



2019 HIV Health Sector Annual Report

NATIONAL AIDS & STIs
CONTROL PROGRAMME



FEDERAL MINISTRY OF HEALTH - 2019

PRE FACE

Nigeria has recorded significant progress in the control of HIV/AIDS. There have been reduction in new Infections through the years and annual HIV/AIDS deaths decreased from 69,000 to 45,000 between 2010 and 2019¹. From the estimated 1.8 million people living with HIV (PLHIV) in 2019, about 1.1 million people are currently on life-saving anti-retroviral therapy (ART).

In 2018, the National Treatment & PMTCT programme (NTPP) was re-established, reflecting government commitment towards achieving the global target of elimination of HIV by 2030. The goal of NTPP is to increase government ownership and sustainability of the HIV health sector response program.

Furthermore , In line with the resolution of the 2004 UN General Assembly Special Session on HIV/AIDS (UNGASS), member states are expected to provide annual reports that will show data on the scale-up of selected interventions and progress towards achieving Universal Access. The Federal Ministry of Health in collaboration with NACA, UN Agencies, USG, AHF, CHAI, Global Fund, and Implementing Partners produce annual reports on the progress achieved in the health sector response to HIV & AIDS. This report showcases progress made on the National Strategic Plan (NSP) targets, strategies, program achievements, trends and gaps. It highlights the performance in the national response, the collective efforts of stakeholders and also provides strategic evidence for improved performance of the HIV program.

The 2019 report provides an insight into the efforts and commitment of all stakeholders in the HIV response. It also highlights information on the following areas: HIV Testing Services (HTS), Prevention of Mother to Child Transmission (PMTCT) of HIV, and Anti-Retroviral Therapy (ART). This is the fifth in the series of annual reports produced. This report will provide resource for program evaluation, target setting and modification of program strategic direction towards achieving epidemic control in Nigeria.

¹ https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf. Accessed 20th September, 2020.

ACKNOWLEDGEMENT

The vital task of preparing the 2019 annual report could not have been fulfilled without the unified resources and efforts of key stakeholders. The National AIDS and STIs Control Programme of Federal Ministry of Health (FMoH) appreciates the contribution of all who worked tirelessly, dedicating their time and resources towards the development of the 2019 Annual Report on HIV & AIDS Health Sector Response in Nigeria.

We would like to recognize the partners who provided financial and technical support towards ensuring that the 2019 HIV Health Sector Response data was validated. These include NACA, United Nations agencies (UNAIDS, WHO, UNICEF), United States Government, Global Fund, Clinton Health Access Initiative (CHAI), AIDS Health care Foundation (AHF), and the Implementing Partners. We would also like to express gratitude to the national data validation steering committee for their dedicated contributions towards the success of the 2019 data validation. Sincere appreciation also goes to CHAI and UNAIDS for their financial support towards the production of this report.

In conclusion, the FMoH acknowledges the State Ministries of Health, State Agencies for the Control of AIDS, Network of Civil Society Organizations and other organizations for their immense input in the entire process.

Nigeria will continue to work towards meeting her set targets of ending the AIDS epidemic in the country by the year 2030.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AFENET	African Field Epidemiology Network
AHF	AIDS Healthcare Foundation
ANC	Ante-Natal Care
ART	Anti-Retroviral Therapy
ARV	Anti-retroviral
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiatives
CTRR	Counselled, Tested and Received Result
CTX	Cotrimoxazole
DNA	Deoxyribonucleic Acid
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother to Child Transmission of HIV/AIDS
FCT	Federal Capital Territory
FGN	Federal Government of Nigeria
FMoH	Federal Ministry of Health
GAM	Global AIDS Monitoring
HCWs	Health Care Workers
HEI	HIV Exposed Infant
HTS	HIV Testing Services
HISP	Heath Information System Project
HIV	Human Immunodeficiency Virus
SHMIS	State Health Management Information System
IDP	Internally Displaced Persons
INH	Isoniazid
IPs	Implementing Partners
IPT	Isoniazid Preventive Therapy
LGA	Local Government Area
MTCT	Mother to Child Transmission of HIV/AIDS
M&E	Monitoring and Evaluation
NACA	National Agency for the Control of AIDS
NASCP	National AIDS & STIs Control Programme

LIST OF ACRONYMS

NHMIS	National Health Management Information System
SKM-TWG	National Strategic Knowledge Management Technical Working Group
NSF	National Strategic Framework
NSP	National Strategic Plan
NVP	Nevirapine
OIs	Opportunistic Infections
PCR	Polymerase Chain Reaction
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PNS	Partner Notification Service
RTKs	Rapid Test Kits
SACA	State Agency for the Control of AIDS
SASCP	State AIDS/STIs Control Programme
STIs	Sexually Transmitted Infections
RM&E	Research Monitoring and Evaluation
SMoH	State Ministry of Health
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TLD	Tenofovir-Lamivudine-Dolutegravir
TFR	Total Fertility Rate
UN	United Nations
USAID	United States Agency for International Development
USG	United States Government
UNAIDS	Joint United Nations Programme on HIV & AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nation Children's Fund
VDRL	Venereal Disease Research Laboratory
WB	World Bank
WHO	World Health Organization



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SECTION 1



INTRODUCTION

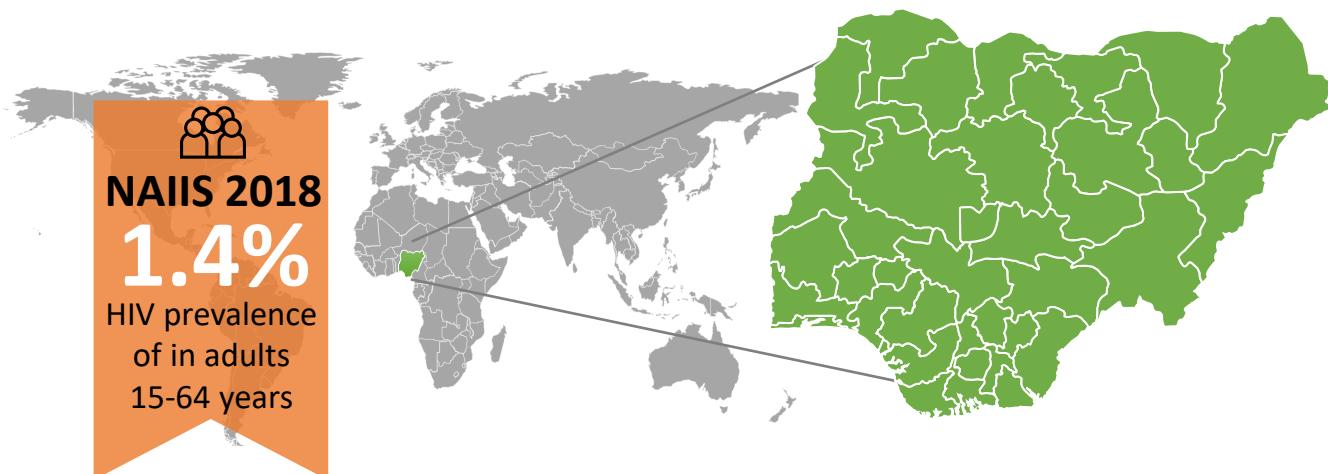
1. 0 Background

In 2019, an estimated 38 million people were living with HIV/AIDS globally; 36.2 million adults and 1.8 million children². Eighty-one percent of the estimated PLHIV knew their status and more than two thirds on Antiretroviral therapy (ART). The global commitment to end HIV epidemic has been relentless as reflected in the 23% decline in new infections worldwide since 2010. Nigeria continues to make progress in its HIV response.

Nigeria is the most populous country in Africa with an estimated population of 200 million . It is divided into six geopolitical zones, comprising of 36 states plus Federal Capital Territory (FCT). It operates a three-tier decentralized structure – Federal, state and local government The median age of the population is 18.5 years, making it one of the largest populations of youth in the world. Approximately 44% of the population are children between 0-15 years. The average life expectancy in Nigeria is 54.5 years (53.7 years for men and 55.4 years for women).

In 2018, Nigeria conducted a landmark survey- the Nigeria HIV/AIDS Indicator and Impact Survey (NAIIS). NAIIS showed HIV prevalence among adults aged 15-64 years was 1.4%. This was lower among men (1.0%) than women (1.8%) and lower in urban (1.3%) areas than in rural (1.5%) areas. HIV prevalence among adults aged 15-49 years was 1.3%. This was lower among men (0.8%) than women (1.7%) and lower in urban (1.1%) than in rural (1.4%) areas.

The National Health sector response on HIV/AIDS is coordinated by the National AIDS and STIs control Program (NASCP) of the Federal Ministry of Health (FMoH). This is replicated at the State level by the State AIDS and STIs control Program (SASCP) of the State Ministry of Health (SMoH).



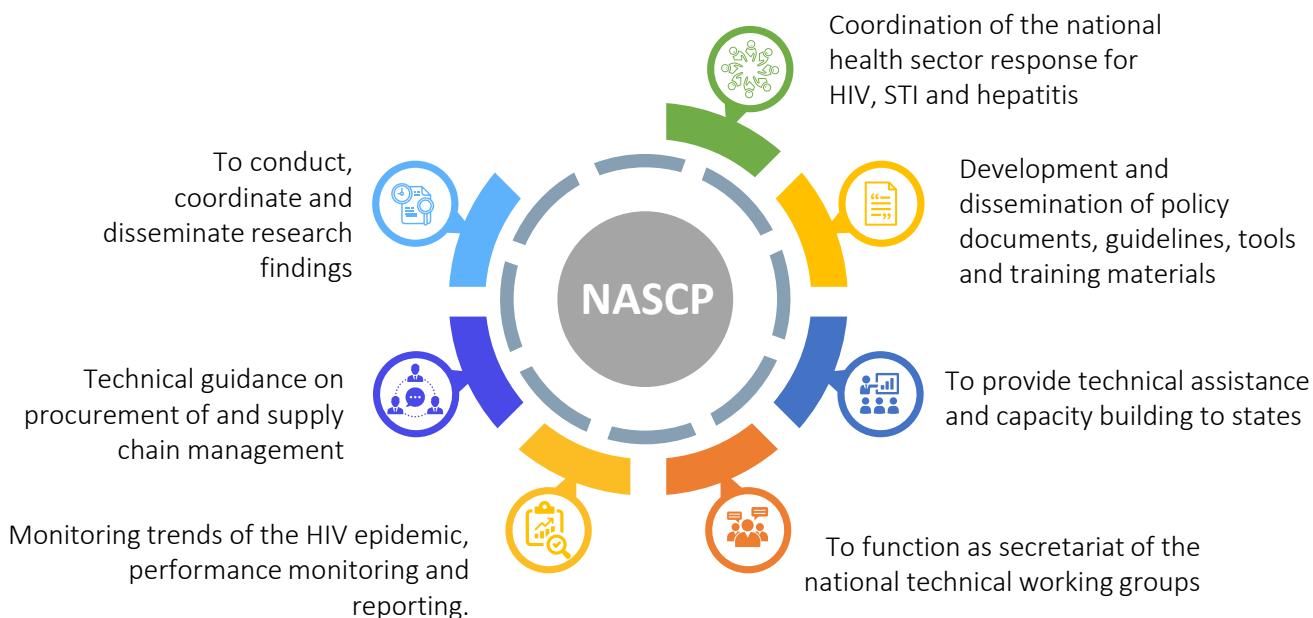
² <https://www.unaids.org/en/resources/fact-sheet>. Accessed 4th September, 2020.

1. 1 Program Mandate

The main program mandate of NASCP is to coordinate the formulation and effective implementation of National policies, guidelines and SOPs for the prevention of new HIV infections as well as Treatment, Care and support for all those infected and affected by the virus and STIs(including Hepatitis) in the country.

Specific roles of NASCP include :

- Coordination of the national health sector response for HIV, STI and hepatitis
- Development and dissemination of policy documents, guidelines, tools and training materials
- To provide technical assistance and capacity building to states
- To function as secretariat of the national technical working groups for the various thematic areas in HIV response and for hepatitis and STI.
- Monitoring trends of the HIV epidemic, performance monitoring and reporting.
- Technical guidance on procurement of and supply chain management of pharmaceuticals and laboratory product.
- To conduct, coordinate and disseminate research findings on HIV STI and Hepatitis



Current Strategies adopted towards achieving the NASCP mandate include;

- i. Provision of comprehensive HIV/AIDS services in a differentiated care approach.
- ii. Continuous quality assurance and improvement across the entire continuum of care.
- iii. Focusing the response on sub-national units with high disease burden and specially targeting key populations at greatest risk.
- iv. Leveraging existing programmes and opportunities for cross learning in-country between the National Programmes and the private sector

1. 2 Leadership and Governance

FEDERAL MINISTRY OF HEALTH (FMoH):

The FMoH has the responsibility of formulating and implementing health policies. It is headed by the Honorable Minister of Health, assisted by the Minister of state and the Permanent secretary. There are several departments and agencies specialized in different aspects of healthcare. Critical departments to the HIV health sector response include

- The department of Public health which focuses on coordination, formulation, Implementation and evaluation of public health policies and guidelines- Including HIV/AIDS Programme.
- The department of hospital services
- The department of health planning research and statistics
- The department of family health

Key agencies and programmes relevant to the HIV/AIDS programme under the FMoH include;

- National AIDS/STI Control Programme (NASCP) which coordinates the national HIV/AIDS health sector response
- National Agency for the Control of AIDS (NACA) which handles the HIV/AIDS multisectoral response
- National Primary Health Care Development Agency (NPHCDA), which supervises primary health care services
- National Tuberculosis & Leprosy Control Programme (NTBLCP) which coordinates Tuberculosis and Leprosy control effort in Nigeria.
- National Health Insurance Scheme (NHIS)

STATE MINISTRY OF HEALTH (SMoH)

The structure of health system coordination in the states is replicated from the FMoH, headed by the Honorable Commissioner for Health and assisted by the Permanent Secretary. The State Ministry of Health is responsible for the planning, budgeting and implementation of the state policies on health. The SMoH is made up of Directorates with each having its own distinct responsibilities. The state AIDS/STI control programme (SASCP) is responsible for coordinating state HIV/AIDS health sector response. At the state level, there is also a replica of multisectoral HIV/AIDS response coordination - State AIDS Control Agency (SACA).

