducted the largest-ever populationbased HIV survey, the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS).

The Federal Ministry of Health sought international collaboration and NAIIS was jointly supported by UNAIDS, PEPFAR and the Global Fund. Carried out in 2018, the survey was managed by the United States Centers for Disease Control and Prevention,

and implemented by the University of Maryland, Baltimore.

It covered all 36 states and the Federal Capital Territory, reaching about 220,000 people across 100,000 households between July and December 2018. The survey was led by the Federal Government through the Federal Ministry of Health and NACA.

The NAIIS data was based on a revised, enhanced and more accurate methodology, providing a clearer understanding of Nigeria's HIV epidemic and shining light on the progress made, and remaining gaps and challenges. This will allow the government to better reach PLHIV and people at higher risk of being infected. It will also permit the adoption of a population–location approach to delivering services to the people in areas where they are most needed.

The 2018 survey showed that the national HIV prevalence in Nigeria was 1.3% among adults aged 15 to 49 years. Previous estimates had indicated a national HIV prevalence of 3% among antenatal care attendees (ANC 2014 Survey). This showed that there were fewer PLHIV in the country than previously estimated and changed the country's standing to fourth highest for HIV prevalence globally behind South Africa,

India, and Mozambique.

However, the survey also showed that women aged 15 to 49 years were more than twice as likely to be living with HIV than men (1.9% versus 0.9%). It also showed that the difference in HIV prevalence between women and men was greatest among younger adults, with young women aged 20 to 24 years more than four times as likely to be living with HIV as young men in the same age group. Among children aged 0 to 14 years, HIV prevalence was 0.2%.

The survey afforded Nigeria the opportunity to improve its geographic targeting and prioritization, with updated state-specific HIV prevalence, illuminating state clusters of similar classification and epidemiology. The South-South geopolitical zone had the highest HIV prevalence, with 3.1% among adults aged 15 to 49 years. In the North-Central zone, it was 2%, in the South-East zone, 1.9%, and in both the South-West and North-East zones, 1.1%. The North-West zone had the lowest rate at 0.6%. NAHS should make it easier for the government and its partners to support people who are HIV-positive, to provide treatment for PLHIV to live longer and healthier lives, and to protect their families. The country can build on its record of


accelerated referrals to treatment facilities for people who test positive for the virus.

NAHS showed that in 2018 more than half of PLHIV still did not have suppressed viral loads. Viral suppression among PLHIV aged 15 to 49 years was at 42.3 to 45.3% among women and 34.5% among men. It should now be easier to focus attention on this group.

The improved understanding of HIV prevalence by population location allows for better, targeted investments in HIV prevention, treatment and care services to specified areas and people with the greatest need. Armed with the new information, the government developed the Revised National HIV and AIDS Strategic Framework 2019–2021, in tandem with the launch of the NAHS results, to better guide the national response. The document articulated the vision to end the AIDS epidemic as a public health threat.

As President Muhammadu Buhari launched the revised Framework, he said: “For the first time, the end of AIDS as a public health threat by 2030 is truly in sight for our country. I urge all of us not to relent but to increase the momentum. Let us work collectively and push for the last mile.”





The new Strategic Framework recognizes the need for a differentiated approach in strategy and interventions in the various regions of the country based on epidemiological classification and programmatic response analysis.

States are categorized by prevalence, burden, and unmet treatment needs, informing the decision for a surge strategy for high-burden states with high unmet treatment needs. The aim is to find those living with HIV in these states and swiftly place them on ART.

The surge strategy is also powered by the Treat All” policy articulated by the Federal Ministry of Health in the updated HIV guidelines aimed at expanding ART to all

“For the first time, the end of AIDS as a public health threat by 2030 is truly in sight for our country. I urge all of us not to relent but to increase the momentum. Let us work collectively and push for the last mile.”

- President Buhari

PLHIV. The revised strategy builds on the principle of long-term sustainability as a foundation for engendering the leadership, ownership and solidarity needed for going the last mile in ending the AIDS epidemic. It has strong linkages with and contributes to achieving universal health coverage and the third goal of 2030 Sustainable Development Goals—ensure healthy lives and promote well-being for all at all ages.

New Strategic Framework Fosters Sustainability through Shared Ownership

The revised Strategic Framework recommended increasing partnership and solidarity with the private sector, including the establishment of a private sector HIV Trust Fund as a critical part of a shared and corporate responsibility. The collaboration aimed at increasing domestic resource mobilization for HIV to scale-up private sector contributions from 2% to an estimated 10% by the end of 2021.

Also, the new strategy aims to increase state ownership and responsibility for HIV 2021 responses. To increase state government budget allocations and fund releases for HIV, a resolution was passed in 2018 stipulating that 0.5% to 1% of the monthly federal

allocations to states should be allocated to HIV programming. This has been approved by the National Economic Council comprising all 36 governors. This additional fund will enable states to play a more active role in the fight against HIV, ensure better coordination at the subnational level, and cushion the effect of any drop in funding from external partners and donor agencies. Key to sustainability will be the greater integration of HIV services into existing government health programmatic and financing strategies.

Another innovative approach to increasing funding is the Basic Health Care Provision Fund launched by the government in 2019. The health financing mechanism has the potential to increase access to maternal and child health services, including access to HIV services by pregnant women.

The various funds mobilized, and the deeper understanding of the epidemic will increase Nigeria's potential to achieve 95-95-95, to end the AIDS epidemic by 2030.

Moving Forward with Precision: A Surge Strategy for Treatment Saturation

Priority setting

UNAIDS noted in its Fast-Track Plan that it was crucial for countries to implement strategies that could achieve HIV epidemic control in the shortest possible time to reduce the future economic and health burden of HIV. Stakeholders in Nigeria's HIV and AIDS response have sought to deploy limited resources efficiently and



(L-R) Ms. Shirley Dady, former PEPFAR Country Coordinator, Charge d'affaires David J. Young, former Deputy Chief of Mission (DCM), U.S. Embassy Nigeria, Professor Isaac Folorunsho Adewole, Former Nigeria Minister of Health, "PEPFAR at 15" photographic exhibition, Abuja.

to produce a positive epidemiological outcome in the shortest possible period. In 2006, this informed PEPFAR's prioritization of geography and populations as the basis for planning, alongside knowledge of the HIV burden and prevalence of HIV in communities.

Benue State, which had reported the highest HIV prevalence in antenatal- and population-based surveys between 2006 and 2011, quickly became a hub of PEPFAR-funded activities, which then expanded into the nearby states of Plateau and Nasarawa.

The new approach was to achieve treatment saturation in selected states. This approach of channeling more resources to the states with the highest HIV burden was later validated in national planning documents which recognized in 2014 that 12 states—Benue, Akwa-Ibom, Bayelsa, Anambra, Plateau, Lagos, Nasarawa, Abia, Cross River, Rivers, Kano, Kaduna—plus one, the Federal Capital Territory or FCT, were responsible for 70% of the country's HIV burden.

This approach became known as the 12+1 Strategy, and it prioritized the specific states for investments to achieve a rapid reduction in HIV infection. Although there were subsequent attempts to further localize the burden of implementation, these were handicapped due to a lack of truly



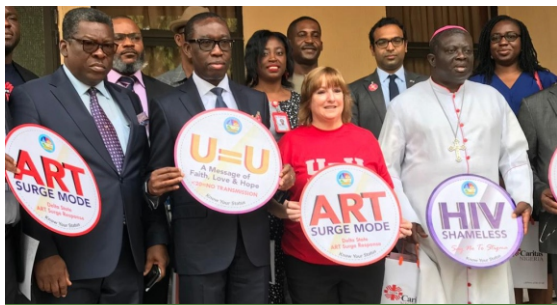
Minister of Health, Prof. Isaac Adewole (C); Director General, NACA (R), Dr. Sani Aliyu and CDC Country Director, Mahesh Swaminathan during the status review visit at the NAIS Data Monitoring Center—Abuja, 2018

representative data on the HIV prevalence and burden in the country.

In 2018, NAIS provided robust information that informed the review of Nigeria's HIV epidemiologic profile. NAIS and subsequent national Spectrum estimation showed that seven States—Akwa Ibom, Rivers, Anambra, Imo, Enugu, Lagos, and Delta—were responsible for more than 50% of the total number of PLHIV who were yet to commence treatment in the country.

Accordingly, these seven states were prioritized as surge states for treatment saturation. By adding Abia and Taraba states, where HIV programs were mainly funded by the Federal Government, the

nine states accounted for 60% of the unmet need in Nigeria.



Deputy Chief of Mission of the US Embassy, Kathleen Fitzgibbon, with the Executive Governor of Delta State, Dr. Ifeanyi Okowa, and key stakeholders at the launch of the SURGE activities in 2021

Alongside geography, PEPFAR also prioritizes investment in case finding and treatment of key and vulnerable populations, those considered to be at greater risk of HIV infection because of their social behaviors and the sociocultural perceptions toward these behaviors. These populations include people engaged in sex work or other less obvious forms of transactional sex, men who have sex with men, transgender persons, and people who inject drugs. Available data showed an increased prevalence of HIV—relative to the general population—among members of these communities, yet they face substantial legal hurdles and stigma, with related risks, in accessing HIV and AIDS services, and

sexual health services in general. Strategic case finding among these communities has been proven to be a more efficient way of locating people living with HIV and linking them to treatment services.

National Surge Plan

In line with the objectives, Nigeria put together a National Surge Plan building on the plans by PEPFAR and the Global Fund to reach 500,000 newly diagnosed PLHIV with treatment services within 18 months, from June 2019. Successful implementation of this plan has increased the number of PLHIV receiving treatment from about 1 million to about 1.5 million, and an increase of HIV treatment coverage from 55% in December 2018 to 86% by the end of 2020.

While it primarily focused on the nine states with the highest need, the National Surge Plan will serve as an innovative learning experience for HIV program implementation in the rest of the country. For this reason, the National Surge Plan is a component of the National Treatment and PMTCT Plan (NTPP) launched in 2018 by the Federal Ministry of Health.

A key theme of the Plan is recognition that all stakeholders should collaborate to remove barriers to the capacity of Nigerians to access HIV services and remain on treatment in order to have viral suppression.

The Plan leans heavily on states' responsibility to provide HIV and AIDS treatment services and mobilize hospital administrators to carry out more intensive reporting and program learning experience. It leverages the deployment of the ECHO remote learning platform for information exchange and knowledge sharing between hospitals, as well as a weekly tracking process with data transmitted to the National Data Repository, which is monitored by an incident management team led by the implementing partner and the State Ministry of Health.

Early successes in Akwa Ibom and Rivers States

From April 2019, PEPFAR prioritized the scale-up of HIV care and treatment services in Akwa Ibom and Rivers, the two states with the largest unmet treatment need for PLHIV. Consequently, the states' governors eliminated HIV-related user fees and procured rapid-test kits to improve case finding.

The implementing partners in both states—the Institute of Human Virology in Rivers and FHI 360 in Akwa Ibom—prioritized case finding among key populations as well as in identified hotspots and difficult-to-reach communities. They also worked to link newly diagnosed PLHIV to care and treatment services.



Team Nigeria at PEPFAR COP Strategy Meeting, Johannesburg, 2020

Overall, the results were impressive and showed a considerable improvement. In Rivers, weekly new enrollment into treatment rose from 82 to over 1,000 people per week. In Akwa Ibom, patient enrollment rose from 200 PLHIV to 1,500 per week. These numbers are likely to rise further with the introduction of the rapid-test kits that stakeholders are advocating for.

The experience will inform and guide implementation of similar surge efforts in other locations in the country.

Advancing HIV Service Delivery by Putting People at the Center of the AIDS Response

Ten states that were prioritized by the national AIDS response for concerted action benefited from a special program supported by PEPFAR and the Global Fund. This paid off in 2020: while many countries experienced HIV service disruptions due to COVID-19, the PEPFAR-supported HIV program in Nigeria experienced significant growth and exceeded some targets.

PEPFAR, together with its implementing partners, developed a people-centered package of services that was informed by data, best practices, and community intelligence. The package recognized that one size does not fit all and catered for the unique needs of the various populations served.

Existing community networks, including key population networks and social groups, were consulted to determine the best way to ensure that the services that people needed were available to them in their homes, at social gatherings, or through support groups—thus minimizing contact with facilities.

Community antiretroviral therapy (CART) teams went to hard-to-reach areas around the country as well as to areas effected by COVID-19 lockdowns. Programs such as a minimum three-month provision of ART and viral load services were provided at treatment pickup areas, which not only helped community-led providers to ensure that people stayed on treatment but saw a record number of PLHIV start treatment. By the end of 2020, the majority of people on treatment were included in the multi-month dispensing program, which had a large impact on HIV treatment retention and adherence.

Viral load samples were collected in the communities, sent to laboratories for analysis, and the results sent to health care facilities, from where people were notified, which had a positive impact on viral load coverage. Index testing was expanded through

community networks, ensuring continuity and safety as well as improvements in testing and case finding.

The growth in the number of people on HIV treatment saw an additional seven states moving toward treatment saturation since the initiation of the Surge Plan, where intervention efforts are dramatically scaled up. Key populations represented approximately 25% of this overall growth, as the number of people on treatment among most key populations tripled.

These results could not have been achieved without the support of community-led organizations. “The Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) wishes to thank PEPFAR for the continuous engagement of our members across the country in the provision of HIV services to people living with HIV,” said NEPWHAN National Coordinator Ibrahim Abdulkadir. “This has increased retention in care and improved the quality of life of PLHIV, as well as viral suppression among PLHIV on antiretroviral therapy.”

PEPFAR Nigeria has designed its approach so that it can be owned by the Nigerian people. The National Data Repository and the National Alignment Strategy are key building blocks of a long-term and sustainable public health and health services approach to ending the AIDS epidemic in the country.

Based on these accomplishments, Nigeria is well-positioned to accomplish the 95-95-95 targets well in advance of 2030.

“The Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) wishes to thank PEPFAR for the continuous engagement of our members across the country in the provision of HIV services to people living with HIV.”

- Ibrahim Abdulkadir

Reforming the Global Fund Country Coordinating Mechanism: Reshaping Nigeria's CCM into an Executive Body Fit for Purpose

The Country Coordinating Mechanism, which is the custodian of Global Fund grants and ensures that funds are utilized effectively, was inaugurated as a public-private partnership in 2002, and its membership includes constituencies such as civil society organizations, as well as the private sector, government officials, media, PLHIV and people involved in related health programs, communities and academia. It also includes technical partners from multilateral and bilateral organizations.

The CCM's functions are guided by its core mandate, which includes the submission of technical proposals to the Global Fund, selection of principal recipients through a transparent process, and overseeing the implementation of grants for efficiency in fund absorption and effective performance for results. For a country to access Global Fund funding on a sustained basis, it is required to have a CCM that meets the key requirements of constituency representation and gender balance.



R-L: Director General, NACA, Dr. Sani Aliyu; Senior Program Officer, Global Fund, Bastien Bandi and Executive Secretary, Country Coordinating Mechanism (CCM), Dozie Ezechukwu, during the grant making mission debrief with the Global Fund Country Team—Abuja, 2019

The CCM in Nigeria has undergone reforms to realign its objectives to its core mandate and improve efficiency. In 2006, the reforms targeted poor grant implementation and introduced a finance mechanism with more than one principal recipient per grant (public and private). This proved to be a game changer. Other changes made included reducing its size by a third to increase meeting efficiency, and tackling problems associated with ineffective local fund agents.

Immediately after the reforms, the CCM in Nigeria became a model to the extent that between 2007 to 2009, it was rated by the Global Fund as the best performing

2017 CCM Reforms and Restructuring

Global Fund Office of the Inspector General audits and CCM Eligibility Performance Assessments (EPAs), undertaken between 2010 and 2017, led to the placement of the Nigeria portfolio under the Global Fund's Additional Safeguard Policy (ASP), triggering a new wave of CCM reforms in 2017. The CCM once again began the process of reforming and restructuring itself for improved performance. The Minister and NACA DG specifically called on UNAIDS to support the CCM to undertake a comprehensive evaluation to inform the required reforms for transforming the CCM.

This evaluation made very bold recommendations for reorganization of the CCM functions into three key distinct workflows. The first was executive and policy decision making. The second was grant development, oversight planning and implementation. The third was informed participation, and broad ownership of stakeholders, with updating of the outdated CCM governance documents. This paved the way for alignment of Nigeria Global Fund programs management with the Global Fund CCM policy and the direction of the Global AIDS strategy 2021–2026.

From a 30-member body, the Nigerian CCM was restructured into a reduced 15+1-member body, with new representations from key populations, on the grounds of epidemiology, the gender constituency through the Federal Ministry of Women Affairs, and State Governments through the Health Commissioners Forum. This new wave of reforms also prompted the review of CCM secretariat staffing, instituting the office of the Executive Secretary for efficient and effective coordination of reorganized CCM functions of resource mobilization and oversight of Global Fund grants, guided by updated CCM constitution and operations manuals. An ethics committee for the management of conflicts of interest among members for improved transparency within the CCM will also be instituted.