LOCAL GOVERNMENT DEPARTMENT OF HEALTH:

Recognized as the lowest level of heath sector coordination. It is also the closest to the primary health care facilities and the communities. They are supervised by mainly the SPHCDA and SMOH, and the local government department of health.

NATIONAL AIDS & STI CONTROL PROGRAM (NASCP) ORGANOGRAM



Figure 1.2.1: National AIDS & STI Control Program (NASCP) Organogram

National Treatment and PMTCT Programme (NTPP)

In the bid to achieve HIV epidemic control and end AIDS by 2030, the Federal Ministry of Health (FMoH) re-established the National Treatment and PMTCT Programme (NTPP) under NASCP in 2018. This aims to strengthen Government ownership and ensure commitment towards developing a sustainable HIV/AIDS response in Nigeria.

The NTPP is envisioned to provide an umbrella coordinating body for the entire HIV/AIDS health sector response with all donors and implementing partners aligning within a single implementation framework driven by the National and spanning across the states and LGAs.

The critical objectives of the NTPP includes; Programme Coordination, Performance Monitoring against set targets at National and Subnational Levels, strengthening institutional capacity of NASCP and state ministries of health, optimizing, leveraging and tracking domestic resources.

STRUCTURAL ARCHITECHTURE OF THE NATIONAL TREATMENT AND PREVENTION PROGRAM (NTPP)

Architecture for the National HIV Treatment and PMTCT Programme

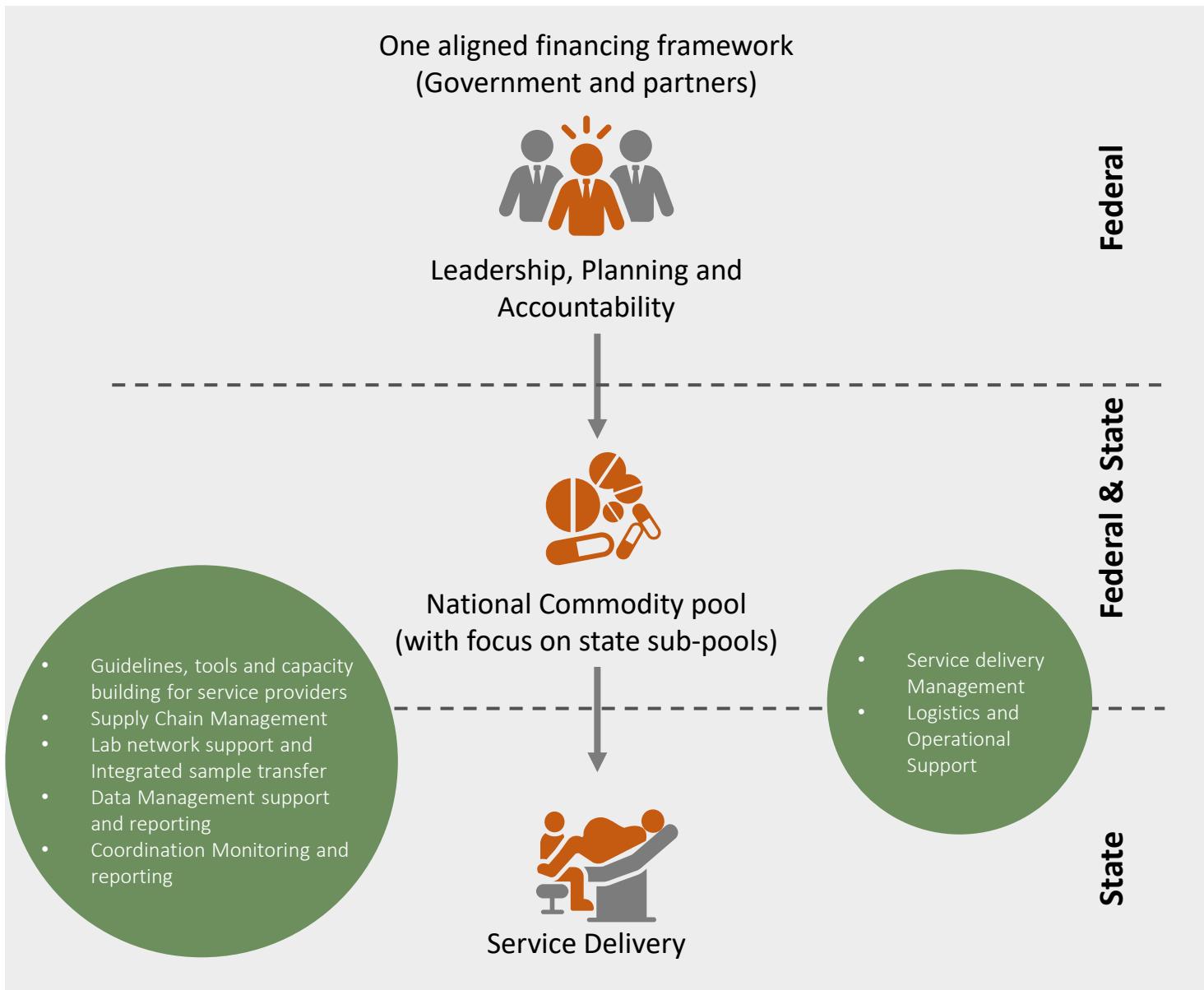


Figure 1.3.1: Structural Architecture of The National Treatment and Prevention Program (NTPP)

1. 3 Technical and Financial support

The Health sector response to HIV and AIDS is supported by Government of Nigeria through the Federal Ministry of Health. Also, the country receives Technical and financial support through the UN Agencies(WHO, UNAIDS, UNICEF), Global Fund, PEPFAR, NACA, CHAI and AHF.

1. 4 Strategic Information

Nigeria has a generalized HIV epidemic. Higher prevalence has been observed in some States and among Key Population groups. It has the fourth highest burden of HIV globally and highest burden in West and Central Africa with an estimated 1.8 million PLHIV. Nigeria has a HIV prevalence of 1.4% (males 0.8%, Females 1.7%). The estimated number of children (0 – 14 years) living with HIV is 150,000 while that of HIV positive pregnant women is 99,000. New HIV infections is 102,940 with 45,000 AIDS related deaths and 41% of new childhood infection in 2018.

During the reporting period (between January 2019 to December 2019), Nigeria has made significant progress in her strive to achieve epidemic control.

The National HIV/AIDS Health sector response data is reported from the facilities to the LGA, to state and the National. The data are collected using the national data reporting forms and Registers which feeds into the national reporting platforms (District Health Information system (DHIS) and the Electronic Medical Records (EMR). Data from the EMR feeds into the National Data Repository (NDR). Also, data from survey and surveillance activities are

1. 5 Health sector data flow

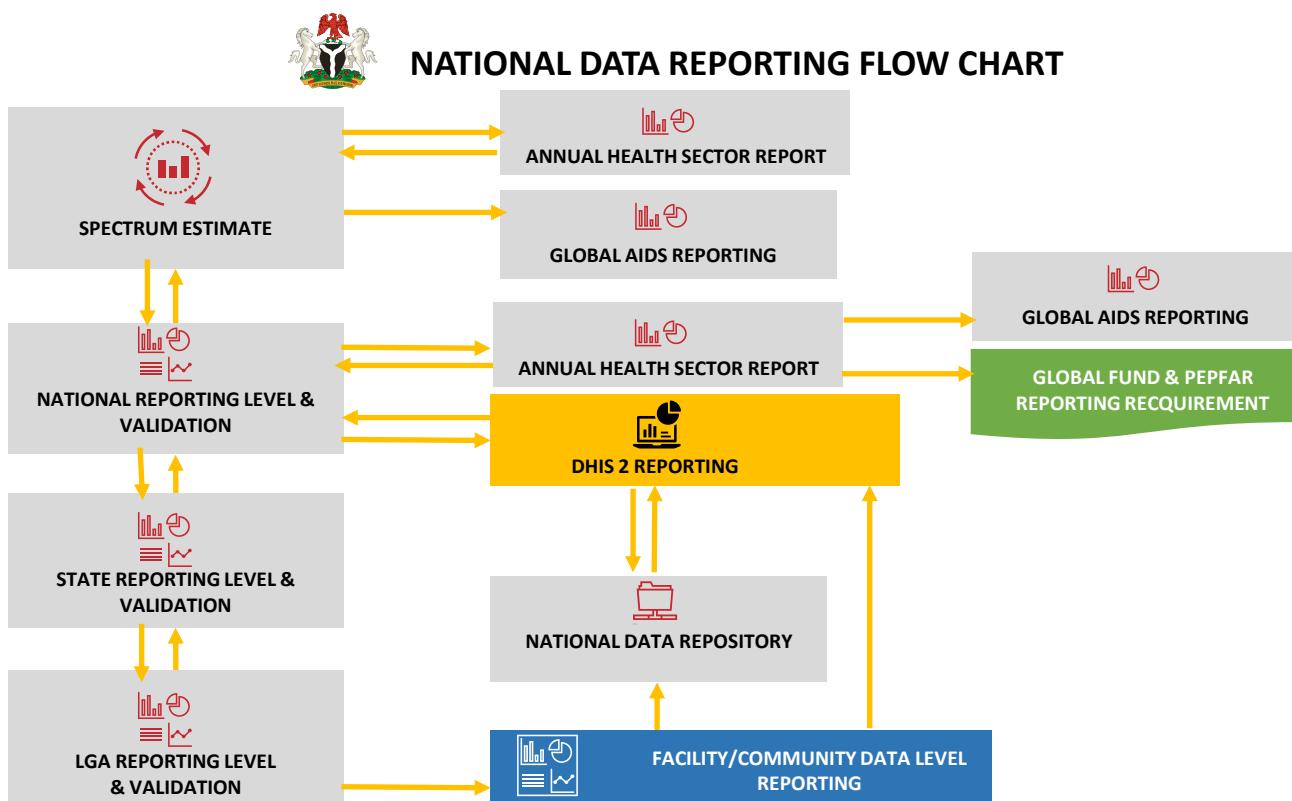


Figure 1.5.1: Health sector data flow (schematic diagram)

1. 6 Reporting Process

Data Validation Process

The data validation process is a three-stage process held bi-annually. The first stage is at the state level, the second stage at the zonal level while the third stage is at the national level (collation, verification, consolidation and report writing). The health sector data validation process is coordinated by the National Health Sector data validation core team and steering committee.

The national health sector data validation core team includes staff from NASCP and NACA. It is the responsibility of this team to ensure the successful conduct of this process and to produce consolidated national health sector validated data disaggregated by sub-national units (states) as well as other relevant elements of disaggregation. The process is concluded with the development and distribution of the annual health sector report.

The steering committee comprises of major stakeholders from Government of Nigeria (GoN), donors, UN Agencies and implementing partners and they are responsible for coordination, oversight, administrative and technical guidance as well as decision-making on all major aspects of the data validation process.



Levels of the Data Validation Process

01

State level data validation



The state-level data validation is conducted on a quarterly basis by the SASCP in collaboration with the State department of Health Planning, Research and Statistics (SDHPRS), SACA and all the Implementing Partners (IPs) in the states to harmonize and validate health sector data. This process involves identification of the gaps and the use of nationally agreed validation rules to harmonize and validate the reported data. The output of this meeting is the consolidated state-level data disaggregated by facility. This data is further reviewed at zonal validation meetings. Data quality issues identified at these meetings are addressed by the national and state teams.

02

Zonal data validation meeting



The 2019 zonal health sector data validation was organized by the national core team. Two zonal validation meetings were held in September 2019 and March 2020 respectively and involved all state M&E officers, national M&E officers, IPs and UN Agencies. The National core team provided support by ensuring that the state level validated data were cross-checked and revalidated in order to ensure quality data. The key output of the meetings were the validated data from all the 36 states including FCT.

03

National Data Validation Process



This is the final stage of the validation process coordinated by the national validation core team. It includes state data collation, verification, harmonization, consolidation, feedback with the states/key stakeholders and consensus building. This is followed by the completion of the Global AIDS Monitoring (GAM) report and development of the final annual report.



SECTION 2



Thematic Area:

HIV Testing Service



Strategic Objective: To increase access to HIV testing services so as to enable 90% of people living with HIV to know their status and be linked to relevant services.

2. 1 Background

HIV testing services (HTS) is a very key component of the National HIV responses and comprises of activities that ensure voluntary and confidential counselling, testing, disclosure of HIV test results to individuals, clinical screening for tuberculosis and STIs. HIV testing is the entry point for HIV prevention, treatment and care services. The services include pre-test information, testing using the national serial algorithm, post-test counselling and linkage to HIV prevention, care and treatment. The National HTS guideline recommends that HTS be delivered using a client centered approach guided by five core principles known as the 5Cs: consent, confidentiality, counselling, correct test results and connection with prevention care and treatment services.

As of 2018, 67% of the estimated PLHIV in Nigeria knew their status. With This showed a gap of about 23% in attaining the UNAIDS 1st 90 targets by 2020. To address this gap, there is need to increase access to HIV testing services.



To increase access to HIV testing services so as to enable 90% of people living with HIV to know their status and be linked to relevant services.

NSP 2017-2021

National Strategic Plan Targets

The Revised National HIV and AIDS Strategic Framework 2019-2021 (NSF) commits to increase access of 60% of the general population, 80% of vulnerable populations, 100% of key populations and children of mothers living with HIV to HIV testing services. The Framework also aims to integrate screening for other co-infections into HTS by 2021.

Key Strategies adopted towards attaining the NSF targets include:

Implementation of the national task-shifting/task-sharing policy to address human resources gaps in HTS



Promote improved testing efficiencies, taking into account local epidemic characteristics

Prioritize facility-based testing through smart integration and Provider Initiated Testing and Counselling (PITC) in high yield streams such as TB, STI and malnutrition clinics as well as ANC.

Targeted community-based HIV testing services strategies, including HIV self-testing, should be scaled up

Strengthen facilitated referral and linkage services between HIV testing services, HIV treatment and related services

2. 2 Key HTS performance indicators

National HTS Cascade trend (2015-2019)



Figure 2.2.1: National HTS Cascade trend (2015-2019)

2. 3 PLHIV known status

The 2020 UNAIDS Global AIDS report shows that in 2019, 73% of the estimated people living with HIV/AIDS in Nigeria know their status (1st 90 target). This shows a gap of about 17% and 22% in attaining the UNAIDS 1st 90 targets by 2020 and 2030 respectively.

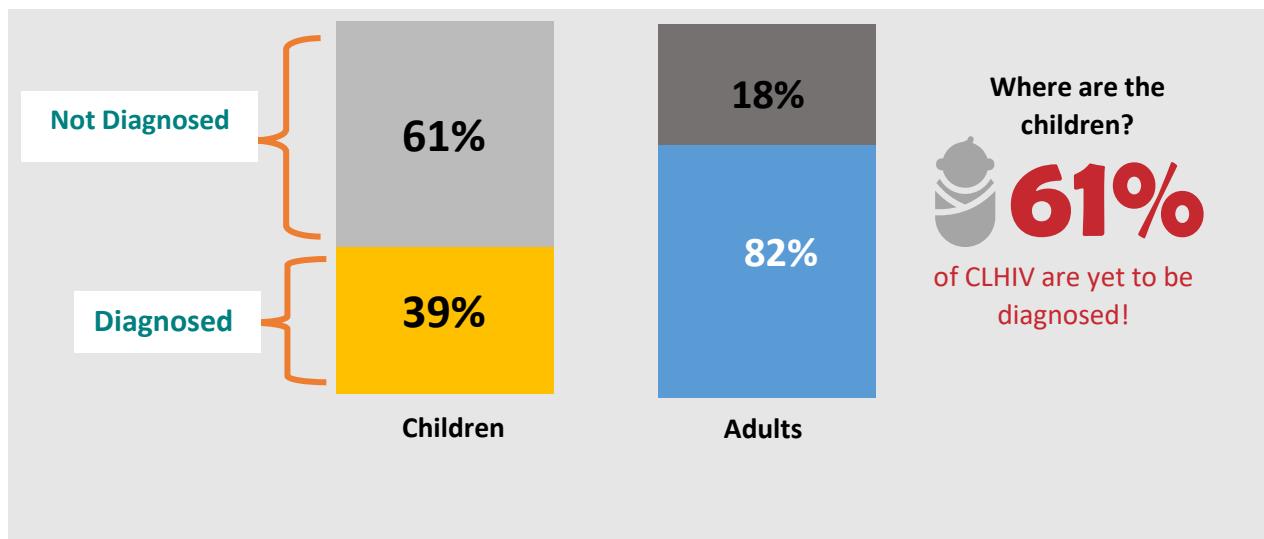


Figure 2.3.1 : PLHIV with Known Status Disaggregated by Age

Fig 2.3.1 above shows that 18% of adults living with HIV are yet to know their status, the picture for children is grimmer as an estimated 61% of CLHIV are yet to be diagnosed. There is need to intensify HIV case finding using specific strategies that will give enough yield among the different populations.

2.3.2: PLHIV known status

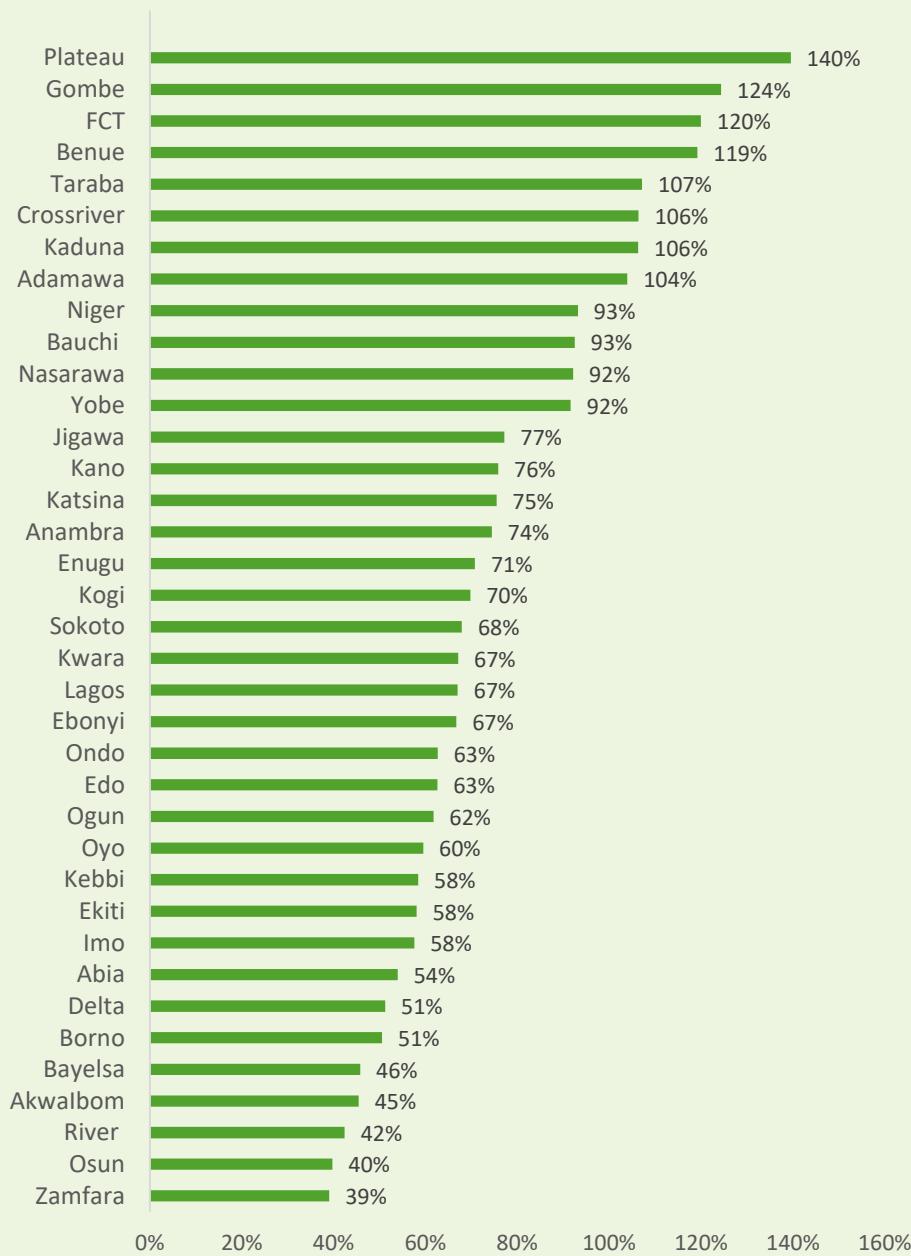


Figure 2.3.2: Percentage of Estimated PLHIV with Known HIV Status by State

Figure 2.3.2 above shows percentage of PLHIV with known HIV status by state. About 68% of the states are yet to achieve their 1st 90, thus much work needs to be done in those states. State specific strategies need to be deployed for the identification of HIV cases



Fig 2.3.3: Map showing progress with 1st 90 by States.

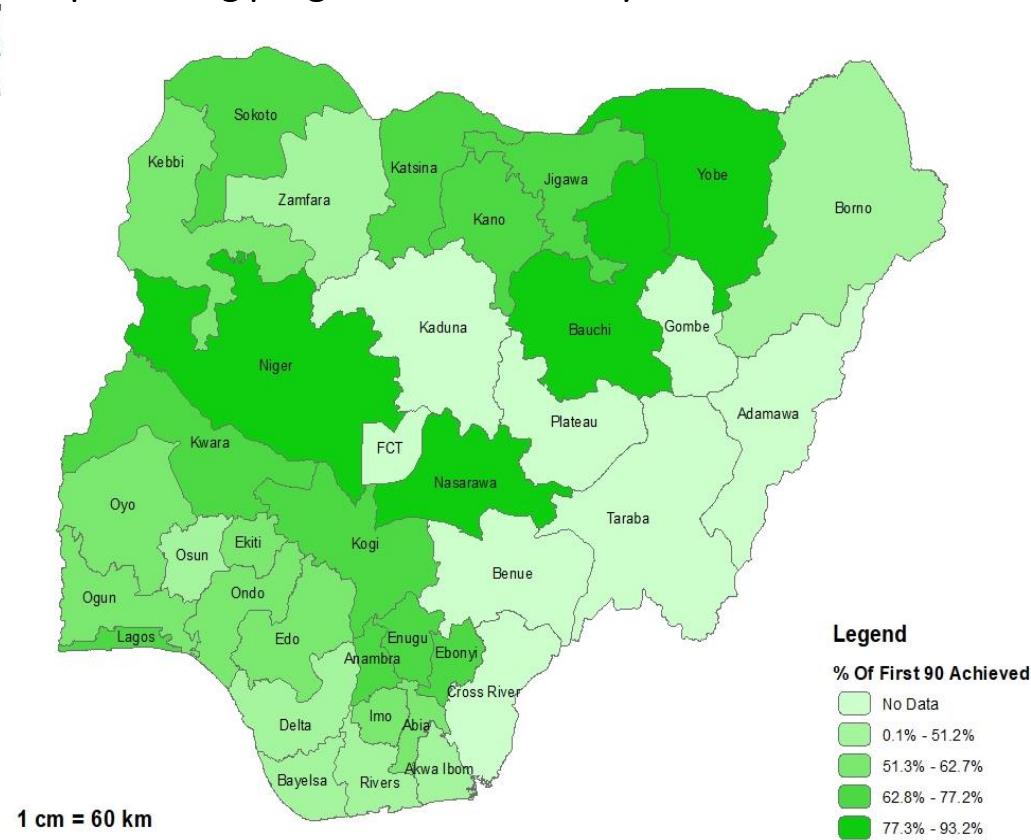


Fig 2.3.3: Map showing known HIV status in General Population by state



2. 4 Performance of HIV Testing Programs

2.4.1 HIV Testing by State

A total of 7,190, 423 persons were tested for HIV in 2019 across all the states in the country.

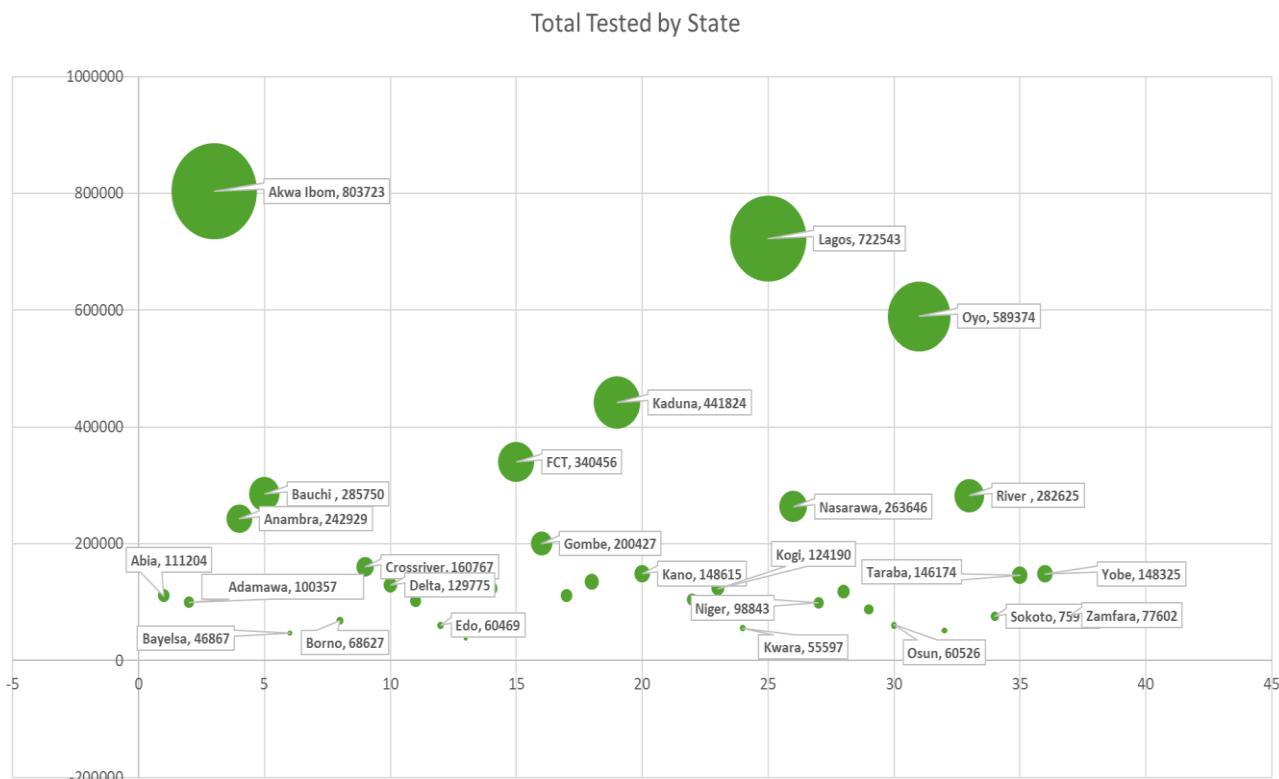


Fig 2.4.1: Total Number of Persons CTRR by State

Fig 2.4.1 above shows a bubble map of number of persons that were Counselling Tested and Received Result (CTRR) in the 36 plus 1 states in Nigeria. The states with the biggest squares (Akwa-Ibom, Lagos, and Oyo) are those with the highest number of persons CTRR. However, this high number of tests does not translate to having a corresponding yield in the number of positives identified.