In 2020 and 2021, under this evolving CCM structure, Nigeria was able to mobilize quickly and successfully US\$1.2 billion for the control of HIV, TB, malaria and COVID-19,

while expanding and strengthening health and community systems, the largest grants to a single country in Global Fund history.

The CCM reforms complement the Global Fund CCM evolution initiated in 2017 to strengthen CCM ethics for a holistic and coherent approach to CCMs. These reforms will ultimately place Nigeria on the path to systems strengthening for removal of the ASP while promoting country ownership for sustainability of the HIV, TB and malaria programs.

civil society organization principal recipient worldwide. Until 2010, countries with a 'C' rating in Africa were referred to CCM Nigeria by the Global Fund for learning tours to enable them to replicate the model used in Nigeria.

After the 2006 reforms, the CCM became more effective in providing the type of oversight required for the grants. In less than two years, it moved from a situation in which the Global Fund was about to cancel all grants to the country, to the point where it was seen as a model to be emulated by others. But this achievement could not be attributed to the CCM alone. Strong collaboration between NACA, the Global Fund, USAID and other partners led to an increase in available funds, from approximately to US\$300 million in 2009 to over US\$1.8 billion in 2021 .

In 2010, Nigeria secured a grant of US\$900 million for health system strengthening, the largest grant it had ever received from the Global Fund.

However, it should be noted that a 2015 audit of grants by the Global Fund Office of the Inspector General did not produce a favorable report and led to the suspension of grants the following year. The report also raised issues about conflicts of interest for some members of the CCM in Nigeria.

The Global Fund imposed a restrictive Additional Safeguard Policy on Nigerian portfolios in April 2016, meaning that the CCM was no longer autonomous in making decisions on behalf of the Global Fund.

The Global Fund secretariat then took on a stronger mandate and role in deciding how the funds were managed in-country and in

the selection of principle recipients. The situation prompted another CCM restructuring including staffing changes. When the new CCM Secretariat team came on board, the CCM's executive board and its structure came under further review.

Following wide consultations, it was recommended that the CCM's executive board membership be reduced from 30 to 15 plus 1. On 30 October 2021, under the leadership of Minister of Health, Dr. Osagie Ehanire, the three year long new reforms were adopted and implemented, thus repositioning the Nigeria CCM to become streamlined, more inclusive a key population representative by proxy, less at risk of conflict-of-interest issues and more efficient and business-like. This has helped Nigeria to, once again becoming the largest recipient of Global Fund grants for 2021-2023.

Lessons from the Donor-Dependency Era

Opponents of overseas development assistance, or ODA, argue that it breeds a culture of dependency, while the programs it supports are not sustainable and collapse when funding ceases.



L-R: Head of the European Union Delegation to Nigeria and ECOWAS, Amb. Ketil Karlsen; British High Commissioner, Catriona Laing CB; US Ambassador to Nigeria, Mary Beth Leonard; German Ambassador to Nigeria, Birgitt Ory. Behind From left: Country Director of World Bank, Shubham Chaudhur; Resident Representative of UNDP, Mohamed Yahya; Resident and Humanitarian Coordinator of the UN System in Nigeria, Edward Kallon and Country Director UNAIDS Nigeria, Erasmus Morah, at a breakfast meeting with the UNAIDS Executive Director, Ms Winnie Byanyima—Abuja, 2021. Credit: UNAIDS/A.Alabi

Proponents of ODA, on the other hand, argue that their investments save lives and improve the health and well-being of people and communities. The support is guided by the principle of global solidarity and the tenets of aid effectiveness, which increase country ownership, alignment, harmonization, and mutual accountability for results.

The Nigeria HIV and AIDS response is over-reliant on international resources, and this is extremely risky as the resources may be reduced significantly. The COVID-19 pandemic has resulted in uncertainties and global economic crises. Accordingly, it will take longer for economies to recover and current ODA commitments may falter. Thus, it may fall to recipient countries to find their own resources to fund a sizable share of HIV and health programs. Nigeria needs to rise to the occasion and increase its fiscal space to finance its HIV program, while developing innovative health financing mechanisms to reduce the significant out-of-pocket payment by households.


In April 2001, the Abuja Summit of African Leaders called for a global commitment to HIV programming and the creation of a global fund dedicated to HIV and AIDS and other infectious diseases. By May, donors had made initial pledges in support of the initiative, and in June the Global Fund to Fight AIDS, Tuberculosis and Malaria was launched. The National Antiretroviral Drug Access and Prevention of Mother-to-Child Transmission Programmes, initiated by the Federal Government in 2001, provided affordable ARVs to over 13,000 Nigerians living with the virus by 2005. The government also committed to investing US\$3.7 million annually to procure ART drugs. By 2005, it was estimated that the

government had contributed US\$10.7 million to the national response.

Nevertheless, there were challenges in maintaining the availability of ARV drugs, mainly due to weak procurement and supply chain management. In 2002, the first call for proposals to the Global Fund was issued and Nigeria responded, mobilizing US\$70.7 million. These resources allowed for the expansion of access to ARV therapy and were intended to reduce the financial barriers to accessing treatment.

Nigeria submitted another successful proposal to the Round 5 call, totaling US\$180.6 million. At the same time, PEPFAR was inaugurated in Nigeria in 2004, and Nigeria received more than US\$70.9 million to support a comprehensive HIV program. In 2005, an additional US\$113.4 million was committed. Other bilateral partners, including Canada and the United Kingdom, also provided support. Also, Nigeria was a recipient of US\$90.3 million from 2002 to 2007 through the World Bank Multi-Country HIV/AIDS Program for Africa. These huge resources, totaling over US\$500 million between 2002 and 2007, eventually dwarfed and disincentivized government allocations to HIV programming.





The National AIDS Spending Assessment for Nigeria provides evidence of the level of dependency of the HIV response on external aid. Between 2007 and 2018, the proportion of government funding for HIV programs in Nigeria ranged from 7.6% to 27.1%. For the same period, funding from the private sector ranged from 0% to 2.1%, while funding from external sources ranged from 70.8% to 92.3%.

In 2021, the two principal funders of the HIV response continued to be PEPFAR and the Global Fund. This arrangement has yielded substantial benefits for the HIV response. The program has incorporated international standards and guidelines that allow for a multi-sectoral response with partnerships among communities both at the administrative and program implementation levels.

Between 2015 and 2020, the percentage of PLHIV who knew their status increased from 54% to 90%. From 2010 to 2020, HIV-positive Nigerians who were on treatment rose from 22% to 86%, and the coverage of the prevention of mother-to-child transmission program rose from 27% to 44%. New infections fell by 26% from 2010 to 2020. Approximately 1.6 million Nigerians are today receiving free ARV therapy.

However, most of the people undergoing treatment are reliant on funds from foreign donors: Nigerian government funding contributed only 8.6% of the total expenditure on care and treatment in 2018, while international funds contributed over 70%.

This heavy reliance on external funding has its disadvantages. Apart from granting international agencies unlimited access to sensitive data and the implications for national security, the country naturally loses significant control over how its HIV program is steered and in what direction. Donor funding is also unsustainable. Priorities are shifting across the world and the HIV epidemic has moved down the ladder of importance. Disbursements from the Global Fund, for instance, have declined, falling from US\$236 million in 2014 to US\$169 million in 2018.

No one can prioritize the health needs of a country better than the leaders and citizens of the country themselves. After the leaders of various African countries gathered in Abuja in 2001 and pledged to allocate 15% of their annual budgets to the health sector, some countries exceeded this target, but Nigeria failed to do so.

In 2012, Nigeria, with support from UNAIDS, developed a domestic resource

mobilization strategy for the HIV response. This was revised in 2021 with assistance from the USG and other partners. Although the institutional arrangements for the HIV and AIDS response have been significantly strengthened in Nigeria, the resource mobilization and management components need to be refocused. NACA's resource mobilization efforts at the national level should be replicated at the state level.

As a promising initiative, Nigeria has instituted the Basic Healthcare Provision Fund founded on the National Health Act of 2014. This will support the national and state health insurance schemes. There is a need for high-level advocacy for the schemes to be universal and compulsory, and to make health care more affordable to Nigerians who are less privileged. The newly launched HIV Trust Fund has the potential to create a pool of resources that prepares the country to finally own its national response.


Nigeria can learn from Ethiopia where development funding is placed in a basket and the government exercises greater control over how it is used while it prioritizes local health needs. Making more money available for health programs may be the more difficult approach, especially with shrinking oil prices, but in the long run, it is in the best interests of the country.

It is believed that the country made the mistake of surrendering control of the bulk of the HIV/AIDS response to external donors and partners. Although donor funding constitutes less than 10% of the country's expenditure on overall health, it contributes as much as 97% of AIDS-related expenditure. Such a situation poses a risk to the health systems and people who benefit from care and support, as continued external support is not guaranteed. To defeat the epidemic, Nigeria needs to take ownership of its program by increasing domestic funding at both the federal and state levels.

The Politics of the HIV Response

Public health and politics have always been intertwined, and this has impacted the HIV response globally and domestically. The emergence of HIV and AIDS as a global public health concern has led to clashes between science and the politics of "morality," which is driven by misinformation, fear, stigma, and confusion.

Key issues debated in the politics of HIV include the ways in which HIV is transmitted and how it can best be prevented. The debate around human rights, especially



comprehensive sexual and reproductive health, and rights, has been an ongoing flashpoint.

The issues of gender equality, girls' and women's rights, commercial sex work, intravenous drug use, and men having sex with men underline the interconnections between public health and politics, as well as the economic and social inequalities both within countries and between countries.

Denial fueled by the politics of "morality" would have resulted in uncontrollable epidemics of not only HIV, but also TB and viral hepatitis. On the other hand, political acknowledgment based on science leads to public education and investment to strengthen the fight against HIV.

Politicians globally were forced to acknowledge AIDS as a public health issue after the World Health Organization created the WHO Special Program on AIDS in February 1987 and later the Global Programme on AIDS, led by Dr. Jonathan Mann, introducing the first rights-based global strategy. Working through the World Health Assembly and regional health conferences, the WHO Special Program first engaged health ministers and then helped expand the AIDS response beyond the health sector.

In 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was launched, and it adopted sector-wide political action on AIDS in which several UN agencies and entities played significant roles according to their mandates and programs. The World Bank Multi-Country AIDS Program (MAP) for Africa in 1997 also made a significant impact. In 2000, the UN Security Council, for the first time, held a debate on a health issue (AIDS) followed by a special session of the UN General Assembly in 2001, which cemented AIDS as a global political issue.

In 2000, the UN General Assembly adopted the Millennium Development Goals (MDGs), which committed to "halting and reversing the AIDS epidemic by 2015." Demands for affordable drugs and public health-based treatment followed, and high-level public and private negotiations led to the emergence of generic ARVs by 2001. In Africa, HIV became a leading cause of death and the rising pandemic spurred calls for a global financial response.

The historic call by then UN Secretary-General Kofi Annan for a war chest of US\$7 billion to US\$10 billion at the Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, hosted by President Olusegun Obasanjo in Abuja, provided an initial global financial target required

for a truly worldwide effort against HIV and AIDS. This in turn focused political will, enhanced scientific progress, and led to the creation of vital institutions with political directions for increased global financial and political commitments to fight HIV and AIDS.

In 2001, the UN General Assembly Special Session on HIV/AIDS led to the declaration adopted by all member states of the United Nations. With the establishment of the Global Fund in 2002 and PEPFAR a year later, the huge funding of the two entities fueled global political machinations on who would manage the resources to drive the response and on the roles of related institutions. Civil society and the media played and continue to play a huge role in the global process, while the UN and regional organizations, such as the Organisation of African Unity (later the African Union), provide leadership.

In individual countries, including Nigeria, PLHIV especially have helped galvanize movements to fight critical issues such as stigma and the high cost of ARV treatment. But while there has been progress, there has also been a backlash, especially against key populations fighting against AIDS. In countries like Nigeria, conservative forces have tried to roll back progress by passing laws prohibiting same-sex relationships,

such as the Same-Sex Marriage (Prohibition) Bill 2014. Claiming to be made on “moral” and “ethical” grounds, such laws have resulted in reinforcing prejudice, stigma, and discrimination, which in turn have had a negative impact on treatment access.

Alongside increasing discrimination against key populations, opportunities are being missed to protect vulnerable groups from HIV. Adolescent girls and young women remain disproportionately affected by HIV in Nigeria. In almost all countries with significant HIV prevalence, young women aged 15 to 24 years are three to five times more likely than their male counterparts to have HIV (2018).

Adolescent girls are also targets of multiple forms of gender-based inequalities and violence especially forced child “marriage,” which often encompasses sexual abuse, intimate partner violence, marital rape, female genital mutilation, sexual exploitation, and trafficking. The importance of protecting and empowering girls cannot be overstated as they are largely invisible, underserved and underrepresented in policies, services, and social investments.

In general, sustainable action to end the HIV epidemic will also mean ending all discrimination against key populations.



United Nations' Defining Moment in Nigeria: UN Role in the Country, Including and Beyond COVID-19

Q&A with Edward Kallon, United Nations Resident Coordinator and Humanitarian Coordinator in Nigeria

How has the UN System in Nigeria responded to national COVID-19 efforts?

Edward Kallon: The first confirmed case of COVID-19 in Nigeria was on 27 February 2020. In March, a Presidential Task Force on COVID-19 (PTF) was established by President Muhammadu Buhari and chaired by the Secretary to the Government of the Federation, Boss Mustapha. Its first task was to develop the National COVID-19 Multi-Sectoral Pandemic Response Plan, a framework for stakeholder agencies and organizations to work together to prevent, prepare for and respond to the pandemic.

We at the United Nations have developed a strategic focus to bridge the health, humanitarian and socioeconomic issues involved. The UN response was an organized, strategic engagement within our system in Nigeria. We used the UN



Edward Kallon, United Nations Resident Coordinator and Humanitarian Coordinator in Nigeria, Oct. 2016 - Nov. 2021

Country Team mechanism, comprising all entities of the UN, as the discussion-team structure for our COVID-19 response. I established a core advisory group to act as a crisis management committee to advise and support me in engaging with the larger UNCT, along with the government and other partners.

We came up with a plan based on broad principles of UN operations, with six response objectives, each with a strategic direction. It was built on two critical strategic frameworks in the country: first, the UN Sustainable Development Cooperation Framework between the United Nations System and the Government of Nigeria, and second, the Humanitarian Response that

guides the UN response to conflict-affected areas, especially North-East Nigeria and the Boko Haram crisis.

The plan focused on the 10 pillars of the PTF, which served as guide for the UN support to the government. What was innovative was leveraging the guiding principles of engagement in the HIV response. This guided us to come up with the Four Ones Coordination mechanism, created for national authorities and partners to work together to prevent, prepare and respond to the COVID-19 pandemic. The Four Ones Coordination mechanism, emanating from experience within the HIV response, included:

- One national COVID-19 multi-sectoral pandemic response plan
- One COVID-19 national coordinating authority with a broad-based multi-sector mandate
- One COVID-19 monitoring and evaluation system for tracking and reporting
- One COVID-19 financing and investment platform

This guided our engagement with the PTF and informs how we marshal the resources of the UN System to deliver and support the Government of Nigeria to prevent, prepare and respond to the pandemic.

We worked together to establish the One UN Basket Fund for COVID-19 to mobilize resources from multilateral and bilateral donors, the UN System, foundations, the private sector, and philanthropic organizations. In 2020, the Basket Fund mobilized US\$61.3 million, including seed capital of over US\$2.2 million from the UN System. The Fund has served to procure urgent essential medical supplies to boost the government's effort.

The UN has also supported the government to leverage a partnership with the Global Fund to mobilize resources of about US\$51 million.

When we came together as one, we were able to advocate for inclusiveness, and leverage the national HIV, malaria, and the polio infrastructure for the COVID-19 response. We utilized what was already existing in the country to support the efforts of the government efficiently. We also used our combined strength to foster accountability and coordination.

The strength of the UN System is critical, and it lies in high-level technical assistance, policy advisory services, and the enhanced delivery of national services. On the COVID-19 situation, we came together to provide epidemiological and surveillance analytics to support the Nigeria Center



for Disease Control (NCDC) for national strategy development. This ensured that global best practices were at hand.



UN Secretary-General Antonio Guterres visits Nigeria for the first time, Maiduguri, May 2022

How was multilateralism applied in the UN response under your leadership?