Fig 2.4.2: Total Number of Persons CTRR by State

2. 4 Performance of HIV Testing Programs

2.4.3 Positivity yield by State

A total of 210,855 positives were identified out of a total of 7,109,423 persons that were tested for HIV. The positivity yield from the HIV tests conducted in 2019 was 3%. The positivity yield was highest in Plateau state (7.4%) and lowest in Yobe state (0.7%).

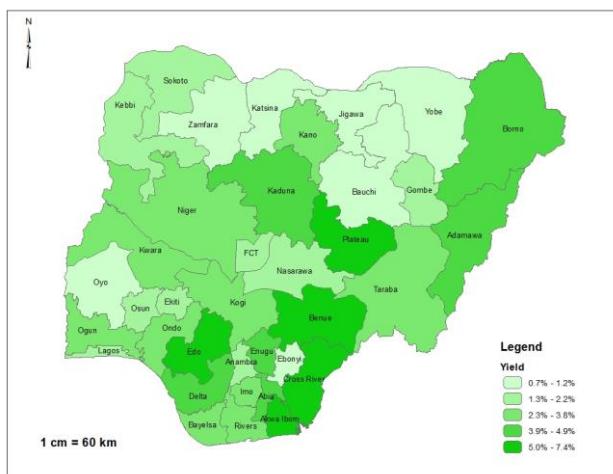


Fig 2.4.3 : Map showing positivity yield in general population by state

Testing and Yield Quadrant Analysis

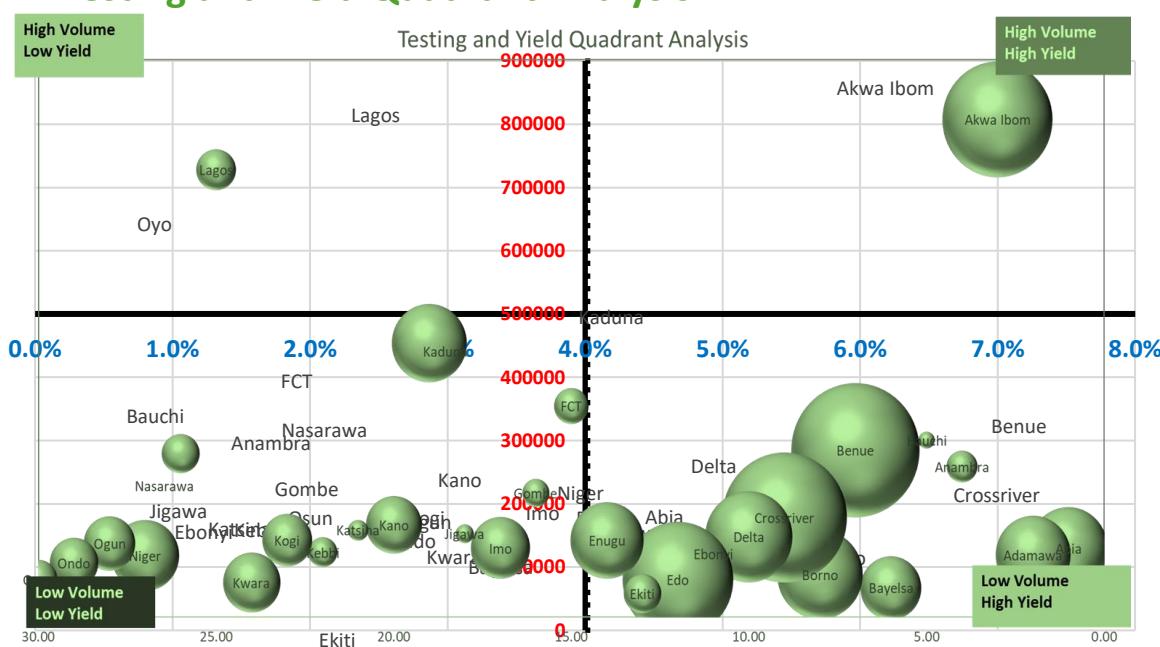


Fig 2.4.4 above shows a quadrant analysis of the yield from tests done across the states. The program adopted targeted testing strategies to optimize case identification in 2019. 16 states are in “low volume low yield” quadrant. A relatively high number of HIV tests were conducted in Akwa-Ibom with a high yield . Lagos state had a relatively high volume and low yield, HIV testing in the state therefore needs to be better aligned with the national recommendations.

2.4.5 HIV Positivity Rate by Age and Sex

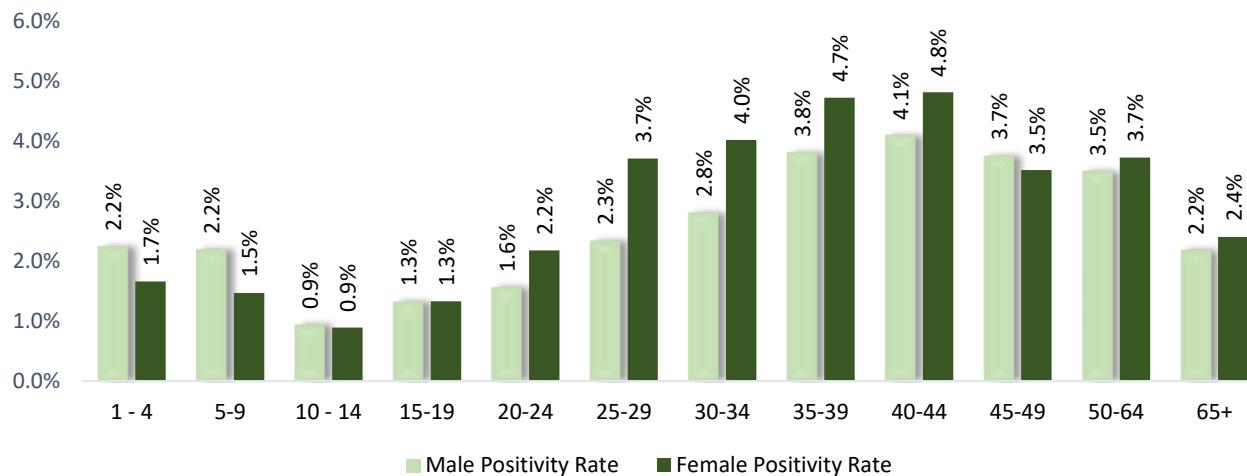


Figure 2.4.5: HIV Positivity Rate Disaggregated by Age and Sex.

Figure 2.4.5: shows HIV positivity rate in 2019 disaggregated by age and sex. HIV Positivity rate was lowest in the group 0 – 14 years (0.9%) and highest among females 35-39 years (4.7%). Overall, the children and adolescents (10 – 19) had the lowest positivity rate . This corroborates the NAIIS study that showed 0.2% HIV prevalence among children. Targeted testing will help in identifying HIV positive cases among this population.

2.4.6: Percentage contribution to positives by age and sex

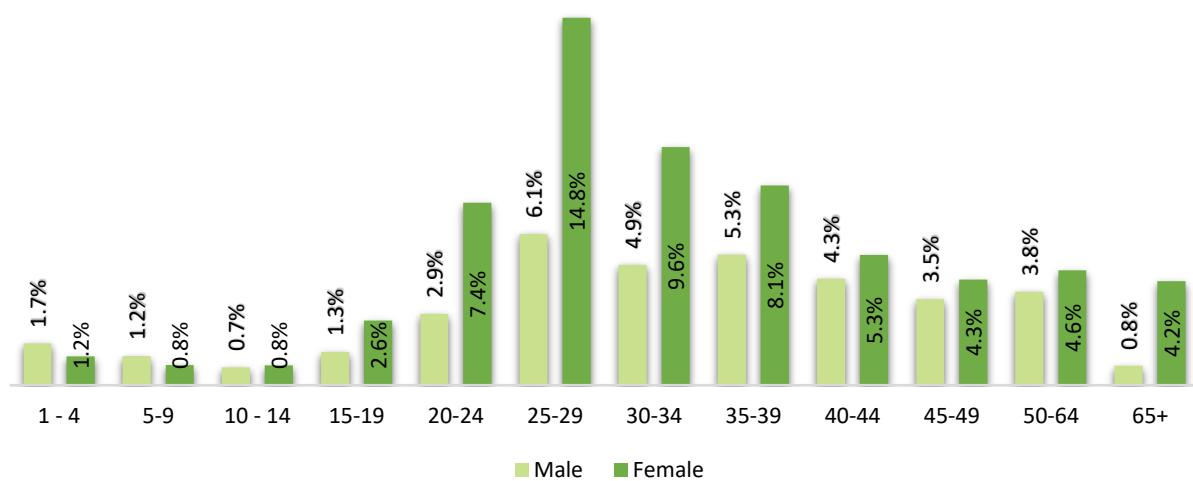


Figure 2.4.6: shows that females contributed more to the total number of positives, this is mostly observed among females of the reproductive age group. Females between the ages of 25-29 years contributed 14.8% of positives identified in 2019. The country should focus on integrating Reproductive Health Services into HIV services while ensuring proper linkage to care. The National HIV program should emphasize on index testing for partners and children of identified female positives.

2.4.7 Trend in the Number of Persons counselled, Tested and Received Results

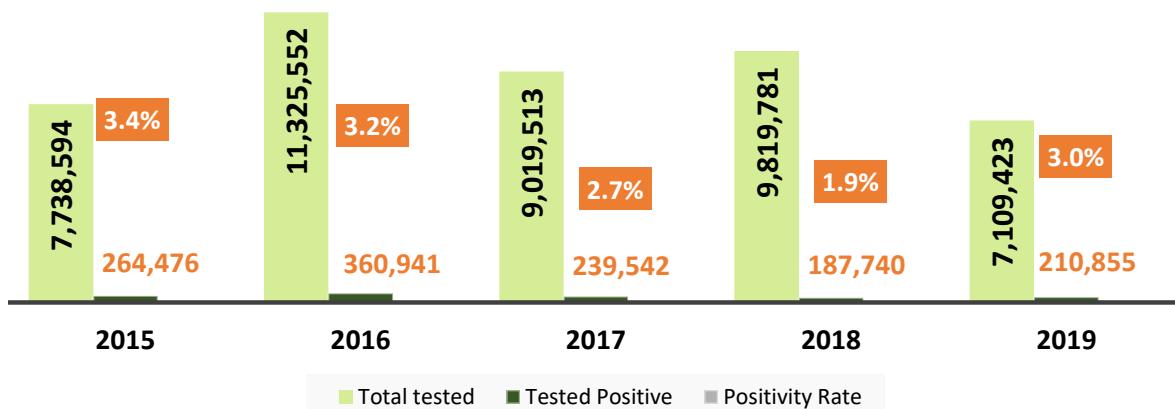


Figure 2.4.7: Trend in the Number of Persons Counselled, Tested and Received Results.

Figure 2.4.7 shows the trend in the total number of persons counselled, tested and received results (CTRR), number positive and the positivity rates between 2015 and 2019. In the last three years, the number of persons tested declined. This may be attributed to targeted testing being done in most of the facilities and the use of HIV stratification checklists.

2.4.8 HIV Testing Sites Vs Total Tested

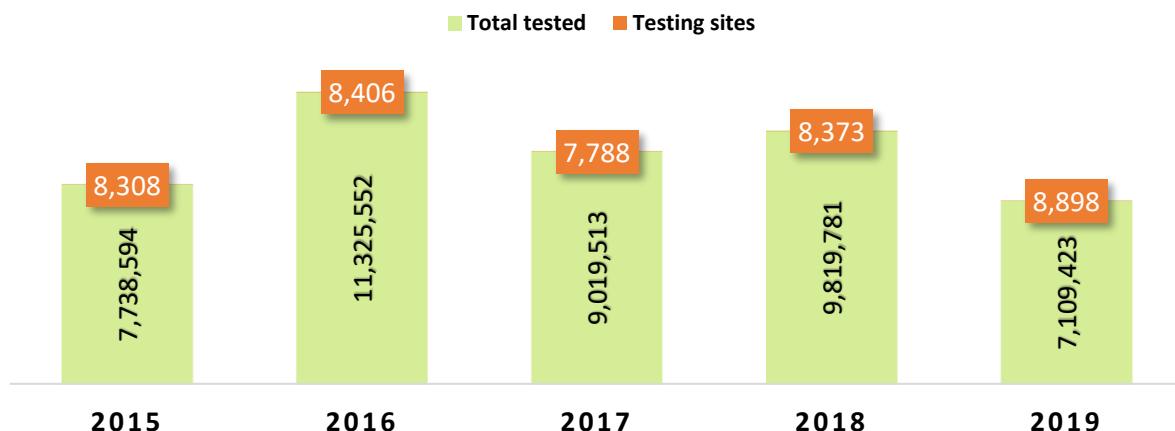


Figure 2.4.8 : Trend in the Number of Persons CTRR and Number of HTS Sites

Figure 2.4.8 shows an increase in the number of HTS site from 8,308 in 2015 to 8,898 in 2019 while the number of persons CTRR gradually decline from 2016 till 2019. This shows that an increase in the number of sites does not imply a simultaneous increase in the number of persons CTRR.

2.4.9 Trend in Linkage to Care

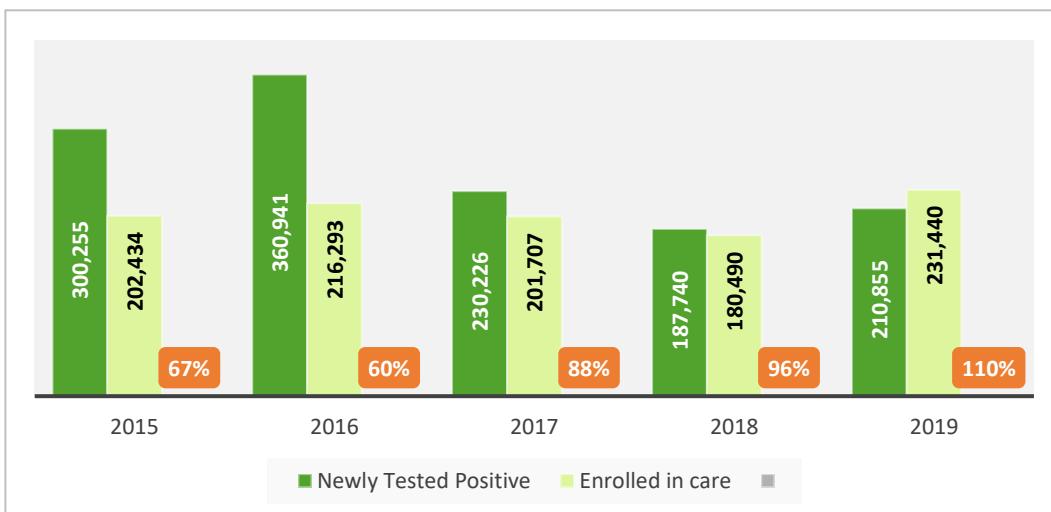


Figure 2.4.9: Trends in Linkage to Care.

Figure 2.4.9 shows trend in proportion of HIV positive cases linked to care in the last five years. Linkage to care is defined as the total number of persons tested positive that are linked to care. Enrolment into care is used as a proxy for linkage to care in ART settings. An increase of 40% was observed from 2016 to 2019, consistent with the ‘Treat-all’ adopted in 2016. There was however the number of clients linked to care in 2019 exceeding the total number of positives identified. This may be as a result of deficit of clients that were not linked to care in the previous year. There is need to maintain this status quo going forward as linkage to care is a critical criteria in achieving the second 90 target

2.5 HIV Testing Strategies

Nigeria has adopted many innovative HIV testing strategies / modalities in order to ensure that all PLHIV are identified, linked to care, initiated and retained on ART while ensuring adherence to antiretroviral drugs and viral load suppression while those who test negative are linked to preventive services

2.5.1 Positivity Yield from Index Testing

The proactive tracking and testing of exposed index contacts is an efficient strategy to identify new HIV positive clients and should be intensified

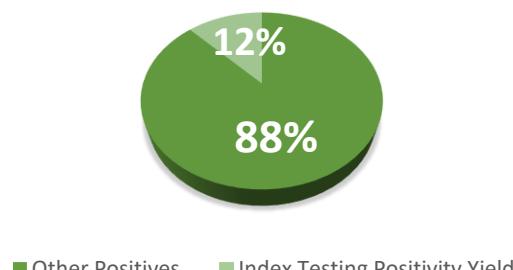


Figure 2.5.1: Positivity Yield from Index case Testing - National

2.5.2 Index Case Contribution to the Total Positives

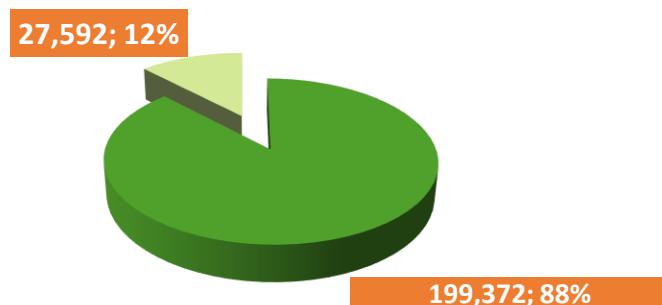


Figure 2.5.2: Index Case Contribution to the Total Positives - National

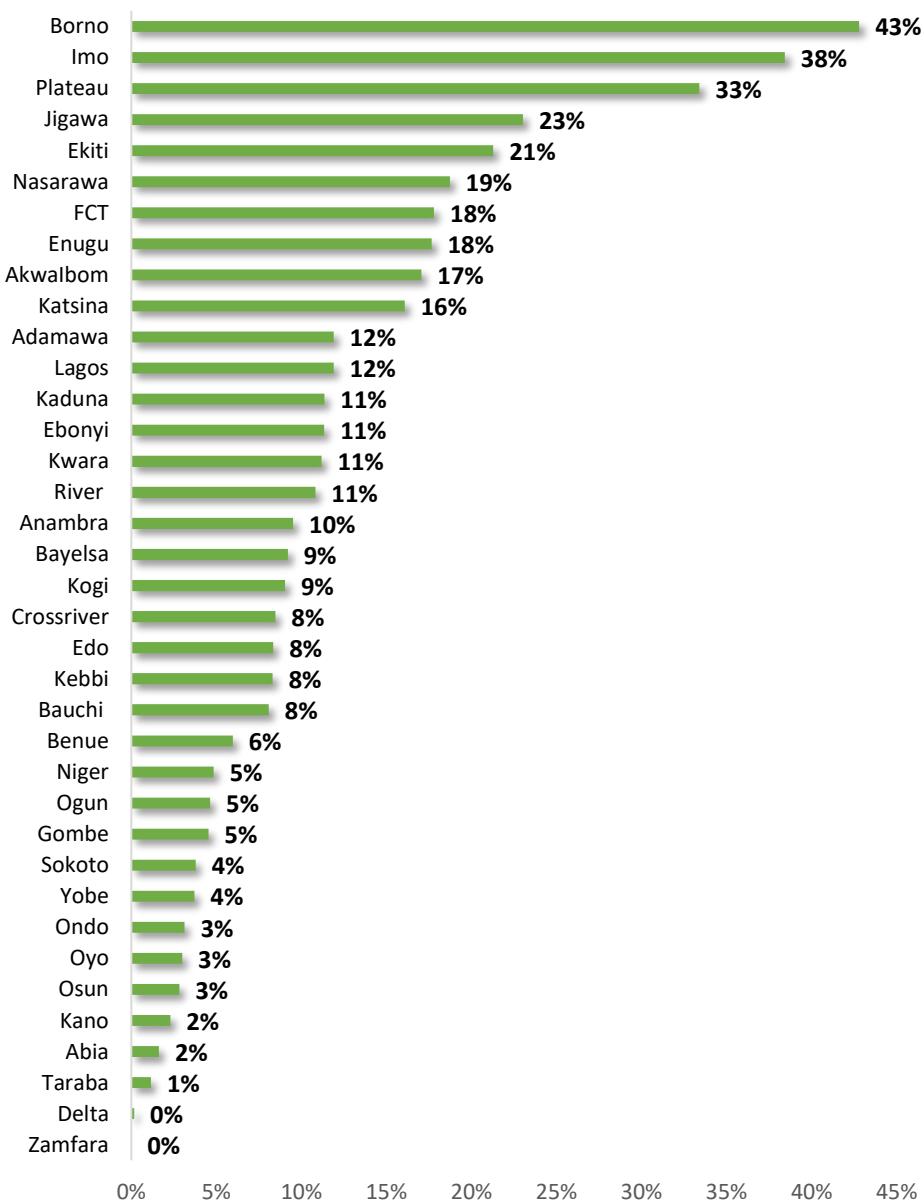


Figure 2.5.3: Index Case Contribution to the Total Positives- States

Figure 2.5.2 and 2.5.3 are showing the contribution of index case testing to HIV case identification in 2019. Twelve percent of the 210,855 new HIV positives were identified through index case testing. In Borno state, 43% of new HIV positive persons reported in 2019 were identified from index tests. In Delta and Bayelsa states, index tests were responsible for 0% of the new cases identified.

2.5.4 Couples Testing Yield

Discordance Rate Among Total Couples tested



Figure 2.5.4: Discordance Rate among the Couples Tested

Figure 2.5.4 shows. A discordance rate of 4% was observed among couples tested in 2019. Access to HIV preventive services should be optimized for patients in this group to ensure they stay HIV negative.



2.6 Screening for Co-infections within HTS setting

The World Health Organization recommended the integration of HTS with other health services such as TB, syphilis, hepatitis, maternal and child health, sexual and reproductive health, harm reduction programmes for people who inject drugs to mention a few. This is to help increase HTS uptake, prompt diagnosis of other co-morbidities and their management in the same place and at the same time.

2.6.1 Screening for TB, Syphilis, HBV and HCV in HTS Setting.

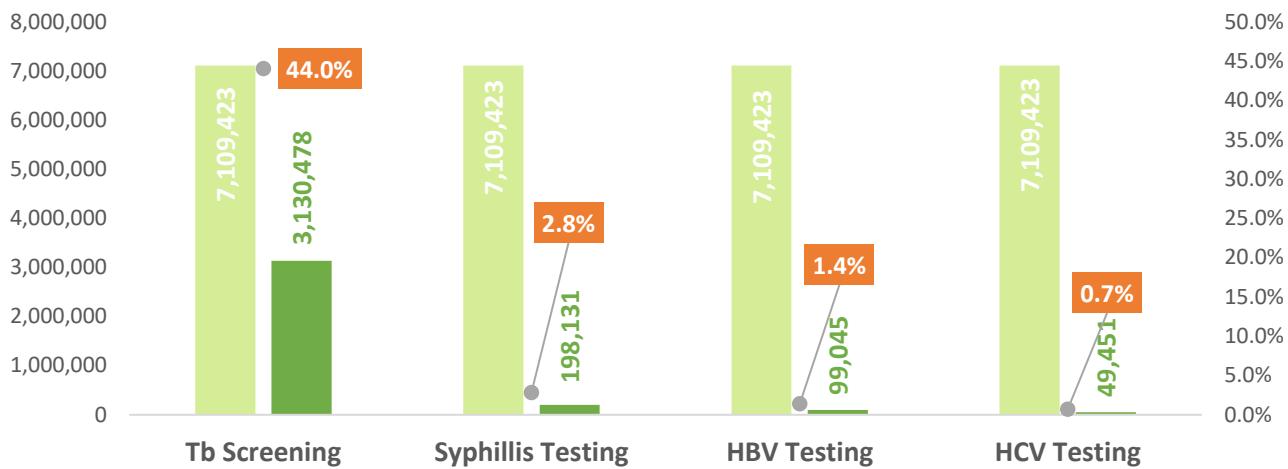


Figure 2.6.1: Percentage Screened for TB, Syphilis, HBV and HCV in HTS Setting.

Figure 2.6.1 shows the various co-infections that are integrated into HTS for prompt diagnosis to assess the high-risk groups and also prompt management. Of the total number of persons CTRR, only 44% were screened for TB, 2.8% were tested for syphilis, 1.4% were tested for HBV and 0.7% tested for HCV. There is a need to increase active screening for co-morbidities in all HIV testing settings.





IMPACT STORES

OYO STATE

Improving HIV Testing Program and Positivity yield with Index testing

Testing strategies - Index case Testing (IT)

Objectives: To increased access to HIV testing and positivity yield between the period of January - December 2019.

Methodology, Inputs – Overall strategy/approach and key inputs

Multiple strategies were put in place to increased access to HIV testing and positivity yield between the period of January - December 2019. One was the site level HIV Quality Improvement program addressing the Cascade for Index testing which showed increased case identification by the contribution of Index to positivity yield within the period. The facility was assigned weekly testing and positive targets by the Quality Improvement team and they conducted quarterly IT review meetings with facility HIV Case Finding managers to ensure target were met and positivity yield achieved.

Other strategies put in place to access HIV Testing Services by index of positive clients between January and December 2019 are:

Engagement of Adhoc staff to support the facility health care provider to intensify strategic testing with the use of Risk Stratification Tools and also supported of Index Testing,

Provision of dedicated phone lines for Integrated Health Messages informing the index of the provision of wrap-around services (urinalysis; Hep B investigation, Malaria test etc...) to improved IT process.

Case Finding Managers at the facilities were supported to ensure all backlog of partners yet to be offered IT were contacted for testing by using dedicated phone lines. This was to prevent missed opportunities of identifying HIV positive cases.

Impact:

The Impact of the above was seen in the achievements of increased positivity yield form IT which was 28%. Also, the IT Cascade for the period is shown below while the table shows clients identified from indexes and those positive.

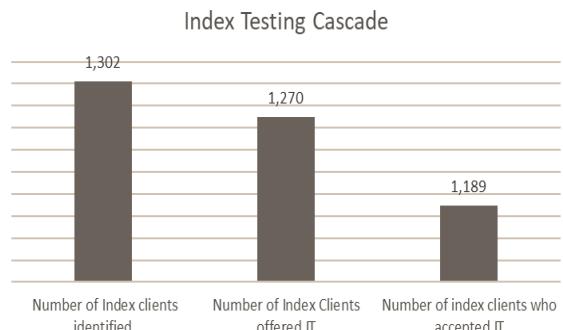


Figure 1: Index Testing Cascade

Total Number of Partners and children identified	Number
Number of partners and children identified	1,823
Number of partners and children tested;	1,823
Number of partners and children Positive	516
Number of partners and children linked and enrolled;	516

Program Results: The system has moved away form general population testing to index testing which has achieved increased positivity yield.