Edward Kallon: If there was ever a time when we valued the importance of multilateralism as a mechanism to respond to the needs of states, I think COVID-19 is one of those engagements. We were able to work with the Government of Nigeria, together with donors, both multilateral and bilateral, along with foundations and the private sector. Such a multilateral framework effectively supports the efforts of Nigeria, and it is an interesting example of how the UN System is able to leverage its synergies and comparative advantages in targeting

specialized population groups, while addressing critical cross-cutting issues with the major objective of ensuring that no one is left behind. I think the establishment of the One UN Response Plan and the One UN Basket Fund for COVID-19, in partnership with the Government of Nigeria and its development partners, is a demonstration of a strategic multilateralism response.

What financing mechanism was adopted by the UN and how has it been effective in addressing the national COVID-19 emergency?

Edward Kallon: One of the most strategic efforts of the UN System and the PTF was to establish one financing mechanism for the COVID-19 response; and the One UN Basket Fund was the instrument used. The One UN Basket Fund is facilitated and implemented in Nigeria, through a project management board comprising representatives of the PTF, relevant government agencies, contributing donors, and the UN System itself. At the start of the pandemic, the UN System was able to mobilize over US\$2.8 million for essential medical supplies to assist the government. The Basket Fund was originally designed to direct investments toward the 10 pillars of the PTF Plan. But over time, we looked at a specific framework to bridge the health, humanitarian, and socioeconomic issues

of the pandemic. At that time, we began supporting socioeconomic intervention for vulnerable groups, with measures such as cash transfers and food distribution.

As of September 2020, the Basket Fund Board had approved the allocations and recommendations of the Technical Review Board for eight proposals totaling around US\$51 million, of which US\$26.1 million is to be used for the procurement of essential medical supplies and equipment.

In addition to the procurement of essential medical supplies, part of the fund was used for programmatic activities:

- US\$2.3 million for technical support in case management
- US\$9.7 million for support in risk communication, community, and civil society engagement
- US\$5.1 million for surveillance and infection prevention and control
- US\$7.6 million for cash transfers

In brief, the finance mechanism used has adapted to the current context and has mobilized all stakeholders to work together to provide efficient and effective support to governments in a period of pandemic.

How has the UN supported the Nigerian government to leverage the existing health infrastructure as part of the COVID-19 response?

Edward Kallon: One of the lessons we have built upon was leveraging the national HIV, malaria, and polio infrastructure for the COVID-19 response. For example, the recourse to community volunteers, laboratory facilities and existing social mobilization against these diseases for the COVID-19 response was of immense value. This enabled us to concretely strengthen our coordination and engagement at the federal and state levels, ensuring that all facilities and volunteer networks on the ground were mapped and brought into the COVID-19 response in a timely manner. So, we built on the infrastructure and partnerships in place. We tried to maximize and optimize existing engagement to support the government in its response to the pandemic.





Top left: R-L: First Lady of Oyo State, Madame Florence Ajimobi (3rd R), Director Resource Mobilization NACA, Josephine Kalu (L), NASCP Coordinator Dr Sunday Aboje (2nd L), Director General, NACA, Dr Sani Aliyu, UNAIDS Country Director, Dr Erasmus Morah; Chief of HIV, WHO HIV Specialist, Dr Rex Mpazanje , during an advocacy visit with the First Lady - Oyo State, 2016.

Top right: Director General, NACA with the NACA Directors. L-R: Alex Ogundipe, Josephine Kalu, Kayode Ogungbemi, Emmanuel Chenge, Baidi Mohammed Gajo, Nsikak Ebong, Akudo Ikpeazu, Gregory Ashefor.

Bottom left: UNAIDS Country Director, Nigeria, Dr Erasmus Morah; UNODC Country Representative, Oliver Stolpe (2nd R); UNFPA Deputy Representative, Erica Walker (3rd R) UNAIDS staff - Melissa Sobers, Gabriel Undelikwo, Rupa Bhadra and Doris Ogbang at the NACA Red Ribbon Award – Abuja, 2019.

Bottom right: Director General of the National AIDS Coordinating Agency, Dr. Gambo Aliyu discusses with National Coordinator of Network of PLHIV (NEPWHAN), Abdulkadar Ibrahim and Civil Society for HIV/AIDS in Nigeria Walter Uguocha during a courtesy meeting with NEPWHAN.





PROFILE OF KEY HIV CHAMPIONS AT THE STATE LEVEL

Louis Anyasoro

Louis Anyasoro, former Community Mobilization Officer of the Anambra State Action Committee on AIDS, was always sympathetic of PLHIV, providing technical support and involving them in the planning and implementation of all activities even before this was spelt out in the Global AIDS Strategy. He was always championing their cause and was committed to helping the community of PLHIV in their programs and projects.

Donald Duke

Donald Duke, Former Executive Governor of Cross River State. This transformation- and reform-minded governor changed the face of HIV in the state. He gave HIV greater visibility and made World AIDS Day an integral part of the Calabar carnival. He invested and personally attracted support for the state HIV/AIDS response from several multilateral and bilateral partners and foundations that facilitated the availability of and access to the full cascade of HIV services. His distinguishing actions included compulsory condoms in hotels and entertainment venues, the establishment the State Agency for the Control of AIDS (CRSACA) with himself as chairman, the Anti Stigma and Discrimination Law, and regular reviews and updates on the progress of the state HIV response. He also ensured that the state and local government HIV structures were functional, with the appropriation and release of resources. Counterpart contributions were regularly paid for the implementation of partner-supported HIV intervention projects.

Sam Ominyi Egwu


Dr. Sam Ominyi Egwu, first Executive Governor of Ebonyi State, established and funded an independent agency of the State government, the Ebonyi State Action Committee on AIDS (EBOSACA), focused on the coordination of the State HIV response in 2003. In 2005, when the availability of HIV treatment was scarce and access difficult, he approved and released state funds for monthly transport of all PLHIV from Abakaliki to Lagos for HIV treatment at a PEPFAR site, the 68 Nigerian Army Reference Hospital in Yaba. He also paid the required State counterpart funds for the implementation of partner-supported HIV intervention projects in the State between 2003 and 2011.

Malo Christopher

Malo Christopher was the first PLHIV in Enugu that lived openly with his HIV status and gave others the courage to openly declare their HIV status and fight for their rights. He founded the premier support group in Enugu, the Coal City Association of People Living with HIV/AIDS and was the chair of NEPWHAN for nine years. He mentored PLHIV in the state and played a key role in developing state strategic plans.

Amina Muhammad

Amina Muhammad was among the pioneer M&E officers at the PHC level in Adamawa State. Her dedication and tireless efforts in the HIV program saw the SACA management recommend her transfer from the LGA to the state government to



take up the coordination of the Adamawa State HIV health sector response. She led the FHI 360 state implementation team, which received the Best State Team Award. She was also recognized by Adamawa SACA in December 2020 as an icon of the HIV fight in the state.

Hassan Mustapha

Hassan Mustapha was the first PLHIV to openly declare his status and appear at events targeted at demystifying HIV in Borno State. He has been a source of inspiration to PLHIV and has supported many to declare their status and combat stigma and discrimination through The Hope Initiative, which he leads. In addition, he has been at the forefront of intensive advocacy and lobbying for the well-being of PLHIV and advancing issues around political support for HIV interventions in the state. He served in the Lake Chad Basin HIV/AIDS Initiative (2009–2012) and on the State HIV/AIDS Implementation Committee (2012–2014).

Ruth Bello Nabe

Dr. Ruth Bello Nabe is a consultant physician (gastroenterologist/hepatologist) who was appointed Executive Director of the Nasarawa State AIDS Control Agency (NASACA) in September 2018. She has made meaningful contributions to the state's HIV response especially around the state government's contribution through several advocacies that resulted in increased funding from N4 million to about N80 million per annum. She also contributed significantly to the HIV surge response in collaboration with the implementing

partner, which resulted in placing an additional 20,000 PLHIV on treatment within two years. Dr Nabe also championed the implementation of the HIV Anti-Stigma and Discrimination Law in Nasarawa. The law was enacted in 2013 but was not fully implemented until she took office in 2018. This has led to fewer cases of stigma and discrimination, and more meaningful involvement of PLHIV in the state's HIV response.

Esse Nwakanma

Esse Nwakanma, as Executive Director of the Positive Care and Development Foundation (PCDF), gave a human face to HIV in Cross River and helped save the lives of many who were in a state of despair and hopelessness. She pioneered the establishment of the Network of People Living with HIV in the state and served as its first coordinator. She facilitated HIV testing, and provided home-based care, as well as counselling and mentoring for adolescents and young people, women and PLHIV. Her exemplary work in sexuality and reproductive health and in economic empowerment for PLHIV stands out.

Morolake Odetoyinbo

Morolake Odetoyinbo is the founder of Positive Action for Treatment Access (PATA) and Mary's Home for Adolescent Girls in Lagos. A licensed mental health counselor, activist, advocate, coach, public speaker, and radio and TV producer, she has worked extensively on issues related to HIV/AIDS, LGBTQ+, sexual and reproductive health and women's rights. Rolake has become a powerful

global voice for HIV treatment access and women's sexual and reproductive health and rights. She has served on advisory committees for WHO, UNAIDS and the Global Fund. In 2011, she was named by Women Deliver as one of the world's top 100 people delivering for women and girls globally.

Valerian Maduka Okeke

Valerian Maduka Okeke, Archbishop of Onitsha Diocese, has helped the community of PLHIV for years. He regularly supports the NEPWHAN support groups with nutritional items, and provides them with psychosocial support. He cares for PLHIV in the state openly and consistently.

Olaokun Soyinka

Dr. Olaokun Soyinka A public health physician, development expert, politician and former Commissioner for Health in Ogun State, he has been at the forefront of improving the governance structure of the HIV architecture in the state. As Commissioner for Health between 2011 and 2015, he rallied support from a coalition of civil society organizations to push for the passage of a bill for the establishment of the Ogun State AIDS Control Agency in 2012. Dr. Soyinka laid the foundation for a strong governance structure for AIDS control in Ogun. During his tenure as Commissioner for Health, he also pushed for the operationalization of the Ogun State community-based health insurance scheme, Araya.

Ifeanyi Ugwuanyi

Ifeanyi Ugwuanyi, Governor of Enugu State since 2015, has contributed to the HIV/AIDS response through his concern for the welfare of PLHIV. His political leadership helped lead to the enactment and signing into law of bills protecting the rights and privileges of PLHIV, such as the Enugu State Violence Against Persons Prohibition (VAPP) Law 2019, and the removal of all encumbrances (e.g., user fees) to PLHIV accessing care in public hospitals in Enugu. He has supported bills on the welfare of PLHIV, as well as supporting HIV/ AIDS preventive and control measures.

Ashi Grace Wende

A public health expert with a background in nursing and midwifery, and a seasoned health development specialist with over 30 years' experience managing health programs, Wende was exemplary in her leadership of the HIV/AIDS response in Benue, both with the State Agency for the Control of AIDS (BENSACA) and the State Ministry of Health for 16 years. She served as the Executive Secretary of BENSACA from 2008. During her leadership at BENSACA, she led the rapid scale-up of HIV treatment that eventually saw the state achieve near saturation of treatment as adjudged by the 2018 NAIIS survey. She is a recipient of the Productivity Merit Award of the Federal Government of Nigeria for the best performing and productive State AIDS Control Agency in Nigeria 2013.

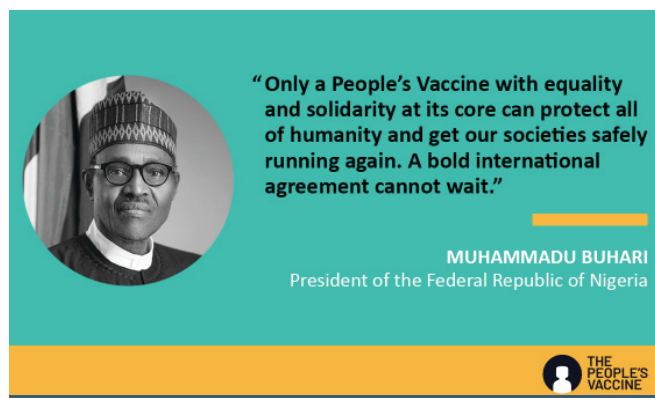


CHAPTER 4

THE DAWN OF A NEW DECADE
AND THE ARRIVAL OF A NEW THREAT

At the dawn of a new decade, the contribution of many brave and hard-working individuals had led the country to a new beginning, and their efforts were recognized at an event to commemorate the 15th anniversary of PEPFAR. However, these individual achievements were overshadowed by the stark reality that Nigeria was still too dependent on donor funding for the AIDS response to be sustainable. HIV was still not a significant enough proportion of health spending, and the 2030 Sustainable Development Goals, particularly SDG 3—“ensure healthy lives and promote well-being for all at all ages”—did not look within reach.

It was against this backdrop that the COVID-19 pandemic came to Nigeria. The country’s response to this new public health threat clearly drew on lessons learned from the HIV response, in particular the need to act fast and be decisive. With COVID-19 battering Nigeria for the second time in November 2020, the leadership of the Nigerian Presidential Task Force on COVID-19 held a retreat to brainstorm the country’s plan of action. The Federal Minister for Health Dr. Osagie Ehanire adopted the language and approach of dealing with HIV: “know your pandemic and know your response.”



This means resisting the temptation to have a blanket response, and instead do the hard work of customizing responses according to local conditions and needs, especially in terms of finding effective non-pharmaceutical responses. Earlier lessons from the AIDS response that benefited the fight against COVID-19 included coordinating diverse multi-sectoral partners, leveraging HIV testing and the community volunteer infrastructure to scale up the COVID-19 response, and a rights-based approach.

As the COVID-19 epidemic in Nigeria has threatened the HIV response, by, for example, interrupting supplies of antiretroviral medications, it has also brought about new partnerships and creative solutions to overcome such obstacles. At the same time, the expertise from the HIV epidemic of organizations such as UNAIDS has benefited the country’s COVID-19

response. UNAIDS, uniquely positioned to mobilize political capital and goodwill in the country, has helped to bring resources and better lines of communication, coordination, and accountability to the national COVID-19 response.

As for the HIV response, there are still significant gaps in the humanitarian emergency context, and among uniformed services, older adults and people living with disability. More also needs to be done to boost the country's research capacity and to ensure sustainable financing.

Celebrating Heroes of the HIV Response (2019)



US Ambassador to Nigeria, W. Stuart Symington presents an award to NEPWHAN Coordinator, Dr Pat Matimola during the celebration of heroes award event—Abuja, Nigeria 2019



PEPFAR celebrates heroes of the HIV response

On June 10, 2019, PEPFAR honored individuals that had made momentous contributions to the control of the HIV epidemic in Nigeria, the culmination of a year-long program of activities in commemoration of PEPFAR's 15th anniversary. Among the awardees were Prof. John Idoko, Dr. Sani Aliyu, Mrs. Samuel Grace Toni, and Mr. Victor Olaore Omoshehin. The full list of awardees is below.

Drawn from government, civil society and other spheres, these individuals served those affected by HIV by providing outstanding leadership and fighting against the stigma and discrimination that impedes HIV service uptake.



L-R: Director General NACA, Dr. Gambo Aliyu; Regional Director International Community of Women Living with AIDS Africa (ICW-WA), Reginald Assumpta and Director Policy, NACA, Dr. Kayode Ogungbemi. during the SRNR award presentation to DG NACA in Abuja



NACA celebrates heroes of the HIV response – Abuja, 2019

At the event, then U.S. Ambassador W. Stuart Symington said: “Through the leadership and generosity of the American

Government and people, together with the work of many partners, PEPFAR has saved millions of lives, averted millions of infections, and changed the course of the AIDS epidemic.”

PEPFAR has kept its commitment and sustained its support for the global HIV and AIDS response. PEPFAR continues to play a major role in accelerating progress toward the global goals for HIV epidemic control and the UNAIDS 95-95-95 goal. In celebrating PEPFAR, it is imperative that we remember and celebrate these phenomenal men and women: Prof. Babatunde Olukayode Osotimehin, Prof. John Idoko, Dr. Sani Aliyu, Mrs. Samuel, Grace Toni, Mr. Victor Olaore Omoshehin, Ms. Tobore Ovuorie, Dr. William Blattner, Mrs. Ukam Reginald Assumpta, Dr. Patrick Olabiyi Matemilola, Mrs. Lucy Attah Enyia, Mr. Alban Anonyuo, MWO Musa Emmanuel (rtd), Major General Ogbonnaya Simon Njoku (rtd), Major General Tahir Umar (rtd), Major General Life Ajemba (rtd), and Brigadier General Nurudeen Ayoola Hussain (rtd).

To date, the U.S. Government’s global commitment to fighting the AIDS epidemic stands at US\$85 billion. In Nigeria alone, it has invested more than US\$6 billion in the national HIV and AIDS response. PEPFAR represents the largest commitment, by any nation, to address a single disease in history.



Taking AIDS Out of Isolation and Sustaining the Response

Health sector financing in Nigeria has always lagged the path charted by global best practice. In April 2001, African Union countries made the Abuja Declaration, urging African governments to dedicate 15% of their national budgets to health care. In 2010, WHO reviewed the progress and found that only one country had achieved the target. At that time, government domestic expenditure on health for each member state of the African Union was about US\$10 per capita.

While Nigeria adopted the Declaration, its overall health investment has hovered between 3.7 and 5%. Thus, it invested less than US\$5 per capita for health, far below the 2001 commitment. For the investment to meet global standards, the country needs to invest at least US\$85 per capita.

In Nigeria, most of the expenditure on health is currently borne, via out-of-pocket payments, by households that are already on the periphery of poverty. This worsens the conditions of those already experiencing serious economic hardship. For most health issues, upfront payments or user fees are required before accessing services.

In the current global health context, it is important to look at how Nigeria will achieve the 2030 Sustainable Development Goals, particularly SDG 3. To do this, it is imperative to build adequate and resilient systems for health at all levels and across disease priorities. For this to be actualized, domestic resourcing for the HIV response has two key features that must quickly be addressed. Nigeria is too heavily donor-dependent, and domestic funding has historically been very low, with bilateral donations from PEPFAR, USAID, the CDC, the U.S. Department of Defence and multilateral resources (Global Fund, UN agencies, and the World Bank) providing the bulk of the resources. Since 2004, Nigeria has received close to US\$7 billion from the U.S. Government. The Global Fund's investment in the country over the years has been about US\$28.62 million for HIV and AIDS.

HIV has not featured substantially in Nigeria's general health financing, partly because of the enormous global attention to the HIV response in the country. The National AIDS Spending Assessment (NASA), 2015–2018 showed that the government contribution to the HIV/AIDS response in 2018 was 17.18%. It has varied widely from the NASA baseline year of 2007 to date. The lowest contribution of 7.6% was in 2008 and the highest of 27%

in 2014. International contributions to the HIV response hovered between 92% in 2008 and 70.8% in 2014.

Inconsistent and unsustainable HIV financing impacts the country's ability to achieve the target of ending AIDS by 2030. One of the areas in which Nigeria is significantly lagging, and remains off-target for achieving the goal, is elimination of mother-to-child transmission. The NASA showed that there was extremely low expenditure on PMTCT programs in Nigeria, accounting for 0.24%, 0.03%, 3.57% and 1.23% of total HIV expenditure in 2015, 2016, 2017 and 2018, respectively.


Nigeria has attempted maximizing opportunities to diversify funding sources and increase domestic resource allocation in three ways: "growing the pie," leveraging existing health and social sector financing mechanisms, and continuing to nurture a partnership with external donors.

A recent effort to grow the pie was the presidential commitment to provide treatment for at least 50,000 PLHIV annually using government resources. The federal budget for 2020 was approved with substantial resources for HIV (N5 billion for NACA and N1 billion for the Ministry of Health) to cover this presidential commitment, in addition

to an estimated 50,000 already under government coverage. Another step was the groundbreaking decision to dedicate between 0.5 and 1% of the states' monthly federal allocation to HIV, which increased the HIV budget allocation at the state level. The third initiative for growing the pie was ensuring the financing and full implementation of the HIV Trust Fund. The main objective of the private sector-led Trust Fund is to increase private sector contributions to the national HIV response from less than 1% to 10%.

The second opportunity for ensuring sustainable financing for the HIV response is leveraging various financial instruments, including the National Health Insurance Scheme; state health insurance scheme; state health funds; single accounts for health; and integration of HIV into other health, social protection and poverty alleviation programming, including ensuring that PMTCT services can be accessed through Save One Million Lives. SOML is a government maternal and child health program supported by the World Bank, which provides incentives, based on the achievement of health outcomes, and helps to drive institutional processes needed to achieve these results. It includes a Performance-for-Results (PforR) initiative financed by a US\$500 million International Development Association credit support.





It is important for leadership at all levels to implement sustainable financing for health. States need to have health trust funds and health insurance schemes. The proposed National Health Insurance Act would help to mobilize leadership for sustaining HIV financing.

The sustainability of the HIV response cannot be delinked from the discourse on sustainable health and social sector financing in Nigeria or from the Global Call to Action in achieving the SDGs and universal health care for its people. Regrettably, Nigeria does not have a national sustainability plan for the HIV response. While the revised NSF has a framework that can be the basis for articulating a sustainability strategy with clear targets, it is important for the plan to take HIV out of isolation and propose concrete actions for shared responsibility, global solidarity and mitigating the complacency in domestic funding of the HIV response in Nigeria. This means that in addition to a domestic resource mobilization strategy for HIV, Strategic Pillar Five of the Harmonized NSHDP II on Predictable Financing and Risk Protection should include HIV. To strengthen the roadmap, HIV financing should be integrated into health financing.

The emergency structures put in place to contain the HIV epidemic are expensive and largely funded by overseas development assistance (ODA), and the emergence of diseases like COVID-19 is likely to divert ODA resources away from HIV and AIDS. In 2021, international donor funding accounted for about 80% of Nigeria's HIV programming. This is worrisome when compared to South Africa, which provides 80% of its own funding while foreign donors make up the remaining 20%. This raises special concern as to the ability of Nigeria to assume ownership and funding of the HIV treatment program should donor or development assistance cease.

Overreliance on foreign donors makes it difficult for countries to own their development agenda and adjust when foreign donors leave. ODA has been declining since 2000 and Nigeria must seek to develop alternative strategies for funding HIV and AIDS prevention, treatment, and care programs.

Many suggestions have been made for domestic resource mobilization including integrating ART services into the benefit package of the National Health Insurance Scheme as an effective cost-saving strategy. Nigeria still runs vertical programs for HIV and AIDS, tuberculosis, malaria,

immunization, and family planning. This is largely because many of these programs were initiated or expanded using donor funds.

Stakeholders in the health sector argue that integration would save money and increase efficiency. The FMOH is driving an aggressive campaign to rehabilitate at least one primary health care facility in each geopolitical ward. These are to be funded through the Basic Health Care Provision Fund and should host these health programs in an integrated manner.

PMTCT has become a cardinal point of the country's anti-HIV strategy due to the high burden of pediatric HIV. It is important that PMTCT is integrated fully into Maternal, Neonatal and Child Health Services, which should also be coordinated within PHCs. Full implementation of the National Task Shifting and Sharing Policy, which allows for a sharing of the burden of care between physicians and non-physicians will greatly assist the take-off of integrated services at the PHC level.

The National Basic Health Care Provision Fund—christened “Huwe,”—was launched in 2019 and serves to increase the fiscal space and overall financing of the health sector to help Nigeria achieve universal health coverage. Funding of the fund was derived from contributions, including from an annual grant of not less than 1% of the Federal Government's Consolidated Revenue Fund, donors, and other grants.

Successfully mainstreaming HIV and AIDS into the health system should be a cost-effective way of running the health sector and ensuring universal health coverage. Integration of HIV services will also reduce stigma and discrimination. In the initial stage, employment of non-physician health care providers, task shifting, and capacity building will increase the ability to handle the workload and provide ready support. With such integration, there is great potential for achieving cost reduction and efficiency in care provision in the long term.



National Task Shifting and Sharing Policy

Due to a shortage of health care workers, facilities offering essential health care services have unused capacity, and community health extension workers may be underutilized. The National Task Shifting and Sharing Policy aims to change the curriculum for pre-service education and in-service training to produce more knowledgeable and skilled health care workers. This is a temporary measure designed to optimize the use of health facility staff.

Byanyima Applauds Country's Progress

UNAIDS Executive Director and United Nations Under-Secretary-General Winnie Byanyima visited Nigeria in March 2021 to meet with President Buhari and discuss the government's priorities and strategies for fighting the colliding pandemics of COVID-19 and HIV. Ms. Byanyima applauded the country's progress toward ending AIDS as a public health threat and the strong partnership between the government and UNAIDS, working toward epidemic control by 2030. She thanked President Buhari for being an early champion of the People's Vaccine campaign, which called for a fair and equitable distribution of vaccines against COVID-19 to ensure that poorer countries were not left behind in the response. She also advocated for and secured President Buhari's political support and commitment for the new Global AIDS Strategy 2021–2026 and UN General Assembly High-Level Meeting, which took place in New York in June 2021 to endorse the new Political Declaration on AIDS.


In his video presentation at the High-Level Meeting, the President spoke on Nigeria's commitment to adopting a robust and progressive evidence-driven Political Declaration on AIDS. His Excellency also gave his assurance that Nigeria would urgently translate the new Political Declaration into country actions as a means of decisively addressing the HIV epidemic in the African region.



UNAIDS Executive Director, Winnie Byanyima, Minister of Women Affairs, Dame Pauline Tallen, First Lady of Ekiti State, Erelu Bisi Fayemi, and Former Minister of Education, Oby Ezekwesili, stand up with powerful women in leadership and advocates for ending gender inequality and promoting women leadership—at the commemoration of International Women’s Day jointly organized by UN Women Country Representative Nigeria, Comfort Lamptey and Resident Representative UNFPA Nigeria, Ulla Elizabeth Mueller —Abjua, March 2021

As Nigeria’s Special Guest of Honor for the commemoration of International Women’s Day, Ms. Byanyima delivered the keynote address at the event on 8 March 8, 2021. She stressed the importance of women’s leadership and participation at all levels of decision making to ensure that issues of importance to women, such as ending gender-based violence and expanding access to essential services, including health and education, were addressed.

One of the highlights of Ms. Byanyima’s mission was a site visit to a community “one-stop shop” clinic in Abuja that focused on meeting the evolving needs of key and vulnerable populations with quality services including HIV prevention services,



referral/linkages to HIV treatment, STI management, tuberculosis prevention services and post GBV care and psychosocial support. She engaged with the end users of the system who shared their stories of challenges faced during the COVID-19 restrictions and of the benefit of the one-stop shop in the community. Ms. Byanyima also met with community groups and activists who have been instrumental in minimizing the disruption to HIV testing, treatment and care services despite the challenges caused by the COVID-19 pandemic and the measures taken to contain it.

She joined the National Coordinator of the Network of People Living with HIV in Nigeria, the NACA Director General and the United States Ambassador for the launch of the maiden community-led monitoring initiative and national framework to guide future community-led responses and advocacy. Additionally, Ms. Byanyima witnessed the signing of a Memorandum of Partnership between NACA and the National Human Rights Commission for the integration of human rights principles into HIV policies and programs, including during pandemics and emergencies. She assured officials of UNAIDS' continued support and partnership with Nigeria to address inequalities and achieve and sustain epidemic control.

Nigeria Commits to New Global HIV Targets

In a recorded message to the UNGA High-Level Meeting on AIDS, held in New York from 8 to 10 June 2021, President Muhammadu Buhari added Nigeria's voice to calls for a global commitment to new global HIV targets for 2021–2026. "My government commits to adopting a robust and progressive evidence-driven political agenda on AIDS to assist in addressing and ending AIDS as a public health threat by 2030," he said.

Nigeria's shift from a data-poor country to a data-rich one, thanks to the results of the world's largest AIDS indicator and impact survey, means the country was able to set realistic targets and identify those PLHIV who were not being reached with the

necessary services, he said. This further enabled Nigeria, through the support of the United States Government, the Global Fund, civil society, and other partners, to enroll almost 1.5 million Nigerians in life-saving HIV treatment.


In addition to making good on its commitment made at the High-Level Meeting Side Event at the 72nd Session of the UN General Assembly in September 2017, to start placing 50,000 Nigerians living with HIV on treatment annually, using Government of Nigeria resources, President Buhari noted that he had personally granted an exceptional waiver for the use of competitive international tender facilities to procure antiretroviral medicines at more than 30% cost efficiency, enabling more Nigerians to be placed on life-saving antiretroviral ARV treatment with the same budget. Nigeria has also committed to playing its part in funding for the Global Fund: at the Global Fund's Sixth Replenishment Conference in 2019, Nigeria pledged US\$12 million.

"The Government of Nigeria is fully committed to the SDGs, and other international and regional initiatives toward eliminating HIV and AIDs in Africa and indeed the world by 2030. We will continue to work with fellow heads of state and governments across the continent to ensure sustained high-level political engagement in achieving these goals," said President Buhari.

"I reiterate my government's full support for a clear and ambitious Common African Position & New Political Declaration that can help to reduce the public health threat of HIV and strengthen resiliency to end AIDS, and in addressing current and future



Nigeria PEPFAR Coordinator, Mark Giambone receiving an award of appreciation from Hon. Minister of Health, Dr. Osagie Ehanire at end of his tour in Nigeria



health emergencies. We further commit to urgently translating all new and agreed Political Declarations into country action as a means of decisively addressing the HIV epidemic in the African region," he said.

HIV and COVID-19: The Lessons Learned

Since early 2020, every country in the world has been compelled to deal with the COVID-19 pandemic, while still grappling with the HIV pandemic. These have been referred to as the colliding pandemics. Nigeria's response to COVID-19 bears all the hallmarks of lessons learned from the HIV response. When COVID-19 made its way to Nigeria, President Buhari acted quickly to put in place travel restrictions and set up the multi-sectoral Presidential Task Force on COVID-19. This benefitted from excellent support from the Federal Ministry of Health and the Nigerian Center for Disease Control led by the Director General, Dr Chikwe Ihekweazu. Dr Chikwe, a Nigerian epidemiologist and public health physician had an impactful role in the preparation of Nigeria to address COVID-19, utilizing modern approaches while importantly retaining Nigeria's context. His team quickly revised the genomic

surveillance strategy to sequence samples among travelers testing positive on arrival in Nigeria in order to catch variants quickly. He also partnered with other institutions to increase capacity and introduce the use of Rapid Diagnostic Tests in public settings such as schools, youth service camps, government offices among others to identify cases even quicker to stop the chain of transmission.

Nigeria's response reflects the absolute need for global solidarity. The UN, including UNAIDS, was Nigeria's partner of choice in responding to the pandemic, and this has been of benefit not just to the country itself but to the African continent as a whole: President Buhari has been an early champion of the People's Vaccine campaign, launched in May 2020, which called for a fair and equitable distribution of COVID-19 vaccines to ensure that poorer countries are not left behind in the response. The signatories called for a mandatory worldwide pooling of patents and sharing of all COVID-19-related knowledge, data, and technologies to



UN Leadership, Bilateral Donors and PTF Chair and members, after the COVID-19 Basket Fund Launch—Abuja, 2020

ensure that any nation can produce or buy affordable doses of vaccines, treatments and tests, and the rapid establishment of an equitable global manufacturing and distribution plan for all vaccines, treatments and tests, with priority given to frontline workers, vulnerable people and poor countries with the least capacity to save lives.

In November 2020, as the second wave of the COVID-19 epidemic washed over Nigeria, the leadership of the Nigerian Presidential Task Force on COVID-19 held a half-day strategic brainstorming retreat with

the UN System, supported by UNAIDS, in collaboration with WHO and the UNDP. Led by Federal Minister for Health Dr. Osagie Ehanire and UN Resident Coordinator Mr. Edward Kallon, the retreat reviewed the current epidemiological status of the COVID-19 response in the country. Ehanire welcomed the adoption of a new language and approach from HIV: “know your pandemic and know your response.”

Addressing the COVID-19 pandemic does not mean a one-size-fits-all approach, as countries need to be able to characterize their own pandemics and take into

consideration peculiar socioeconomic and cultural settings, without which an effective non-pharmaceutical response may not be



Dr. Chikwe Ihekweazu, Former Director-General Nigeria Centre for Disease Control and current WHO Assistant Director-General for Health Emergency Intelligence

found. Earlier, the COVID-19 response in Nigeria benefited from the global lessons of the HIV pandemic, such as the adoption of the Four Ones principles of coordination among diverse multi-sectoral partners, the leveraging of HIV actors and testing and community volunteer infrastructure to scale up the COVID-19 response, and the protection of human rights during pandemics.



Community pharmacists providing services to PLHIV during the COVID-19 lockdown—Nigeria, 2020

Putting People at the Center Brings Good Results in Nigeria

Nigeria has demonstrated that putting people at the center of the AIDS response works in advancing HIV service delivery. The 2018 Nigeria HIV/AIDS Indicator and Impact Survey identified 10 states with HIV prevalence above 2%, nine of which had a significant unmet need for HIV treatment and were at risk of being left behind if no action was taken. These states were prioritized by the national AIDS response for concerted action with the help of PEPFAR and the Global Fund.

In 2020, while many countries experienced HIV service disruptions, the PEPFAR-supported HIV program in Nigeria experienced significant growth and exceeded some targets.

“The achievements of Nigeria with PEPFAR and the Global Fund in 2020 have significantly moved the needle toward treatment saturation and advanced the hope of epidemic control and the end of AIDS in these states and the entire country,” said Osagie Ehanire, the Minister of Health of Nigeria.

PEPFAR’s leadership and implementing partners took quick action and fast-tracked their community engagement plans, utilizing existing community network machinery to ensure there were no disruptions in the delivery of HIV services.