Program Impact – The IT positivity yield was 28%. That form the general population was 1% for the period of January to December, 2019

Future Potential – The QI team at the facility will continue to ensure improvement in service delivery.

A photograph showing a woman from behind, holding a baby. They are standing in a doorway made of weathered wood. The woman is wearing a dark blue top with white polka dots. The baby is wearing a light blue onesie with a cartoon character on it. A green circular inset in the upper right corner shows a close-up of the baby's head and shoulders.

SECTION 3



Thematic Area:
**Elimination of
Mother-to-Child
transmission
of HIV**



Strategic Objective: To eliminate
mother-to child transmission of HIV in
Nigeria by 2021

3.1 Background

Mother-to-Child Transmission (MTCT) of HIV infection is one of the global and prevailing sources of HIV infection among children. UNAIDS estimated that 90% of HIV infections among children is through MTCT. Nigeria has an estimated MTCT rate of 13% and 22% at 6 weeks and 18 months of birth respectively. Transmission of HIV infection occurs during pregnancy, labor and breastfeeding. This is dependent on maternal viral load, infection of placenta, antepartum hemorrhage, prolonged labor, invasive delivery procedures, prolonged rupture of membrane, pre-term birth and breastfeeding.

Prevention of mother to child transmission (PMTCT) of HIV refers to interventions aimed at preventing the transmission of HIV from an infected mother to her child during pregnancy, labor, delivery and breastfeeding. PMTCT is of national priority because of its impact on the number of new infections among children. Nigeria is committed to the goal of Eliminating Mother to child transmission by 2020 and has initiated a number of strategies to achieve it. The goal of the eMTCT is to contribute to the elimination of new HIV infections among children and keep their mothers alive by 2020. To achieve the goal of elimination of MTCT, at least 90% of HIV infected women must have access to comprehensive PMTCT services including anti-retroviral drugs (ARVs) during pregnancy, labor, delivery and breastfeeding periods.

The comprehensive package of PMTCT interventions put in place includes; HIV testing services (HTS), cervical cancer screening, use of lifelong antiretroviral therapy (ART), care of HIV-exposed infants including Early Infant Diagnosis (EID) and linkage to treatment (EID/T), antiretroviral (ARV) and cotrimoxazole prophylaxis for mother-infant pairs and family planning services. Other activities involved in PMTCT program includes screening and management of tuberculosis, demand creation for PMTCT, decentralization of services to primary care level , greater private sector involvement in PMTCT service delivery, community engagement, Integration of PMTCT with other Reproductive Health services including Family Planning, access to EID for children of HIV positive mothers. Overall, gradual progress has been made in the percentage of pregnant women living with HIV accessing ARV from 27% in 2010 to 43% in 2019. Final vertical transmission rate including during breastfeeding has reduced from 31% in 2010 to 22% in 2019and EID has improved from 9.6% in 2010 to 26.6% in 2019 and resultant drop in new HIV infections among children from 28,000 in 2010 to 22,000 in 2019. In addition, PMTCT has experienced gradual scale-up in public and private health facilities at all levels which spread across the country bringing the number of sites providing PMTCT services to 6,694 by the end of 2019. The national PMTCT programme involves a comprehensive approach consisting of four components (the four prongs of PMTCT) that must be implemented in order to optimize the effectiveness of the programme . These include:

Table 3.1: PMTCT programme Comprehensive Approaches.

SN	Approaches/ Components	Target Population	Additional Information
1.	Primary prevention of HIV infection among women of child-bearing age.	Women and men who are sexually active.	To prevent new HIV infection.
2.	Preventing unintended pregnancies among women living with HIV.	Women living with HIV.	Addresses family planning and contraceptive needs of women living with HIV to prevent unintended pregnancies and thus, fewer infants exposed to HIV.
3.	Preventing vertical transmission of HIV from infected mother to her infant.		<ul style="list-style-type: none"> • Access to HIV testing and counselling during ANC, labour and delivery, and the postpartum period. • Provision of ARV drugs to mother and infant. • Safer delivery practices to decrease the risk of infant exposure to HIV. • Infant feeding information, counselling and support for safer practices.
4.	Providing care, treatment and support for mothers with HIV and their children.	HIV infected women, their children and families.	Addresses the treatment, care and support needs of HIV-infected women, their children and families.

However, there is need to sustain the existing strategies and come up with innovations to increase PMTCT coverage towards achieving the global PMTCT target.

3.2 National PMTCT Targets

Targets set in the 2017 - 2021 National Strategic Plan (NSP) is committed to ensure modern contraceptive prevalence rate of 40%; 95% of all HIV positive pregnant and breastfeeding mothers receive antiretroviral therapy; 95% of all HIV-exposed infants receive antiretroviral prophylaxis; 95% of all HIV-exposed infants have early infant diagnosis within 2 months of birth and 95% of all HIV exposed infants receive cotrimoxazole prophylaxis within 2 months of birth by 2021.

The National PMTCT Program set target by the end of the year 2020 includes,



3. 3 PMTCT Strategy for Nigeria

Key strategies adopted towards meeting the NSP targets:

- 01  Strengthening the National coordination platforms on PMTCT;
- 02  Mapping of all ANC service provision facilities in the states;
- 03  Supply plan meeting at state level to identify testing gaps for pregnant women;
- 04  Creating engagement platforms with formal private sector at the state level;
- 05  Engagement of Non-Formal Health Actors (NFHA) in the state to improve community PMTCT service linkages;
- 06  Strengthening the capacity of the State and LGA structures to manage PMTCT coordination through collaboration with other related bodies;
- 07  Improving RMNCAH/PMTCT integration at states;
- 08  Streamlining the availability of POC with the existing PCR structures;
- 09  Leveraging on existing technical and financial support at state level on Linkage and Retention in Care for Positive Pregnant Women and HIV positive Infant;
- 10  Engagement of community resource persons or community leaders, community outreach programmes to increase ANC attendance;

Despite these key strategies, there has not been appreciable increase in PMTCT coverage. There is need to understand barriers to PMTCT coverage through programme evaluation, operations research and implementation science. This is critical to innovation and targeted scale-up of strategies to improve PMTCT coverage.

3.4 Antenatal Care Attendance at HIV Service Delivery Sites.

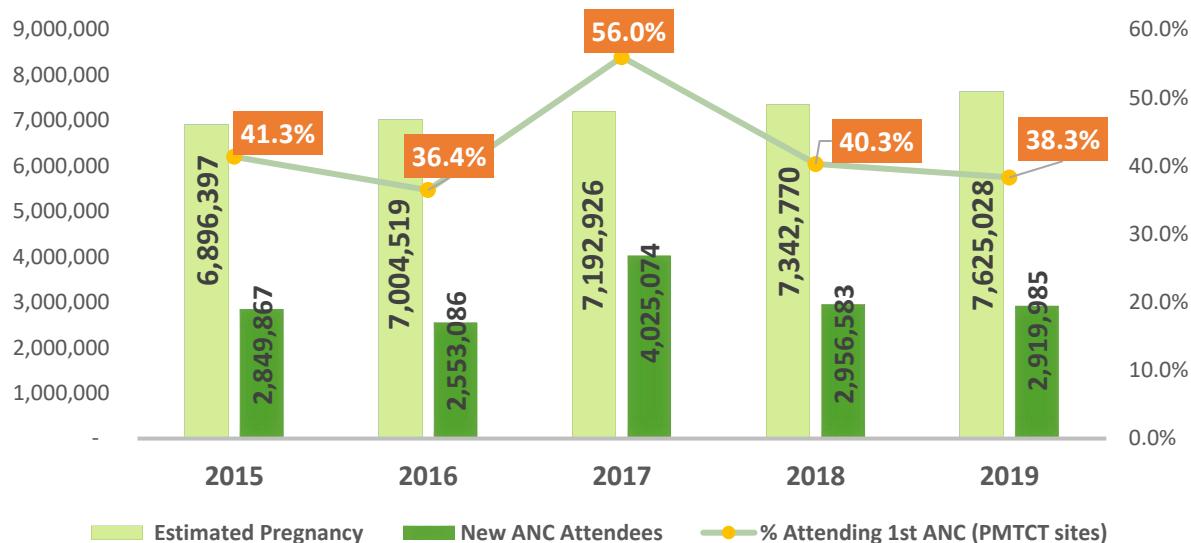
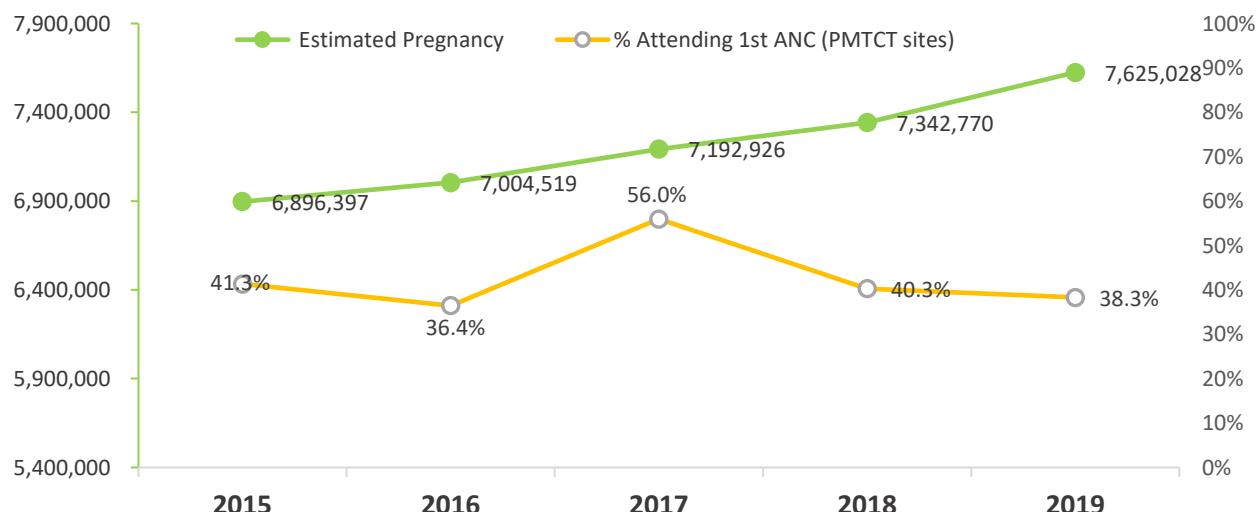


Figure 3.4.1: Trend in ANC Attendance Coverage at HIV Delivery Sites.

Figure 3.4.1 above shows trend in ANC attendance coverage from 2015 to 2019. The denominator of this coverage is the estimated pregnancy per year which was generated from the Spectrum. Antenatal care (ANC) is a very key public health intervention aimed at ensuring safe pregnancy outcomes and also play a key role in the elimination of maternal to child transmission of HIV. However, its uptake has been sup-optimal as shown in the chart. This sup-optimal uptake could be because these ANC attendances were only captured at the HIV delivery sites and excludes other facilities that are not providing HIV services. Nevertheless, there is need for the National PMTCT programme to further engage all key stakeholders to come up with strategies that will improve ANC attendance. An implementation science on barriers influencing the uptake of ANC will contribute to the national and global goal of eMTCT



ANC Coverage by States

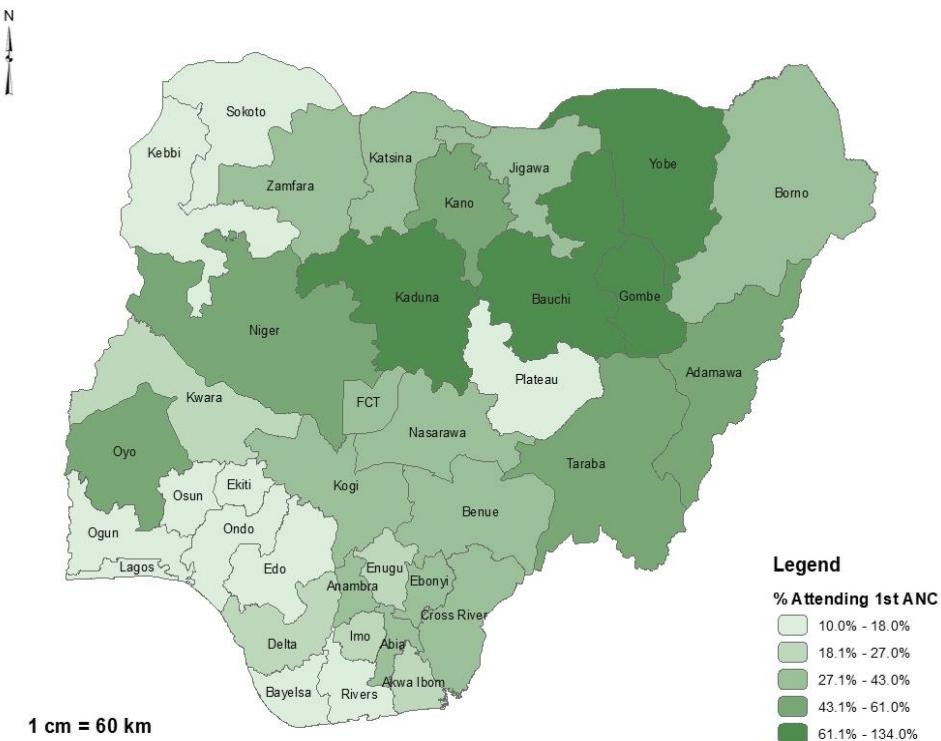


Figure 3.4.3: Map showing ANC Coverage by States

Figure 3.4.3 above shows map of Nigeria showing ANC coverage i.e. number of pregnant women attending first ANC visit across states. The highest coverage across Kaduna, Bauchi, Gombe while lowest coverage of ANC 1st attendees are mostly in Plateau , Edo and Kebbi.