“Thanks to PEPFAR and its implementing partners, Nigeria was able to ensure not just continuity of HIV services, but was able to expand the reach, despite the country being locked down due to COVID-19,” said Gambo Aliyu, Director-General of the National AIDS Coordination Agency. “A record 279 000 people living with HIV additionally were put on treatment during this period.”


PEPFAR, together with its implementing partners, developed a people-centered package of services that was informed by data best practices, and community intelligence. The package recognized that one size does not fit all and catered for the unique needs of the various populations served.

Existing community networks, including key population networks and social groups, were consulted to determine the best way to ensure that the services that people needed were available to them in their homes, at social gatherings or through support groups—thus minimizing contact with facilities.



Acting Country Coordinator, PEPFAR, Dr Murphy Akpu delivering a module of the Patient Education and Empowerment Programme to PLHIV—Abuja, 2021.

Community antiretroviral therapy teams (CART teams) went to hard-to-reach areas around the country as well as to areas affected by COVID-19 lockdowns. Programs such as a minimum three-month provision of antiretroviral therapy and viral load services were provided at treatment pickup areas, which not only helped community-led providers to ensure that people stayed on treatment but saw a record number of people living with HIV start on treatment. By the end of 2020, most people on



treatment were included in the multi-month dispensing program, which had a large impact on HIV treatment retention and adherence.

Viral load samples were collected in the communities, sent to laboratories for analysis and the results were then sent to health care facilities, from where people were notified—this had a positive impact on viral load coverage. Index testing was expanded through community networks, ensuring continuity and safety as well as improvements in testing and case finding.

Results were seen across the entire 90-90-90 cascade as follows:

- An increase in PLHIV on HIV treatment of more than 279,000 in 2020, with more than 131,000 people being initiated and retained in care during the fourth quarter alone. PEPFAR Nigeria showed excellent success, accelerating efforts to identify PLHIV and linking them to care, with quarter-on-quarter growth. The growth in the number of people on HIV treatment saw an additional seven states moving toward treatment saturation since the initiation of the “surge” program approach, where intervention efforts are dramatically scaled up. Key populations represented approximately 25% of this overall growth, as the number of people on treatment among

most key populations tripled. Key populations also had a testing yield of more than 10%.

- Improvements in pre-exposure prophylaxis (PrEP) uptake, especially among key populations. The number of people newly initiated on PrEP rose from nearly 2,000 in the third quarter of 2020 to nearly 23,000 in the fourth quarter.
- Scale-up of multi-month dispensing from 55% in the first quarter to 94% in the fourth quarter of 2020 was a key factor in improved continuity of treatment.
- Improvement in viral load coverage (88%) and suppression (93%) by the third quarter, building on previous successes and maintaining those gains to approach the third 90 target in a little over six quarters.
- PEPFAR’s orphans and vulnerable children program achieved and exceeded all targets set for the year, including more than one million orphans and vulnerable children served by PEPFAR Nigeria by the end of 2020. Additionally, 98% of those under the age of 18 years in the orphans and vulnerable children program have a documented HIV status, and approximately 100% of those who tested HIV-positive began treatment.

These results could not have been achieved without the support of community-led organizations. “The Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) wishes to thank PEPFAR for the continuous engagement of our members across the country in the provision of HIV services to people living with HIV,” said Ibrahim Abdulkadir, NEPWHAN National Coordinator. “This has increased retention in care and improved quality of life for people living with HIV, as well as viral suppression among people living with HIV on antiretroviral therapy.”

PEPFAR Nigeria has designed its approach so that it can be owned by the Nigerian people. The National Data Repository and the National Alignment Strategy are key building blocks of a long-term and sustainable public health and health services approach to ending the AIDS epidemic in the country.

“I am profoundly impressed by the progress that PEPFAR Nigeria has made, in collaboration with the Government of Nigeria, partners and allies, to identify, enroll and sustain so many Nigerian people living with HIV on life-saving treatment,” said Bill Paul, the Deputy Coordinator for Program Quality, Office of the United States Global AIDS Coordinator. “Their success in

sustaining the effort despite the impact of COVID-19 would not have been possible without a supportive policy environment both in the government and in the United States embassy.”

Based on these accomplishments, Nigeria is well-positioned to accomplish the 95-95-95 targets well in advance of 2030. At the end of 2020, progress on the 90-90-90 treatment targets was 73-89-78—that is, 73% of people living with HIV had been diagnosed, 89% of those diagnosed were accessing treatment, and 78% of those accessing treatment were virally suppressed.

The proposed new Global AIDS Strategy calls for putting people at the center of the HIV response, empowering communities, and closing the gap on inequalities. “Nigeria is poised to be the next HIV turnaround country, after South Africa. We have all the ingredients to make this happen and I commend PEPFAR for working with the government, communities and partners to show the world that this is the only way to end this pandemic, by working with the affected communities,” said Erasmus Morah, UNAIDS Country Director for Nigeria.





Delivering Antiretroviral Medicines to Homes in Nigeria and Côte d'Ivoire

The COVID-19 epidemic in Nigeria brought restrictions on movement, and lockdowns that threatened to interrupt supplies of antiretroviral medications. To help mitigate this, the International Community of Women Living with HIV (ICW) West Africa partnered with community pharmacists to make home deliveries of HIV medications and other treatments. Community pharmacists have been visiting hard-to-reach semi-urban and rural areas and helping to ensure that no one is left behind because of the COVID-19 crisis, especially adolescent girls and young women who cannot access their treatment themselves.

Under the arrangement, the medicines are provided by the Institute of Human Virology Nigeria, while the NGO, Positive Action for Treatment Access (PATA), provides the logistics, with support from the Open Society Initiative for West Africa (OSIWA), and ICW West Africa is responsible for the final home delivery.

Community pharmacists are providing services in three high-burden COVID-19 states—Lagos, Federal Capital Territory and Oyo—covering 26 health care facilities. In addition to their work delivering medicines, the community pharmacists also sensitize adolescent girls and women living with HIV on COVID-19 prevention measures, such as physical distancing, wearing face masks and regular hand washing.

UNAIDS and the Wider United Nations System Supporting the COVID-19 RESPONSE in Nigeria

The United Nations system in Nigeria joined the fight against COVID-19 shortly after the first case was detected in the country in late February 2020.

UNAIDS' lessons learned and expertise in facilitating, linking, and bringing stakeholders together have been instrumental in guiding the UN multi-agency response, led by the Resident Coordinator, Edward Kallon. And by proactively mobilizing its political capital and goodwill in the country, UNAIDS has helped to bring resources and better lines of communication, coordination, and accountability to the national COVID-19 response.


In mid-March, the Presidential Task Force was established to develop a COVID-19 response plan for how organizations should work together. Appointed as the only development member of the task force, the Representative, a.i., of the World Health Organization, Fiona Braka, provides the overall United Nations technical leadership to the government. Lessons learned from



Flag off of Ebonyi State COVID 19 Sensitization and Vaccination Program for PLHIV organized by NEPWWHAN, WHO and UNAIDS—December 2021

the HIV response fed into the development of the Four Ones guiding principles for the national response to the COVID-19 pandemic—one national COVID-19 multisectoral pandemic response plan, one COVID-19 national coordinating authority, one COVID-19 monitoring and evaluation system, and one COVID-19 financing and investment platform. “The Four Ones principles will simplify and clarify roles, responsibilities and relationships, including within the government,” said the Minister of Health of Nigeria, Osagie Ehanire.

Another lesson learned from the HIV response was the importance of ensuring that marginalized and vulnerable people are given consideration at every step of the development of a response to a pandemic.



The potential impact of COVID-19 on people living with HIV, key populations and the poor also had to be at the center of decision-making.

“UNAIDS regularly coordinated with the networks since the beginning of the COVID-19 outbreak, providing technical guidance and ensuring synergy with the efforts of the government,” said Abdulkadir Ibrahim, the National Coordinator of the Network of People Living with HIV/AIDS in Nigeria.

Working with the United Nations Development Programme, UNAIDS liaised with the wider United Nations System and the government, and facilitated the handover of US\$2 million worth of emergency medical commodities to the government, ensuring that the supplies and equipment were prioritized for use in public health facilities and by health care workers.

The One UN COVID-19 Basket Fund was launched on 6 April 2020. Part of one of the Four Ones, the one COVID-19 financing and investment platform, the Basket Fund channels the contributions of donors to the COVID-19 response. UNAIDS played a critical role in its establishment, working with the United Nations Resident Coordinator and the United Nations Development Programme to ensure

that the financing platform put people and communities at the center. UNAIDS, UN Women, WHO and the United Nations Population Fund helped to mobilize US\$6.5 million for civil society and community engagement, social protection for vulnerable households, community-led surveillance and monitoring of COVID-19 and HIV, and the documentation of community best practices.

In announcing a €50 million contribution to the Basket Fund, the Head of the European Union delegation to Nigeria, Ketil Karlsen, said, “The COVID-19 Basket Fund gives us the opportunity to cooperate and act rapidly in the deployment of assistance that can help to enhance health care services and cushion the most vulnerable.”

Perhaps the most important contribution by UNAIDS to the COVID-19 response in the country, however, has been advocating to harness the vast HIV infrastructure in the country for the fight against COVID-19. “We must leverage HIV assets on the ground, including not just laboratory facilities but community health workers and volunteers. To fight COVID-19 effectively we will have no choice but to engage communities to own the response,” said Erasmus Morah, the UNAIDS Country Director for Nigeria.

In a joint effort, the United States Government, the National Agency for the Control of AIDS, the United Nations Children’s Fund, WHO, UNAIDS and the Presidential Task Force mapped and initiated the engagement of approximately 100,000 community health care workers and volunteers to undertake risk communication, social mobilization, contact tracing and home care.

COVID-19 is not over and continues to evolve with seasonal peaks and relatively low number of cases. However, as Mr. Kallon said, “The United Nations must stay open for business and deliver for the people while ensuring that staff members and their dependents are provided with the necessary environment for their protection against

COVID-19.” Following this, a COVID-19 isolation and treatment center as an extension of the United Nations clinic was established for staff as frontline workers, together with their dependent family members.

Moving forward with the COVID-19 response, in addition to the continued support for the Presidential Task Force, the United Nations Country Team, including UNAIDS, is gearing up to support Nigeria to address major gaps in subnational preparedness. Key issues such as the loss of livelihoods, heightened vulnerabilities and food insecurity, the increased risk of gender-based violence and limited access to essential health services will also be addressed in the coming months.

Nigeria Pilots Community-Led Monitoring of HIV and COVID-19

Four decades of the response to the HIV epidemic has demonstrated that health programs and interventions are more effective when affected communities are involved in their design, implementation and monitoring. This recognition has given birth to the practice of community-led monitoring (CLM). CLM is a quality improvement and accountability mechanism aimed at improving service provision. It is a process whereby PLHIV and other affected groups or communities, systematically and routinely collect and analyze data on HIV service provision to generate evidence for advocacy to address gaps, improve service provision, accountability and governance of HIV and health services.

Implemented with funding from the One UN Basket Fund for COVID-19 for Nigeria, the CLM initiative in Nigeria was launched in September 2020 by the NEPHWAN National Coordinator alongside the NACA Director General, the U.S. Ambassador and the UNAIDS Executive Director. It is being implemented by NEPHWAN, with technical support from ITPC West Africa, facilitated by UNAIDS Nigeria. Following a theoretical framework, the overall goal of the CLM Initiative in Nigeria is to use a data-driven approach to improve both advocacy and service delivery, and client outcomes for end users of services at the facility and community levels. This is done through monitoring of HIV and COVID-19 services across six domains: Availability, accessibility, affordability, acceptability, appropriateness, and awareness. The geographical spread covers 15 states. As of September 2021, quantitative data collection had spread across 81 health facilities while qualitative data had been collected through 163 focus group discussions and 727 interviews.

An advocacy agenda to address identified gaps has been developed and is being implemented. Improvements have been recorded to issues of stock-out and confidentiality.



UNAIDS Executive Director, Winnie Byanyima (2nd L); US Ambassador to Nigeria, Mary Beth Leonard (3rd R); Director-General, National Agency for the Control of AIDS, Dr. Gambo Aliyu (3rd L); Coordinator, Network of PLHIV in Nigeria, Abdulkadir Ibrahim (2nd L); UNAIDS Country Director, Dr Erasmus Morah (1st L); PEPFAR Country Coordinator, Mark Giambone (1st R); at the launch of the maiden Community-led Monitoring Report and National Framework for Community-led monitoring—Abuja, 2021

While challenges remain, health workers across the 15 states have embraced CLM, which remains the tool for HIV and health service users to hold stakeholders accountable, improve the quality of services, and ultimately achieve better client outcomes.



HE President Mohamed Buhari hosts UNAIDS Executive Director, Ms Winnie Byanyima—Abuja, March 2021

Lagos State Governor Mr. Babajide Olusola Sanwo-Olu : A Proactive Force in the HIV and COVID-19 Pandemics

The city of Lagos joined the global Fast-Track Cities initiative in 2017, to accelerate ending AIDS as a public health threat by 2030. To combat HIV/AIDS, Lagos State Governor Babajide Sanwo-Olu has consistently called for stronger collaboration among all stakeholders. He has demonstrated leadership through commitment to the Fast-Track Cities project and support for the Lagos State AIDS Control Agency through timely budgetary releases to the agency to mitigate the impact of AIDS in Lagos State with an increase of 22% in 2020 over 2019. Concerning the State HIV response, he once said: "Let us move forward in a bold new spirit of partnership to overcome the cycle of HIV transmission and deliver health and well-being for all our citizens." The Governor reiterated a similar call for tackling COVID-19 in 2020.



Lagos State Governor, Mr Babajide Olusola Sanwo-Olu, receives his COVID-19 vaccine—
Lagos, 2021

Very early on in the COVID-19 pandemic, Lagos, which is densely populated, accounted for close to half of the reported COVID-19 cases. First, the Governor aptly demonstrated his leadership mandate and, among many early achievements, instituted the State COVID-19 Incident Command Structure chaired by himself.

Second, he commissioned, among others, a permanent triage and oxygen therapy center in Eti-Osa Local Government Area to provide swift emergency oxygen therapy. The facility, which doubles as a COVID-19 sample collection center, is located within the premises of the Eti-Osa Maternal and Child Care Center.

Another critical step in the management of COVID-19 by Lagos State, including State Commissioner of Health Prof. Akin Abayomi, was the activation of an oxygen plant within at the Infectious Diseases Hospital, Yaba, to provide swift support to COVID-19 patients who require high-flow oxygen therapy. The plant was activated amid increased demand for oxygen in the second wave of COVID-19. The plant—which is expected to supply about 300 cylinders per day and six cylinders per hour—is in furtherance of the commitment of the State government to deploying an effective response to the pandemic.

Third, Lagos State Governor Sanwo-Olu established decentralized triage and oxygen therapy centers, so that citizens requiring oxygen therapy would not have to travel a long distance to the Mainland Infectious Disease Hospital to access care, stressing that patients requiring oxygen treatment in Eti-Osa can walk to the center for treatment and care.

The leadership demonstrated by the Lagos State Governor and Health Commissioner led to the emergence of the Lagos State Government as the most responsive COVID-19 State Government of the Year at the Nigerian Healthcare Excellence Awards 2021. The state's Commissioner for Health, Prof. Akin Abayomi, emerged as winner of the Most Outstanding COVID-19 State Health Commissioner of the Year at the event.

Although COVID-19 remains a challenge for Lagos State, with the recent announcement of the beginning of a fourth wave, the proactive approach, and the consistency in addressing bottlenecks have saved many lives and improved care quality for the users of the systems.

Gaps in Nigeria's HIV Response

There are gaps in Nigeria's fight against HIV which, if not properly addressed, can undermine the progress made so far.

HIV in the humanitarian context is an area in which more needs to be done. In northern Nigeria, more than 7 million people need humanitarian assistance due to ongoing insecurity due to the Boko Haram low-intensity conflict, the farmer–herdsmen crisis, and banditry. Communities in the oil-rich Niger Delta region have suffered kidnapping, militancy, and environmental degradation, which present unique problems that affect the HIV response.

HIV in the *humanitarian emergency* context remains a deficit area in which more needs to be done, despite the north having a lower HIV prevalence (0.5%) compared to southern and central Nigeria. Internally displaced people in camps need information to be able to prevent HIV, and



Chairman NACA Governing Board, H.E. Dame Pauline Tallen and Director General National Agency for the Control of AIDS, Dr Sani Aliyu present food items to the Internally Displaced Persons—Abuja

access to condoms and reproductive health services, as well as the management of opportunistic infections. While this category of citizens is getting services, not enough attention has been given to the HIV needs of people on the move, those uprooted from their home environments.

Another group on the move are those in the *uniformed services*, such as the police, military, and paramilitary agencies. Members of these services tend to be highly mobile, often staying away from their family. Over time, they have been left alone to handle issues of HIV awareness and prevention. Although the Federal Government has a law against stigmatization of PLHIV, these security-related services are known to have mandatory medical tests for new entrants during which PLHIV can be screened out. HIV among the elderly is also a missing issue. The Nigeria AIDS Indicator and Impact Survey showed that while the bulk of those infected were aged 15 to 49, there was a significant level of HIV among people aged 60 and above. Other studies have also shown that the elderly are less likely to take HIV testing and treatment seriously. However, they can spread HIV to younger people who are more sexually active and reproductive.

Another significant gap exists in the availability of information on HIV/AIDS among *people with disabilities*. The *World Report on Disability* (2011) stated that about 25 million Nigerians had at least one disability, while 3.6 million of these had very significant difficulties. The data paucity is largely informed by their special needs not coming up for emphasis


during enumeration, as well as persons with disabilities being underserved in strategic communications design. For example, messaging tends to be targeted toward the mainstream, which often excludes those who are sight or hearing impaired as cases in point. Persons with disabilities are also sexually active and are as susceptible to HIV and AIDS as the general population and equally in need of access to HIV and AIDS resources.

Generally, an approach towards including these missing groups in the mainstream HIV treatment program is needed and this can be done by partnering with NGOs that work specifically with these groups.

Armed forces AIDS response

The seemingly impregnable military enclosure cannot protect against infectious diseases, and Nigeria's armed forces authorities have classified men and women of the uniformed services as most-at-risk populations.

The military were also among the earliest responders in the HIV epidemic. In 1989, the Nigerian Army Expert Committee on AIDS and Emerging Infections was formed to handle the virus within the military.



The following year, this body became the Forces Blood Transfusion and AIDS Control Committee (FOBTAC), which, in 1991, transformed into Armed Forces Programme on AIDS Control (AFPAC). This program has engaged in policy formulation, created awareness for behavior change communication, trained counselors and peer educators, and distributed prevention commodities. There has also been testing and treatment of local troops and those deployed to foreign missions.

Part of the military's response has also been collaboration with foreign partners. One such collaboration was in 2005 in the military-to-military partnership between the Nigerian Ministry of Defence (NMOD) and the United States Department of Defense. The pact was initially known as the NMOD Emergency Plan Implementation Committee, but this was later changed to NMOD Health Implementation Programme in 2014. This reached beyond Nigeria's borders and became a turning point in the war against HIV/AIDS in the military. The statistics speak volumes: 1,057,611 service personnel have been provided with HIV counseling and testing services. There have

been 87,043 returned positive tests, with 50,223 so far accessing ART. Some 176,059 pregnant women have gone through the military's PMTCT program, with 12,053 positive cases that have all been linked to treatment.

The military has retained synergy with NACA's approach and routinely releases its findings to the agency to support the development of new policies aimed at tackling and eradicating the disease.

These responses have given birth to progressive changes in the outlook of HIV and AIDS management in the military. Today, there is free comprehensive HIV and AIDS care and treatment through provision of ARVs, infrastructural improvements and human capacity development. Provision has also been made for appropriate laboratory diagnostic equipment and clinical research, contributing more widely to a strengthening of the military health system.

A society that protects members of its elite military from an epidemic like HIV and AIDS has the solid assurance of raising soldiers fit to protect their country's territorial integrity.


Challenges and Keys to Increasing the Country's Research Capacity

A 2010 analysis of Elsevier's Scopus database ranked Nigeria second in Africa for scientific publications behind South Africa. Despite that, the country has few researchers relative to its population size. Reasons for the shortage include systemic problems such as poor science education, lack of equipped laboratories and inadequate funding and investment into research, lack of motivation among individual researchers, inadequate training in research methods, inadequate infrastructure, lack of political leadership committed to research, lack of collaboration between research institutions, and poor dissemination of research outcomes to key stakeholders. Historically, funding for HIV research in Nigeria has been poor, with only about 0.9% of the total HIV budget spent on research, according to the 2014 National AIDS Spending Assessment.

HIV research initially concentrated on the epidemiology of the disease and its prevention, with little attention paid to the other areas of the disease including its social and behavioral aspects.

However, as the country's HIV program matured and expanded, a more comprehensive approach to HIV research emerged with an increase in the number of published studies between 1998 and 2003. These publications cut across subject areas such as advocacy, human rights, basic sciences, social sciences, epidemiology and prevention.

There was also a marked increase in the number of abstracts presented at regional and international conferences from 1.4% to 72.6% between 1986 and 2005. Despite the increasing appreciation for an evidence-based response to the HIV epidemic, research efforts in Nigeria continued to lag implementation until recently when research findings were used to make programmatic decisions.



There is a critical need to address the identified gaps in the country's research efforts into HIV, to identify ways to tackle the epidemic to achieve and sustain effective control. The 2009 HIV revision policy by NACA included a sound research policy framework to guide the design and implementation of evidence-based strategies.

The policy dealt with issues of research priority setting, mechanisms, capacity building, financing, evaluation, and advocacy. NACA is responsible for providing leadership and coordination to ensure a multi-sectoral approach for effective and efficient implementation of this policy.

It is vital that there is greater engagement of researchers and program implementers with policymakers at all levels to promote and strengthen HIV research in Nigeria.

Private Sector Backs Sustainable Financing

The HIV Trust Fund of Nigeria is a private-sector-led fund promoted by Nigeria's National Agency for the Control of AIDS alongside the Nigeria Business Coalition Against AIDS. Established in November 2020, the Trust Fund aims to mobilize US\$150 million when launched and fully operational. Its core objective is to ensure the sustainable mobilization of resources from the private sector to make significant contributions toward the funding of HIV

programs across Nigeria. The champions of this fund are seven blue-chip companies, and it is co-chaired by the managing directors of Total Nigeria and Access Bank.

The rationale for establishing an HIV/AIDS Trust Fund came with the realization that the burden of funding the response to HIV and AIDS in Nigeria, and meeting the challenges of fund management, could no longer be left to government alone if the country was to end AIDS as a public health threat.

The Nigerian Business Coalition Against AIDS (NiBUCAA) is a business membership



CEO of Access Bank and Chair of NiBUCAA, Herbert Wigwe (C); Chair of NACA Board, Senator Dipo (R); Director General, NACA and member of HIV Trust Fund Board, Dr Gambo Aliyu (2nd R); CEO of the HIV Trust Fund, Dr Jekwu Ozoemene (L); UNAIDS Country Director for Nigeria, Dr Erasmus Morah (2nd L), at the high-powered advocacy meeting regarding the HIV Trust Fund

organization that was established in 2003 as the private sector response to HIV and AIDS. NiBUCAA was put together on the premise that businesses have collective leadership roles to play in the multi-sectoral response to HIV and AIDS, led by NACA. In view of the Nigeria's size and the complexity of its needs, it was clear that government would need to collaborate with the private sector on HIV and AIDS. The goal of the fund is to increase private sector contributions to the HIV/AIDS budget from 2.1% to about 10% in the four years to



CEO of Dangote Group, Aliko Dangote (4th R); CEO of Access Bank and Chair of NiBUCAA, Herbert Wigwe (3rd R); CEO of Julius Berger Nigeria PLC, Dr Lars Richter (5th L); Chairman of Shell Petroleum Development Company of Nigeria, Osagie Okunbor (8th L); CEO of Total Energies, Mike Sangster (2nd R), CEO of the HIV Trust Fund, Dr Jekwu Ozoemene (R); Director General, NACA and member of HIV Trust Fund Board, Dr Gambo Aliyu (6th L); US Ambassador, Mary Beth Leonard (7th L); UN Resident and Humanitarian Coordinator for Nigeria a.i. Matthias Schmale (L); UNAIDS Country Director, for Nigeria, Dr Erasmus Morah (2nd L) at the Presidential launch of the HIV Trust Fund—Sate House, February 1, 2022

2022. The fund is devoted mainly to funding strategic inputs such as antiretroviral drugs, test kits, reagents and the logistics to deliver PMTCT services at facilities all over the country.

Business coalition bolsters HIV response through innovative action

The Nigerian Business Coalition Against AIDS continues to make significant media appearances through radio, television, and newspapers to encourage its members to be active, particularly in commemoration of special events such as the World AIDS Day. The coalition has partnered with other key funders and stakeholders to reach out to member companies' supply chains with HIV/AIDS Workplace Programme and Policy development initiatives.

In collaboration with Total Nigeria, the coalition, with technical assistance from the Global HIV/AIDS Initiative Nigeria, a PEPFAR-supported project, carries out mobile voluntary counseling and testing at selected Total petrol stations in Nigeria. In a strategic partnership, Total Nigeria and NiBUCAA, under the umbrella of a community HIV preventive education project empowered a number of petrol station attendants and supervisors to provide consumers of their products with information on HIV/AIDS.

Public-private Partnership

The Private Partnership Forum was instituted with several companies including Shell and Chevron oil companies to address their specific issues such as the sourcing of funds and carrying out their social responsibilities.



Top left: UNAIDS Country Director for Nigeria, Dr Erasmus Morah (2nd L) receives a thank you card from NEPWHAN Coordinator, Abdulkadir Ibrahim 3rd L); Regional Director International Community of Women Living with AIDS Africa (ICW-WA), Reginald Assumpta (L) and Youth Coordinator, Sunday Aaron, in appreciation to UNAIDS for support to PLHIV and young people—Abuja, 2021.

Top right: Former UNAIDS Executive Director, Michel Sidibé, and International Partners. During a High-Level Stakeholders Meeting at the Head of State and Government Special Summit on HIV/AIDS, Tuberculosis and Malaria Held at the State House Abuja.

Bottom left: Lagos Health Commissioner, Dr Akin Abayomi, awarded for most responsive COVID-19 state government of the year, 2021.

Bottom right: Hon. Minister of Foreign Affairs of Nigeria, Goeffrey Onyeama with UNAIDS Executive Director, Michel Sidibé during the signing of the Basic Cooperation Agreement granting UNAIDS full diplomatic accreditation, Abuja, March 2019



Top left: Connecting the past with the present. UNAIDS Country Director, Dr Erasmus Morah (C) meets with the first NEPWHAN Coordinator Mr John Ibekwe (L) and the current NEPWHAN Coordinator Mr Abdulkadir Ibrahim (R)—Akwa Ibom, 2021.

Top right: Director General, NACA, Dr. Gambo Aliyu; Inspector General of Police, Mohammed Adamu; Chairman Senate Committee on AIDS, TB and Malaria, Senator Haliru Dauda Jika with cross section of delegates during the Medical Officer's Conference—Abuja, 2019.

Bottom right: L-R: Director General, NACA and Chairman, Abidjan-Lagos Corridor Organization (ALCO) Board, Prof. John Idoko; Representative of Minister of Health, Dr Segilola Araoye, UNAIDS Country Director, Dr Bilali Camara, at the first annual statutory meeting of ALCO, Governing Board—Abuja.



Top Left: Hon. Minister of State for Health, Dr. Adeleke Olorunnimbe Mamora (C) officiating at 2021 World AIDS day commemoration.

Top Right: Hon. Minister of Health, Prof. Isaac Adewole (C), UNAIDS Executive Director, Michel Sidibé (R), UNAIDS Country Director, Dr Erasmus Morah (L), discussing post-NAIIS strategies.

Bottom: National Human Rights Commission (NHRC), Executive Secretary, Mr Anthony Ojukwu Esq., PEPFAR Deputy Country Coordinator, Murphy Akpu and UNAIDS Advisor for PEPFAR/GF Implementation, Erva-Jean Stevens-Murphy at the NHRC training of staff members on the Protection of the Rights of Key Population (in collaboration with UNDP) - Nigeria, 2021.

Civil Society Organizations

Civil society organizations represent a wide array of organizations outside of government and the public service structure. The story of Nigeria's journey in the control of the HIV epidemic over the years has CSOs at center stage, from strong advocacy for free HIV treatment, through to creating multi-sectoral and multidisciplinary partnerships at the national and international levels. CSOs have been particularly effective in drawing attention to populations and communities that are often left out because of legal and social systems, as well as delivery of community-level interventions, prevention and the provision of care and support services. Nigeria is blessed with a flourishing HIV CSO sector replete with institutions and groups that serve as a source of vital social capital across PLHIV communities. Through programming, advocacy and activist movements, there have been great milestones in the progress toward ending AIDS.

CSO networks

The emergence of national CSO networks has had a huge impact on the national HIV and AIDS response in the face of several challenges, service delivery gaps, discrimination, and human rights issues.



Youth advocate, Onuh Faith Eberé, represents adolescents and young people at the HLM Civil Society conference 2021

Networks have acted as preparation grounds for unity of purpose, experience sharing and catalyzing of actions beyond State boundaries. As challenging as the network-building process has been in the HIV context, these constituencies have made a mark. The historical role, determination, sacrifices and commitments of civil society have contributed significantly to turning the tide in the fight against HIV and AIDS. In Nigeria, such community groups include, among many others, the below organizations that have in many ways contributed to the progress with the HIV response over the years.

Civil Society for HIV/AIDS
in Nigeria (CiSHAN)



The Network of People
Living with HIV/AIDS
(NEPWHAN)



Nigeria Youth Network on
HIV/AIDS (NYNETHA)



Youth Network on HIV/AIDS in
Nigeria (NYNETHA)

The Nigeria Labor Congress



Nigeria Network of
Religious Leaders Living
with HIV (NINERELA)



Key Population Secretariat Nigeria



KEY POPULATIONS HEALTH
AND RIGHTS NETWORK

Journalists Against AIDS
(JAAIDS) Nigeria



Association of Women
Living with HIV in Nigeria
(ASWHAN)



Society for Women and
AIDS in Africa Nigeria
(SWAAN)



Nigeria Business Coalition
Against AIDS (NiBUCAA)



Nigeria Supreme Council
on Islamic Affairs (NSCIA)



Treatment Access
Movement (TAM)



Federation of Muslim
Women's Associations
of Nigeria



The Christian Health
Association of Nigeria
(CHAN)



The Nigerian Network of
Sex Work Projects (NSWP)





CHAPTER 5

REFLECTIONS, CONCLUSION
AND THE ROAD AHEAD

A new dawn brings us to a new day in the Nigerian AIDS response. Today, the journey of more than 35 years continues. To conclude the account of the journey so far, representatives of two of Nigeria's major funders since 2003-4—the Global Fund and US Government—provide an objective overview of the HIV response and progress in Nigeria. This is followed

by the reflections of the UNAIDS country director, on behalf of the global organization that leads and inspires the world to achieve its vision of ending AIDS as a public health threat by 2030. Although looking at the broad sweep of the HIV response so far, this is also a forward-looking chapter, rounded off with some parting visionary remarks by key figures in the Nigerian HIV leadership.

Reflections on the Journey so Far

Q&A with U.S. Ambassador to the Federal Republic of Nigeria, Mary Beth Leonard

Q: The SURGE approach has put the results of the NAIS to good use, resulting in the highest number of persons to date on antiretroviral treatment. What advice would you give for further evidence-based planning?

The results of NAIS were foundational to the surge approach. NAIS allowed us to target services in those states and LGAs with large, estimated numbers of people living with HIV, who were not receiving treatment. It was the basis of evidence for planning human and financial resources to address identified challenges, and directed



U.S. Ambassador to the Federal Republic of Nigeria, Mary Beth Leonard

the adoption of an incident command system approach that had previously been used successfully in the Ebola and Zika



public health emergencies.

The need for up-to-date evidence for critical decision-making has not changed. It continues to be important for ensuring we are using our resources in the most efficient and cost-effective manner possible, to enable us to provide an even greater number of people with life-saving ARV treatment.

So far, through the surge, over 1.6 million PLHIV now have access to treatment. We need to find the remaining 200,000 people, and, frankly, it is like finding a needle in a haystack, given Nigeria's low prevalence. Moving forward, while we continue to invest in service delivery, it is essential to invest resources to help understand the progress and impact of these services and identify the remaining gaps in order to gauge the epidemic's trajectory and recalibrate and validate our path to epidemic control.

Q: PEPFAR and the USG supported Nigeria to change the treatment narrative, bringing epidemic control within sight. How can the USG support Nigeria to hold onto these gains and achieve the broader sustainability agenda?

The U.S. Government will continue to work with our Nigerian counterparts to prioritize health and development-related budgetary allocations, funding release and program implementation. This means focusing our partnerships on ensuring that Nigeria's human and economic resources work to the benefit of all Nigerians.

In addition, we cannot understate the importance of diplomatic engagement with governors and local officials, religious and traditional leaders, and civil society groups. These engagements helped combat HIV stigma and engendered greater partnership with the Nigerian government to eliminate user fees, which was a significant barrier for PLHIV to access HIV treatment services.