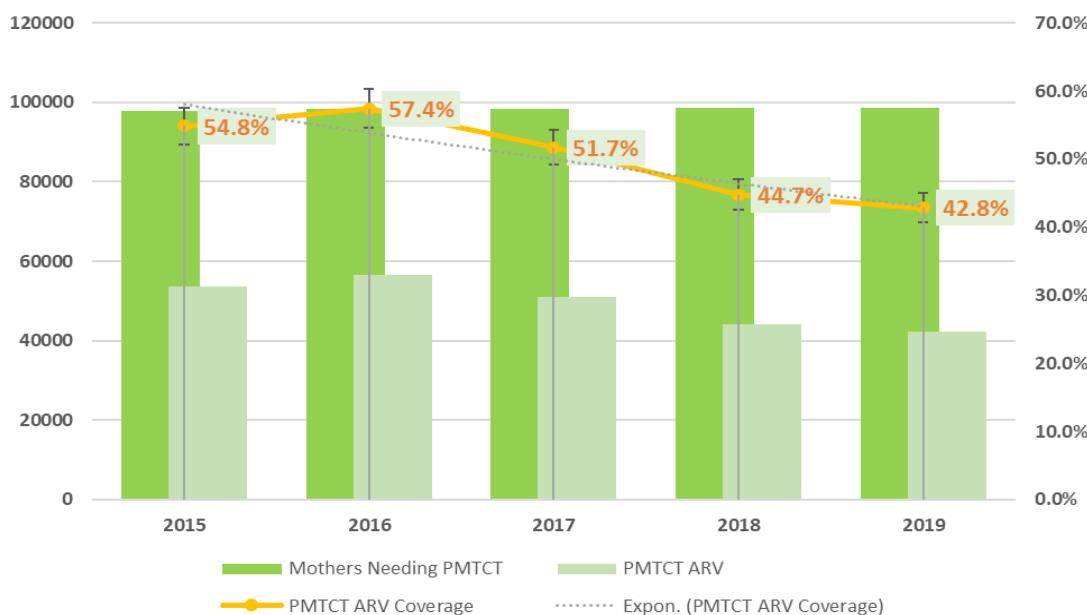


Figure 3.4.4: Chart showing Trend of PMTCT ARV Coverage across 5 years

Figure 3.4.4 Shows the trend of PMTCT ARV coverage from 2015 to 2019. The figure shows a reducing trend in PMTCT ARV coverage and a dipping volume of HIV positive pregnant women provided with ARVs. This trend however calls for a critical appraisal of the PMTCT uptake within the HIV program.



3.5 PMTCT HIV Testing Services

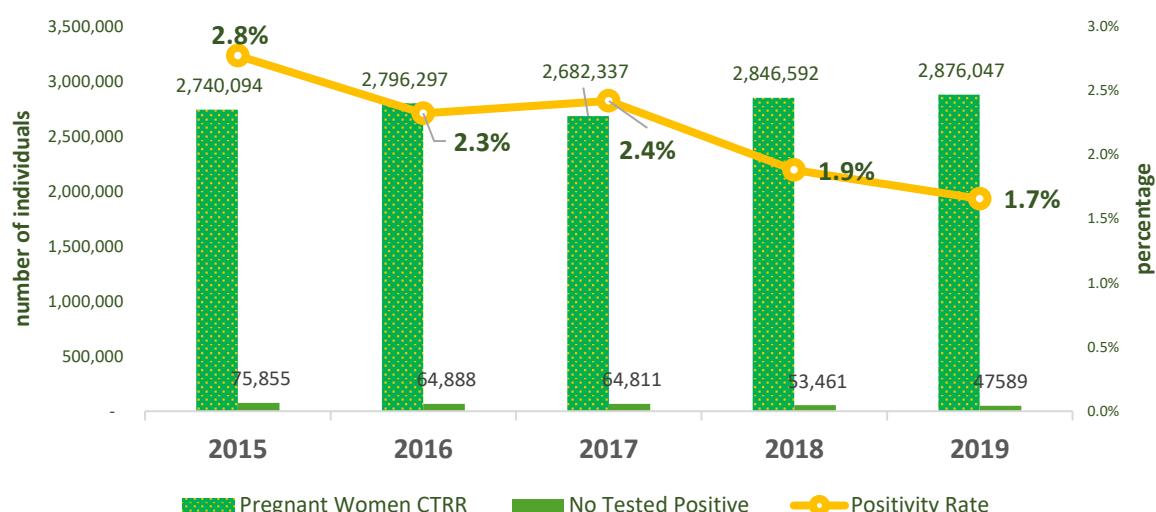


Figure 3.5.1: Trend in HIV Testing among Pregnant Women.

The entry-point for PMTCT services is through HIV testing of pregnant women during antenatal care, labour and delivery including post-partum while retesting is done for those who tested negative in early pregnancy. Figure 3.5.1 above shows HIV testing among pregnant women in the last five years. HIV positivity rate has gradually declined from 2.8% in 2015 to 1.7% in 2019.

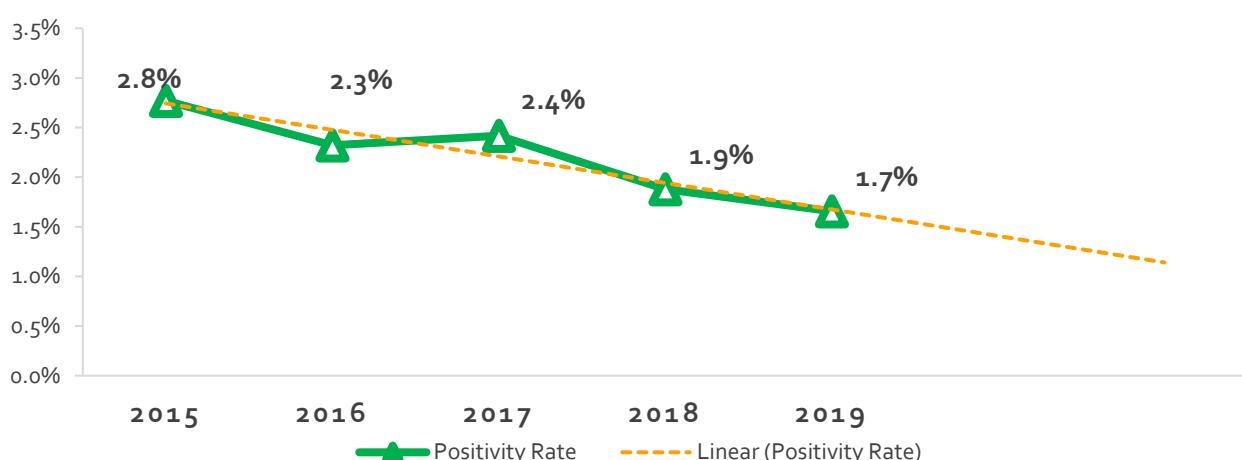


Table 3.2: Positivity Rate among Pregnant Women by Entry Point

Indicator	Total Tested	ANC	Labour & delivery	Post-partum
Total No of Pregnant women CTRR in PMTCT settings	2,876,047	2,642,513	213,433	20,101
Tested Positive	47,589	42,336	4,131	1,122
Positivity Rate	1.65%	1.60%	1.94%	5.58%

Table 3.2 above shows testing of pregnant women at the entry points into PMTCT and the positivity rate. The positivity rate is lowest among the pregnant women CTRR at ANC and highest at postpartum. However, ANC attendees contributed most (89%) to the total number of positives. More needs to be done with regards to increasing utilization or uptake of ANC.

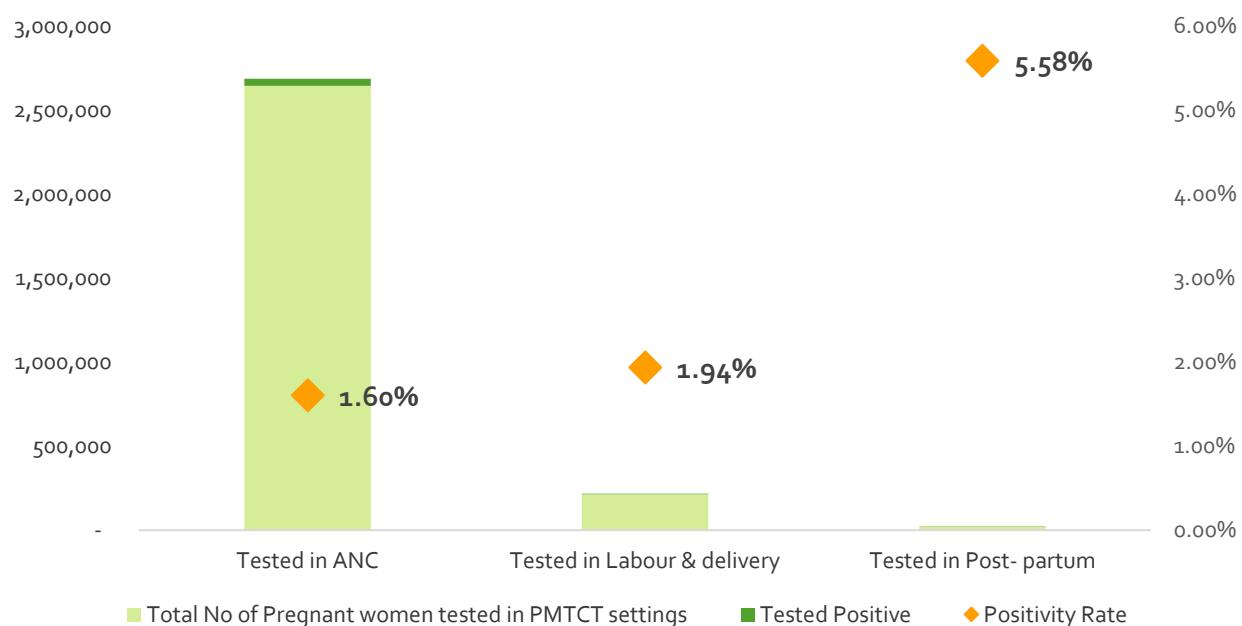


Figure 3.5.3: PMTCT CTRR and outcomes by testing point.

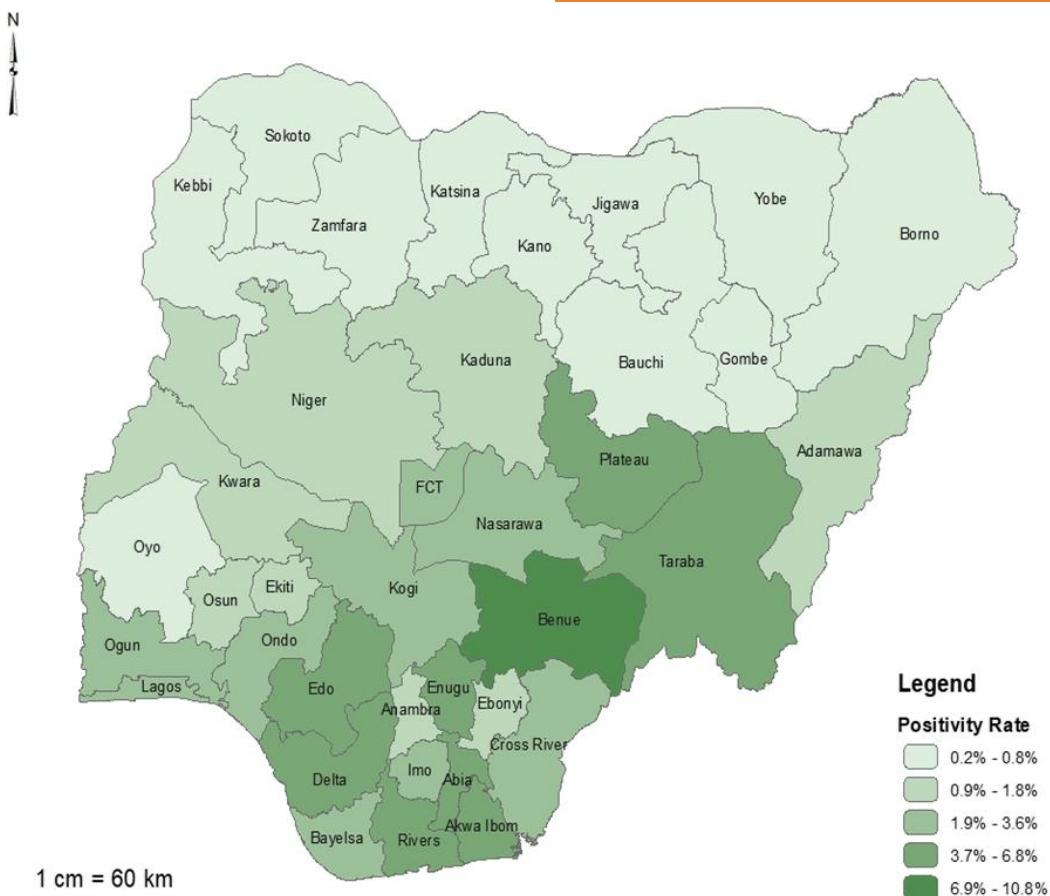


Figure 3.5.4: Map showing HIV Positivity Rate in PMTCT across the 36 States plus FCT