We are working with the government at both the national and state levels to scale up the Clinical Mentors' Program. This program is designed to increase the Nigerian government's ownership of and accountability for HIV care. It does so by engaging highly experienced Nigerian government clinical mentors to utilize continuous quality improvement methodology in facilities and communities, to implement national HIV guidelines with fidelity. This approach ensures Nigeria maintains quality implementation of HIV/AIDS programs and contributes to the

sustainability of the HIV/AIDS response in the country.

One area of PEPFAR support for domestic resource mobilization targets the inclusion of HIV services into health insurance schemes to ensure the longterm sustainability of HIV services through increased host country investment in the response. Now that HIV has formally been integrated into national and state health insurance schemes (thanks to our investment), we are starting with coverage for HIV testing and plan to include ARV drugs in the future. The success of health insurance in Nigeria, however, will require support from both the public and private sectors. The establishment of the HIV Trust Fund is a key opportunity for channeling both public and private resources to support HIV services in the country. The fund could support health insurance schemes through the provision of HIV test kits and drugs or even direct support to the Equity Fund, which is essentially the pool of funding used to cover health care services for the most vulnerable.

Finally, I cannot understate the importance of community-led monitoring to the sustainability of HIV services. This empowers beneficiaries to regularly collect and

disseminate qualitative and quantitative feedback on the quality of services. The demand for equitable and clientcentered services is channeled through this mechanism, using that information to engender respectful and constructive dialogue with service providers.

Q: The protection of the rights of Nigerians who are key populations remains a challenge for Nigeria. What advice would you give policymakers and programmers to move the needle on this aspect of the HIV response?

NAIS showed that key populations—female sex workers, men who have sex with men, transgender women and men, or people who inject drugs—have the highest national prevalence rates in the country. Yet, HIV services for these key populations and children of key populations remain largely inadequate. We cannot achieve and sustain epidemic control without reaching them. The marginalized position of these communities requires a different approach, one that engages with responsive community-based organizations and peer groups to reach clients in their communities. The success of “one-stop shops” serving key populations is an example of how we can scale innovation for greater impact.



The foundation of better health outcomes is patient-centric care. A patient-centric care model for HIV patients demands that they are armed with the tools and knowledge to stand up for their rights, not just as patients, but also in relation to basic human dignity. This principle lies at the heart of the *National Consolidated Service Delivery Guidelines on HIV and STIs for Key Populations in Nigeria*, a document codeveloped by the Government of Nigeria, PEPFAR, the Global Fund and civil society, and launched in 2021. If they continue to be supported and implemented, these guidelines will increase awareness of the needs of and issues important to key populations: improve equity of services, and the coverage and uptake of effective and acceptable services, and catalyze greater national commitment to adequate resources for responding to these needs and services. Ultimately, we hope this document will be an important tool in the implementation of health services, HIV and AIDS care and treatment, and health and gender issues.

For their part, policymakers and programmers should make deliberate efforts to work with responsive community-based organizations to identify, offer and advocate for tailor-made HIV services to key populations, such as those

described in the guidelines. This has a multiplier effect when the community is engaged and empowered, such as those engaged under the Patient Education and Empowerment Project, or PEEP. Through PEEP, civil society organizations provide people living with HIV with the information and tools needed to both achieve their desired health outcomes and overcome social challenges, like stigma and discrimination, which make them vulnerable to the impacts of HIV and AIDS on their lives.



U.S. Ambassador to Nigeria, Stuart Symington (L); Director General, NACA, Dr. Sani Aliyu, (R) and PEPFAR Global Coordinator, Dr Debbie Bix, (C), during the signing of the MOU between the Government of Nigeria and the US Government—Nigeria ,2019

Q&A with Global Fund Jean-Thomas Nouboussi, Global Fund Country Portfolio Manager, Nigeria

As a long-term partner and major investor in the Nigerian HIV response, is the Global Fund investment in the country producing impact and achieving good value for money?

The Global Fund is certainly proud for its partnership with Nigeria since its inception 20 years ago and especially as one of the major investors in the Nigerian HIV response. In the current three-year cycle alone (2021-2023), the Global Fund provides USD328M to support the fight against HIV in Nigeria. This represents the largest investments in a single country by the Global Fund to date and this reflects the importance of our partnership with Nigeria. The Global Fund is particularly pleased with the remarkable progress towards the 95-95-95 targets for HIV and especially with the high ART coverage achieved despite service disruptions in the past two years due to the COVID pandemic. This is a good illustration of the positive impact produced by the Global Fund investment in Nigeria.

Through joint planning at all levels of implementation, the HIV alignment agreement that brings together the Government of Nigeria, PEPFAR and



Dr. Jean-Thomas Nouboussi, Global Fund Country Portfolio Manager, Nigeria

the Global Fund has helped us improve synergies, reduce duplication of efforts and a significant savings in the cost of HIV commodities. As a result, there has been a remarkable increase in efficiency and value for money over the last 2 years, with significant savings reinvested to procure additional commodities.

What key challenges and constraints has the Global Fund faced in its collaboration and partnership with Nigeria? What concerns you and what gives you hope?

The major challenge the Global Fund Secretariat has so far faced in its collaboration and partnership with Nigeria is the mobilization of domestic resources both at federal and state levels to comply with the Co-Financing Incentive Requirements. The current grant agreement (grant confirmation) includes a requirement

for an updated commitment letter detailing the commitment of the Federal Republic of Nigeria with details on relevant budget commitments for each year from 2021 to 2023; and A comprehensive transition and sustainability plan and budget setting out steps, starting in 2023, for the progressive governmental absorption of funding and implementation of Program Activities independently of Global Fund support. Hope for a better future of our collaboration and partnership comes from two important initiatives: i) The very recent launch of the HIV Trust Fund of Nigeria is important milestone towards sustainable mobilization of resources from the private sector to make significant contributions towards funding of HIV programs across Nigeria and ii) the ongoing work on the development of an integrated domestic resource mobilization and sustainability plan for HIV, TB, Malaria and RSSH programs is another important step towards the sustainability of the national response against HIV. The Global Fund look forward to collaborating through the Federal Ministry of Health and the National Agency for the Control of AIDS (NACA), to support these important initiatives.

Going forward, what key recommendations might you propose to accelerate the end of HIV, TB and Malaria as public health threats in Nigeria?

Going forward, the Global Fund secretariat recommends: i) to spearhead the ongoing work on the development of an integrated domestic resource mobilization and sustainability plan for HIV, TB, Malaria and to start its implementation; and ii) to leveraging the HIV alignment agreement between the Government of Nigeria, PEPFAR and the Global Fund as the breakthrough to close the gap in PMTCT and pediatric ART coverage that are lagging behind and has not seen the same rapid success as other key areas of the HIV program. The Global Fund is committed to support innovative measures to improve PMTCT and pediatric ART over the next few years and we therefore really welcome the engagement of the HIV Trust Fund of Nigeria in this area.



Hon. Minister of Health, Nigeria, Dr. Osagie Ehanire with Head of High Impact Africa One Department GF, Maria Kirova during her first visit to Nigeria, May 2022



Conclusion: One-on-one with UNAIDS Country Director Dr. Erasmus Morah

How do you see the relationship in the global fight against AIDS and COVID-19?

The HIV pandemic, which is not over, has been with us for almost 35 years, and the COVID-19 pandemic became globalized within one year. We know that global lessons learned from fighting HIV have proven relevant in combating COVID-19. Let me give you a few quick examples.

We had the Three Ones principle in HIV for coordinating and harmonizing contributions and engagement across government and diverse partners, including donors and civil society, to achieve results. The fight against HIV, as with COVID-19, is not something that the government alone or one ministry can fight. The Three Ones principle acknowledges that one national multisectoral plan would be needed to harness contributions across society. In Nigeria, the government produced the one Multi-Sectoral Pandemic Plan for COVID-19. It then set up one national coordinating authority, known as the Presidential Task Force for COVID-19, made up of 10 government ministries and WHO. The Nigerian Center for Disease



UNAIDS Country Director, Nigeria, Dr Erasmus Morah

Control (NCDC) was designated as the one national monitoring and evaluation framework for tracking and reporting on progress. Although not many know of a proposed “fourth one” in HIV, this was also successfully applied in the management of COVID-19 in Nigeria and became a best practice for the UN globally. The Government of Nigeria, through the UN System, established one financing framework

for the response, known as the One UN Basket Fund for COVID-19, to channel donor resources totaling some US\$73 million to-date.

The second important lesson applied from HIV is the centrality of human rights and putting people living with or affected by the disease at the center of the fight against COVID-19. Human rights are not something that can be suspended during pandemics or emergencies. HIV was the first global health epidemic fought within the context of human rights. With COVID-19 in Nigeria, UNAIDS effectively advocated with NACA and the Nigerian Human Rights Commission for the rights of people including during lockdown. If you are locking down, you need to think about how people are going to feed and earn a living. In Nigeria, up to eight people lost their lives during the enforcement of the lockdown in the early days of the pandemic.


In all of this, it is noteworthy that key actors in charge of managing the HIV response in Nigeria were tapped to mount the response on COVID-19. The Presidential Taskforce on COVID-19 in Nigeria was chaired by the Secretary to the Government of the Federation, who also oversees the National Agency for the Control of AIDS. The former Director General of NACA was tapped to

serve as the National Coordinator of the PTF, while the Minister of Health and in charge of the Nigerian Coordinating Committee for the HIV, TB and Malaria was the most prominent Minister in the PTF. Furthermore, the vast HIV infrastructure of community health workers, mobilizers and volunteers were also leveraged for the COVID-19 response.

What has Nigeria done right in the HIV response and what key issues remain unaddressed?

Early in the epidemic, Nigeria, under President Olusegun Obasanjo, led Africa in the response to HIV. In 2001, the Nigerian government led the establishment of the African Union AIDS Watch Africa (AWA), made up of some African presidents, to bring significant political attention to HIV. Also, in 2001, Nigeria hosted the First African Heads of State Summit on HIV/AIDS, TB, and Other Related Infectious Diseases, during which the UN Secretary-General, Kofi Annan, and the Government of Nigeria called for the establishment of a global fund to fight HIV, TB, and Malaria, which was realized in 2002. That same year, Nigeria became one of the first countries on the African continent to commence a relatively large-scale national treatment program for PLHIV, reaching more than 13,000 individuals and pregnant women with ARVs by 2005.





Then came the period from around 2004/05 when significant funding from the Global Fund and PEPFAR reached Nigeria, and the country hosted the 14th International Conference on AIDS and STIs in Africa in 2005. Instead of Nigeria building and leveraging on the outpouring of the global goodwill, Nigeria pulled back and stopped investing significantly in HIV. Hence, from 2004 until about 2015, Nigeria went from being a continental leader in HIV to being a laggard, particularly with regards to investing in, directing, and owning its national response.

During 2015 and 2016, President Buhari made two key appointments that changed the course of Nigeria's ownership of the HIV response. The appointment of Dr. Sani Aliyu as Director General of NACA and Minister of Health Professor Isaac Adewole, coincided with the appointment of my predecessor, Dr. Bilali Camara, as the UNAIDS Country Director for Nigeria. Together, these three leaders began looking critically at what Nigeria was not doing right in the response. They quickly zeroed in on two points: that the data used for planning and measuring progress in the HIV response was doubtful, and that Nigeria had completely abdicated to the donors the responsibility of treating and caring for its citizens with HIV.

The new Nigerian HIV leadership mobilized donors and the country to undertake NAHS, the largest HIV survey ever done anywhere in the world. This became the biggest gamechanger for the HIV response in the country.

The other thing that Nigeria's HIV leadership did right was that it started to look seriously at the issue of sustainability. Under the leadership of Dr. Sani Aliyu, NACA determined "to re-engage government in financing HIV once again and not leave it to the Americans to pay for everything." Shortly thereafter, in November 2018, the former Minister of Health, Professor Adewole, jointly with Dr. Sani Aliyu, took the bold decision to re-establish the National Treatment and PMTCT Programme, thus putting in place the much-needed foundation and instrument for sustainably appropriating budget from the National Assembly. Professor Adewole referred to this historical move as "going back to the future" (i.e., to when Nigeria led treatment rollout in Africa), while Dr. Aliyu referred to it as "the right thing to do" (i.e., to bring back the Ministry of Health into the treatment and management of HIV in the country).

To-date, the Government of Nigeria has not only upheld this newfound commitment—

which translates into an approximately N2.5 billion increment to the annual treatment budget—but President Buhari went further to grant an exceptional procurement waiver in the use of international competitive bidding to procure ARVs using the resources. This welcome move has meant that up to an additional one-third of ARV patients can be reached with the same budget amount.

Related to the above, NACA's drive to ensure the inclusion of HIV as one of the diseases to be included in the package of support offered by the National Health Insurance Scheme (HIV testing and ART, including for treatment) is another important step in the right direction. The same applies to NACA's ongoing efforts, in partnership with UNAIDS and WHO, to support the Nigerian private sector to play its part, through the establishment of the National HIV Trust Fund, under the Nigerian Business Coalition Against AIDS (NiBUCAA). Launched by President Buhari on 1st February 2022, the HIV Trust Fund aims to mobilize capital of US\$100 million to invest toward reversing the tide of Nigerian children being born with HIV.


How have donor agencies collaborated to support Nigeria in the evolution of the HIV response?

I earlier talked about NAIS, the world's most comprehensive survey on HIV. This was supported by the U.S. Government investing about US\$80 million and the Global Fund about US\$20 million. Next to the provision of life-saving antiretroviral treatment to people, this is probably the most valuable donor contributions to the national response on HIV.

This scientific evidence base for the response then connects to the next immediate step of helping the country with the process of bringing people and experts together, to foster an inclusive and costed strategic plan to prioritize and guide investment actions by the government and partners. Strengthened by the game changer findings of NAIS, the donors and the UN quickly supported Nigeria to revise its five-year National Strategic Plan on AIDS, which was launched in March 2018 by H.E. President Buhari, in the company of UNAIDS Executive Director Michel Sidibé.

Thereafter, donors started to look at how they could invest and align their support around the national priorities and targets as set out





in the strategic plan. This is where PEPFAR and the Global Fund were exceptionally generous to the government and people of Nigeria, investing in total nearly US\$4 billion in the Nigerian HIV response to date, with a commitment to invest another US\$2.2 billion over the next three years.

The role of the UN family working in HIV—WHO, UNICEF, the World Bank, UNDP, UNODC, UNFPA, UN Women, UNESCO, WFP, UNHCR, ILO—has been to support both the government and donors with the technical inputs and partnerships associated with applying for and securing these funds. In 2021, for example, the UNAIDS family of agencies was able to support Nigeria to secure approximately US\$1.2 billion from the Global Fund for the next three years (US\$320 million for HIV and US\$250 million for COVID-19). Thereafter, the UN’s role seamlessly shifted toward “making the money work,” ensuring that the committed funds are invested for the intended purposes and properly accounted for.

Is Nigeria winning the war against HIV and what would be your advice?

I attended the UN General Assembly Special Session on AIDS in New York in 2016, during which former UNAIDS Executive Director Michel Sidibé admitted

that his own region of West and Central Africa was holding back the continental response. At the time, Nigeria accounted for more than half of the burden of PLHIV and approximately 60% of new HIV infections in the sub-region.

The data today is unequivocal. Nigeria has good data on the epidemic and is now finally moving in the right direction, with treatment coverage dramatically increasing from less than 40% in 2015 to more than 80% in 2020, and new infections declining 25% between 2010 and 2020, thus positioning Nigeria as the next HIV turnaround country after South Africa. Though Nigeria did not achieve the 90-90-90 target by 2020 the country made great progress with 73-89-78. Achieving 95-95-95 by 2030 is no longer a pipe dream in Nigeria. As stated by President Buhari in his speech at the June 2021 UNGA, “Nigeria is proud that the results of the largest AIDS Indicator and Impact Survey (NAIS)... have enabled it to set realistic targets and identify those who were not being reached... [and] to enroll almost 1.5 million Nigerians on life-saving HIV treatment.”

At the 2011 UNGA High-Level Meeting, President Goodluck Jonathan of Nigeria, supported by the young Nigerian HIV activist, Ebube Taylor Glory, led advocacy

on the global initiative to eliminate mother-to-child transmission. Nonetheless, Nigeria today remains one of the world's largest contributors to the number of children born with HIV. In 2020, there were an estimated 21,000 new HIV infections among children in Nigeria.


Nigeria has made laudable progress in scaling up services for key populations across the country, through the establishment of more than 60 “one-stop shop” clinics and the recent historical breakthrough appointment of a key populations’ representative (by proxy) in the Nigeria CCM. These achievements notwithstanding, ending AIDS in Nigeria as a public health threat by 2030 will eventually require bold decisions to be taken to remove the existing punitive laws and other forms of institutional barriers infringing on the health access and social justice rights for MSM, sex workers, IDUs and incarcerated persons. Continuously fighting stigma and discrimination, and putting PLHIV at the center of the response will be key, including using PLHIV and their networks for community-led monitoring and implementation of services.

UNAIDS and the Government of Nigeria—
NACA, MOH, Women Affairs, Foreign
Affairs, and the Office of the Presidency—

have a privileged and close working relationship. Now more than ever, the joint UNAIDS family is being relied upon to help the country achieve its last-mile goals and targets on HIV. The UNAIDS office in Nigeria is well-staffed, robust, and politically backed by both the UNAIDS leadership and the Government of Nigeria at the highest level, achieving full diplomatic accreditation and recognition in March of 2018. Going forward, the entirety of the Joint UN Team and Programme on AIDS will endeavor to steadfastly support the Government and people of Nigeria and partners to focus on four priorities:

- Address the fact that Nigeria still accounts for 1 in 7 children born with HIV globally.
- Close unmet HIV treatment needs (particularly among children and men) and address the slow pace of decline in HIV incidence, especially with regards to the constrained rights of adolescents, women and young girls, key populations, and vulnerable groups.
- Maintain donor engagement and solidarity, given Nigeria’s present heavy dependence on external financing for HIV.
- Foster a significantly increased, predictable and sustainable domestic strategy for financing the dual pandemics of HIV and COVID-19 and the broader health sector.





You have been credited with a key role in making this publication happen. What motivated you?

The former UNAIDS Executive Director, Mr. Michel Sidibé, was requested by President Jacob Zuma of South Africa to support the country in telling its HIV story of success and turnaround in time for International AIDS Conference held in Durban in 2016. As UNAIDS Country Director in South Africa at the time, I was tasked with this responsibility, which worked out well for both parties. I found the assignment very stimulating, professionally.

Coming to Nigeria, I often discussed Nigeria's HIV challenges with the former Minister of Health, Professor Adewole. On one occasion, he shared with me how Nigeria had done so well during the early days of the response, leading the continental response, and initiating the largest treatment in Africa. But this was before the advent of the Global Fund and PEPFAR. That's where the spark for the New Dawn publication arose. Just like South Africa, Nigeria has its own good story to tell, of past glory and a future that can be made great by the current leadership.

Working on the publication, however, another motivation became increasingly prominent: to tell the story through and by as many Nigerians as possible, such that the list of names of authors and contributors (over 150) conveys a very strong and unmistakable message: The AIDS response in Nigeria has been due to the combined efforts of many people, from the highest levels of government downwards. It is the message that everyone, however big or small in the picture, whether living or dead, whether retired or still working, wherever they are now, played a part. The list may not be exhaustive, but every effort was made to be inclusive. This, to me, is extremely appealing. It captures that idea that there is something very democratic about the publication, and that everyone involved in the struggle and in the creation of the content of the publication can run their finger down the list of authors and see their name or the name of someone they know. More than producing a readable, engaging, and attractive coffee table book, I believe that we have succeeded in supporting the Government to honor as many Nigerians involved in the response as possible.

The Road Ahead in the Words of Key Figures in the Nigerian HIV Leadership



Hon. Minister of Health, Dr. Osagie Ehanire

From the desk of the Honourable Minister of Health, Dr Osagie Ehanire (2019 - Current)

“Nigeria remains committed to achieving epidemic control and the goal of ending the AIDS epidemic by 2030. We reaffirm the critical role of country ownership and sustainability as important elements of this endeavor, including domestic

investment, an enabling environment and ensuring people-centered policy-making and implementation.”

Dr Ehanire has long championed the agenda for HIV prevention leadership and accountability, both locally and globally. As Chair of the Nigerian Coordinating Committee Mechanism for HIV, TB, and Malaria, he ensured that reforms to the structure of the HIV response took place, transforming it and making it more efficient, fit for purpose and as inclusive as possible with a voice for voiceless and marginalized. His reform accomplishments saw Nigeria become even closer partners with the Global Fund, and achieve an historic status of being its biggest recipient of grants worldwide, both for HIV and COVID-19. He completely transformed and revitalized the leadership and role of the NASCP in the national response, and made NTPP the convener and harmonizing focus for all donors and partners working in HIV.



Director-General of NACA, Dr. Gambo Aliyu

**Director Generals of the National Agency
for the Control of HIV/AIDS (NACA):
Carrying on the LEGACY**

Dr. Gambo Aliyu (2019 - Current)

“The last mile push for HIV epidemic control goes beyond identifying the hard-to-find cases to achieve UNAIDS conditional 95s. Establishing a framework for sustaining the control is an uncharted territory critical to ending AIDS as a public health threat.”

Dr. Gambo has focused on the home stretch: the last mile required to reach HIV epidemic control by guiding the

multi-sectoral response closer to the 95-95-95 targets. In a bid to cover this last mile, his tenure will also shift more toward community-based interventions to bring tailored services closer to the people who need them most. Dr. Gambo, a medical scientist, believes in the power of data and science to guide the HIV response.

Dr. Sani Aliyu (2016–2019)

“We have made tremendous progress in putting persons living with HIV on treatment in the last few years. It has been a great honor to be part of this work. However, the job is not done until we can confidently show that HIV is no longer a public health threat to our communities.”

Among his many achievements, Dr Aliyu facilitated the Presidential commitment to place 50,000 PLHIV on treatment annually. He restructured NACA for improved performance and service delivery, and led the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS)— the largest HIV-specific survey in history that was completed in a record time of nine months. Jointly with the Health Minister, he initiated a three-year reform of the Nigeria Global Fund CCM.

Professor John Idoko (2009–2016)

“Political commitment and government ownership will be needed at all levels, as well as integration with co-infections and emerging diseases and community interventions.”

Dr. Idoko oversaw the significant reversal of the HIV/AIDS epidemic in Nigeria, and is best remembered for the development and implementation of the President’s Comprehensive Response Plan for HIV/AIDS (PCRP) and the World Bank HIV/AIDS Program Development Project (HPDP II). Dr. Idoko ensured government ownership of the HIV/AIDS program by transforming the state action committees into agencies (SACAS) and he also ensured that Nigeria’s strategies were driven by evidence as seen in its participation in clinical trials of ARV drugs issues and pre-exposure prophylaxis. With funds from the Sure-P HIV/AIDS Program he established the government ART programs that commenced in Taraba and Abia states with 30,000 patients.

Professor Babatunde Osotimehin (2007–2008)

“We also need humility to engage people and facilitate change—humility to engage with the other person of the other community in such a way that they know that you respect them.”

Pioneer Director General, Prof. Osotimehin chaired the National Action Committee on AIDS and served as Senior Special Adviser to the President on HIV/AIDS. He was the face of the transformation of the HIV response in Nigeria. As DG NACA, he supervised the transformation of the response from a health sector focus to a multi-sectorally driven effort, facilitating the transformation of NACA from a committee to an agency backed by law. This helped to shape NACA’s mandate and institutionalized the subnational structures nationwide. Prof. Osotimehin rose to serve as Health Minister and UNFPA Executive Director and Under-Secretary General of the United Nations, passing away in office in June 2017. As an active member of the UNAIDS family of cosponsors, he championed HIV prevention among adolescent girls and young women.

Professor Ibrionke Akinsete (2000–2002)

Women carry the brunt of this epidemic because more than half of the people infected worldwide have been shown to be women and young girls. This is because there is violence against women! Women’s rights are not observed, so many are poorly educated and do not have income generating skills. We must look into all these because AIDS is not just a medical condition but a socioeconomic issue.”

Prof. Akinsete was the pioneer Chairperson of the National Action Committee on AIDS (later renamed NACA) and Presidential Adviser on HIV/AIDS. She laid the foundation of the national response to HIV.

NACA Board Chairpersons: Providing Leadership and Advocacy for HIV Prevention and Control in Nigeria



**Senator Oladipo
Olusoga Odujinrin
(2020–present)**

“Despite our numerous achievements, there is still a lot to be done. I enjoin us all to put our hands together to ensure we fulfill our mandate and put an end to AIDS by 2030.”

A Senator of the Federal Republic of Nigeria in 1983, an accomplished lawyer, politician and philanthropist, Senator Odujinrin has been a member of the Board of the National Agency for the Control of AIDS since 2018. He was elevated to the position of Board Chairman in 2019.



**Dame Pauline Tallen
(Board chair 2018–2020)**

“As Minister of Women Affairs, I have worked collaboratively to raise national consciousness of the urgent need to address gender-based violence and the root causes of GBV and other inequalities.”

Dame Tallen was the first woman to be appointed as Chairperson of the NACA governing Board in 2018. She provided oversight of the agency in facilitating the largest population-based HIV survey in the world. She has moved on to become the Minister for Women Affairs.



**Emeritus Professor
Umaru Shehu
(Pioneer Chairman,
Governing Board 2008)**

“Strengthening the integration of HIV services with other health programs including sexual and reproductive health, maternal and child health, TB, malaria and health systems; promoting task sharing or task shifting toward addressing health human resource gaps to ensure that other cadres of health care workers, especially nurses can provide some services usually provided by doctors to people living with HIV will help to reduce, if not stop, the spread of the disease.”

Prof. Shehu, a professor of medicine and former Vice Chancellor of the University of Nigeria, Nsukka, and former President of the Nigerian Academy of Science chaired the agency’s first Governing Board in 2008. During his tenure, he brought to bear his wealth of experience in governance in the setting out of a viable, vibrant organization.

Lawmakers: Providing an Enabling Policy Environment for Ending HIV in Nigeria

Chairmen: Senate committee on Primary Health Care and Communicable diseases



**Senator Mao
Arukwe Oluabunwa**

“We have resolved as a parliament that in 2018 we are going to implement the National Health Act, 2014, which states that 1% of the consolidated revenue fund should go to basic health care so that we can fund all our health services, including HIV/AIDS. Immediate implementation of the National Act 2014, especially the clause on basic health care provision funds, to free up funds for health care services, is necessary if the country would take ownership of the HIV/AIDS funding.”

Senator Mao Arukwe Oluabunwa served as the Senator representing Abia North Senatorial District in the 8th National Assembly. Senator Oluabunwa was

instrumental in the effort toward ensuring proper funding for health care in the country through the implementation of the National Health Act 2014.



**Senator Chukwuka
Godfrey Utazi**

“With the appreciable control of this epidemic and the increasing expectation of further shrinking, the usual funding from foreign donors will equally shrink leaving Nigeria to battle in funding the management and care of people living with HIV.”

Senator Chukwuka Godfrey Utazi is the senator representing Enugu North Senatorial District in the Nigerian Senate. A lawyer, he is a senator of the 8th and 9th Senate of Nigeria and is the current Chairman of the Senate Committee on Primary Health Care and Communicable Diseases. Senator Utazi has also been a strong voice in the quest to ensure adequate funding of the HIV response in Nigeria.

House Committee Chairpersons on HIV/AIDS, Tuberculosis and Malaria (ATM)



**Sarki Abubakar
Dahiru**

“The National Assembly will support NACA to push for commitment by governors advocating on the issues on ground.”

Sarki Abubakar Dahiru (9th Assembly) (2019–Date): Senator Dahiru, who is serving as the Federal Representative in the House of Representatives representing Lafia/Obi constituency of Nasarawa state, is the House Committee Chair on HIV/AIDS, Tuberculosis and Malaria. He is also committed to moving the HIV response forward and taking forward the sustainability discourse.



**Rt. Honorable David
Emmanuel Ombugadu**

“We as parliamentarians have been engaging a lot of stakeholders to see that the minimum 1% intervention in the health sector is improved to strengthen the health system and these are the things we are looking forward to achieving in the 2017 budget. But it not just achieving the 1% intervention of the consolidated budget of the country... but what component of that is going to the public health sector? What

component of that 1% will address HIV/AIDS, will address malaria, will address TB?”

Rt. Honorable David Emmanuel Ombugadu (8th Assembly) (2015–2019): A graduate of economics, Ombugadu was elected to the House of Representatives in 2011 and re-elected in 2015 for a second tenure. He was appointed House Committee Chair on AIDS, Tuberculosis and Malaria due to his purposeful leadership, where he contributed toward the implementation of the National Health Act recommendation of setting aside at least 1% of the Consolidated Revenue Fund to the health sector.



NEPWHAN'S FALLEN HEROES



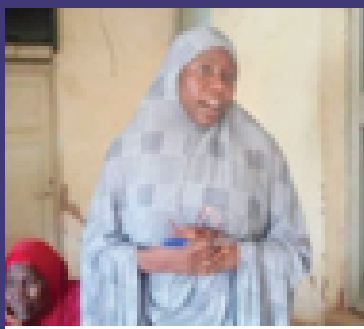
Danjuma Adamu, one of the most powerful advocates of NEPWHAN, fought for the rights of PLHIV in Nigeria. He was the Deputy National Coordinator North between 2009 and 2012.



Abraham Johnson was NEPWHAN zonal coordinator, North-East. He was a great champion and died during the NAIS survey in 2018.



Doris Emmanuel, National Secretary of NEPWHAN between 2009-2012. She led women groups during the campaign for passage of anti-discrimination bill.



Hadiza Jibril was NEPWHAN assistant secretary from 2012 to 2015. She died in 2016.



Hajiya Jamila Yahaya was the Board of Trustees secretary of NEPWHAN, a great champion of women and young people. She died in 2018.



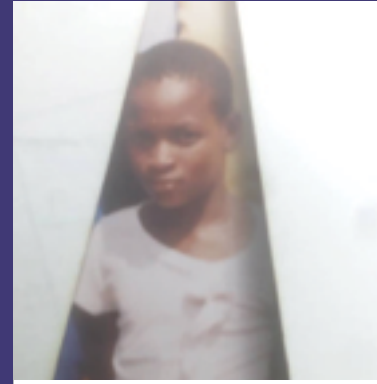
Prince Gambo was NEPWHAN deputy national coordinator, North. He died in 2021.



Chief Terkula Kuhwa was a founding member of the NEPWHAN Board of Trustees. He died in 2021.



Salomi Ugwuanyi was the founder of Ogadimma support group in Nsukka, Enugu state.



Ogbonna Chimdalum was an award winner in skills acquisition during a Positive Action for Treatment Access (PATA) adolescent holiday camp.



Jomo Evans Ettah was NEPWHAN Coordinator for Cross River state from 2014 to 2018. He was hardworking and dedicated to coordinating support groups in the state. He died in 2018.



Nenka Alobi was the State AIDS/STI Programme Coordinator in Cross River state. She contributed so much during the joint alignment process and was passionate about her work in the HIV response. She died in 2021.



Sikiru Jinadu was NEPWHAN coordinator for Ekiti state. He was a great advocate for HIV treatment, prevention and care for PLHIV. He died in 2020.





Maurice Azenda was the support group coordinator at Federal Medical Centre, Makurdi.



Gloria Nwagboniwe was the South NEPWHAN coordinator. She was a role model to PLHIVs in Delta state. She died in 2013.



Angela Ifeyinwa Ibekwe was an Impeccable HIV Counsellor, who lived openly with her HIV Positive Status. She fought against discrimination. She was an Advocate for rights of PLHIV, OVC and PMTCT, a Home-Based caregiver and Drug Adherence Supporter.

Angela was a former member of National ASWHAN EXECUTIVE and Anambra State ASWHAN Coordinator. Angela until her death was the deputy ASWHAN national coordinator, South. She was the wife of the first NEPWHAN national coordinator Mr John Ibekwe. She died in 2016.



Caroline Anthony was ASWHAN secretary for Akwa-Ibom state and the focal person for care and support in Excellence Community Education Welfare Scheme (ECEWS), an implementing partner in Akwa Ibom State. She died in 2017.



Late Alex Ogochukwu Ibekwe was one of the Hero's of the fight Against HIV stigma and discrimination. During his tenure as coordinator NEPWHAN Anambra Chapter he lived openly with HIV and engaged State Government on the involvement of PLHIV in decision making and policy formation geared towards improvement of the lives of PLHIVs. He engineered the formation of support and care groups of PLHIV in almost all the Local Government Areas of the State. Alex died in 2014.



Ifeyinwa Ibenne gave HIV a human face by making herself available to be used as an instrument for destroying stigma and fought for the right of women living with HIV. Until her death, she was the Anambra state ASWHAN secretary. She died in 2018.



Nancy Nkem Gbenoba was NEPWHAN secretary for Edo State. She died in 2019.



Late Louis Anyasoro the ever caring and loving Anambra SACA (ANSACA) Community Mobilization Officer was most supportive of all PLHIV in care. He saw to the day-to-day wellbeing of all identified PLHIV- new and old. He always made sure that whatever was due to PLHIV in the State was given to them. In addition, he sacrificed time, money and personal comfort to make sure that the needs of PLHIVs were met. Late Anyasoro had milk of kindness and love towards PLHIVs. The most significant of all was his ability and desire to assist anyone achieve set goals, especially the ones geared towards improvement of the life of PLHIVs. He died in 2020.



PUBLICATION PRODUCTION CORE TEAM



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United Nations system working on AIDS in Nigeria
in collaboration with NACA, MOH and NEPWHAN

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