PMTCT ARV COVERAGE

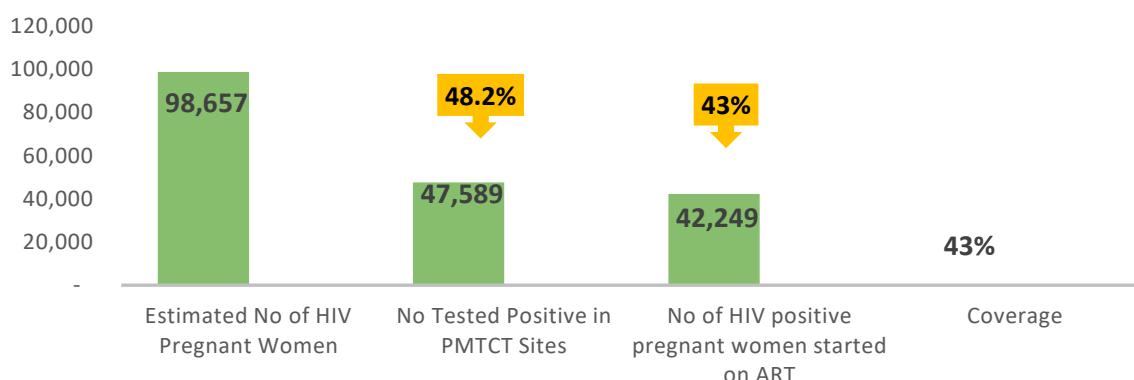


Figure 3.5.5: PMTCT ARV Coverage among HIV Positive Women

Above map in figure 3.5.4 shows the HIV Positivity Rate in PMTCT across the 36 States plus FCT with Benue have the highest positivity rates and Borno and Oyo having the lowest rates of positivity in PMTCT. The Figure 3.5.5 above shows the ARV coverage among HIV positive pregnant women in Nigeria as at 2019. Out of the estimated 98,657 pregnant women needing PMTCT services, 48.2% were identified HIV positive. A total of 42,249 were placed on treatment. This puts the national PMTCT ARV coverage at 43%. It also shows that, of the 47,589 pregnant women that tested positive at service delivery points, 88% were placed on treatment for PMTCT

MATERNAL CASCADE FOR PMTCT

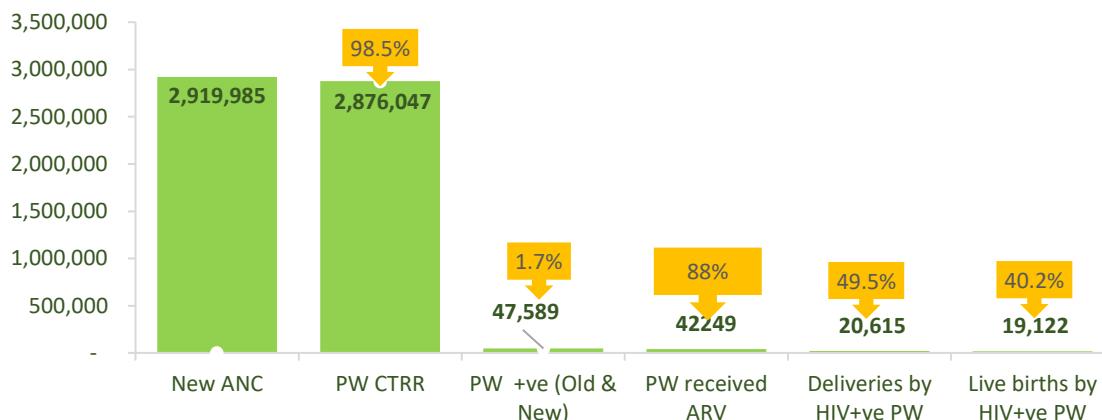
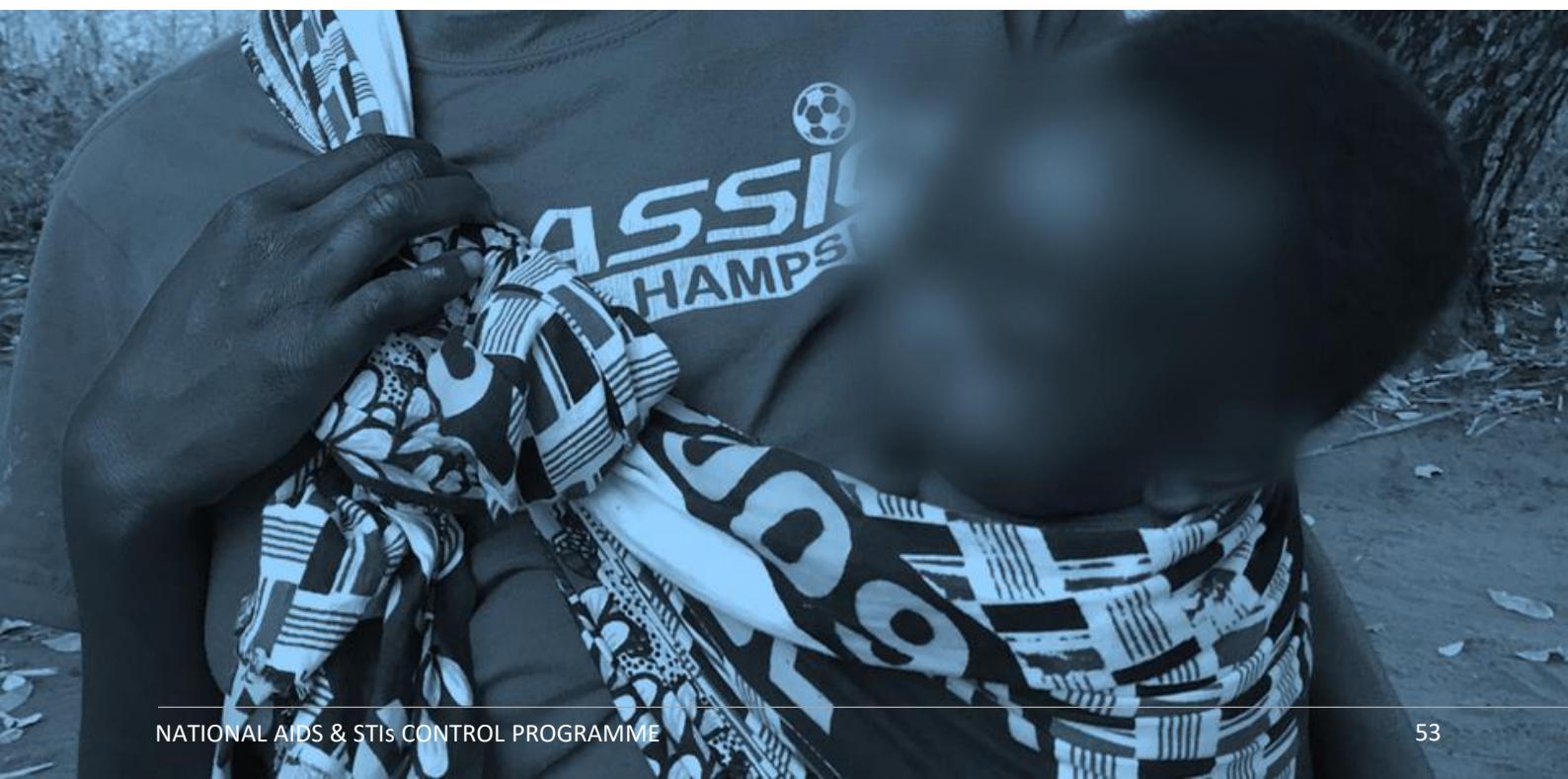


Figure 3.5.6: 2019 Maternal Cascade for HIV Positive Pregnant Women

Figure above shows the maternal cascade of all the pregnant women who attended ANC in designated PMTCT sites. Out of 2,919,985 that were new ANC attendees, 98.5% of them were counselled tested and received result. The number of pregnant women who tested HIV positive was 47,589 of which 88% received ARVs. About half (49.5%) of the pregnant women delivered in the health facilities while only 92.8% had live birth deliveries. Thus, it is evident that majority of the pregnant women still deliver outside the health facility. This indicates the need for the concerted efforts of the mentor mothers/care and support teams from the facilities to follow up on the identified HIV positive pregnant women in order to reduce the risk of MTCT. In addition, there is need to strengthen linkage of HIV positive pregnant women from TBAs to health facilities to ensure that all missed opportunities of HIV positive pregnant women needing PMTCT services are captured.



Early Infant Diagnosis Cascade

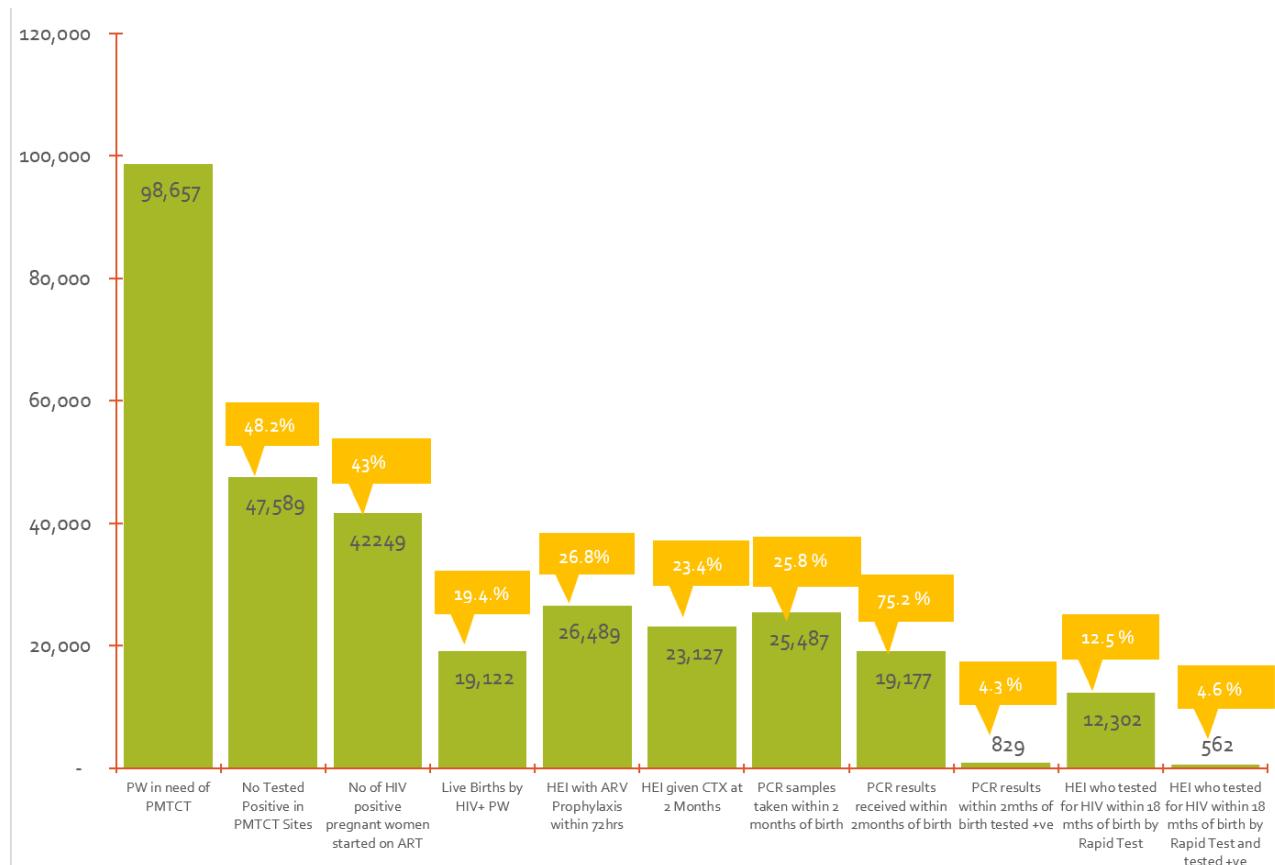
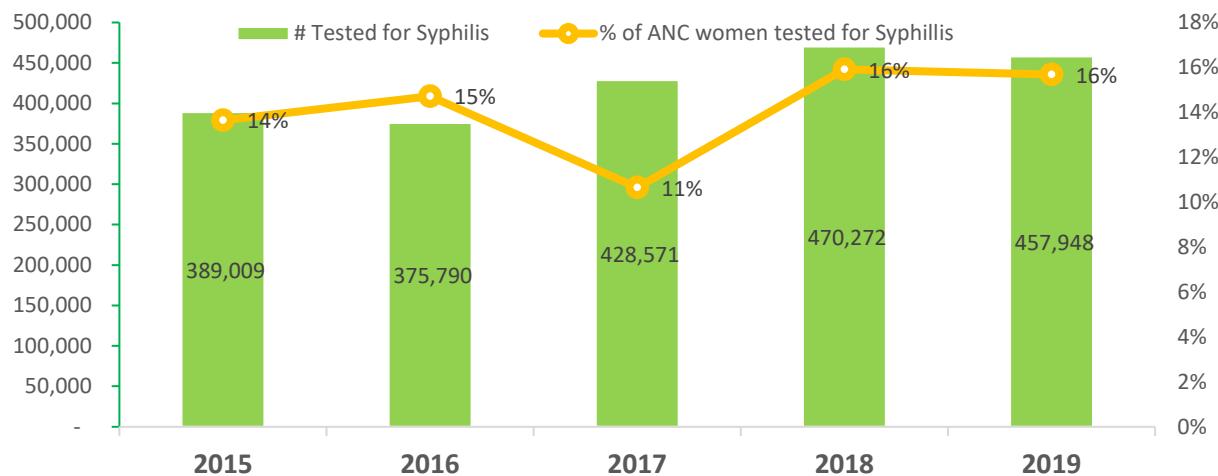


Figure 3.5.7: 2019 Early Infant Diagnosis Cascade



Syphilis testing & treatment Cascade



3.5.8 Trends in ANC Syphilis Testing

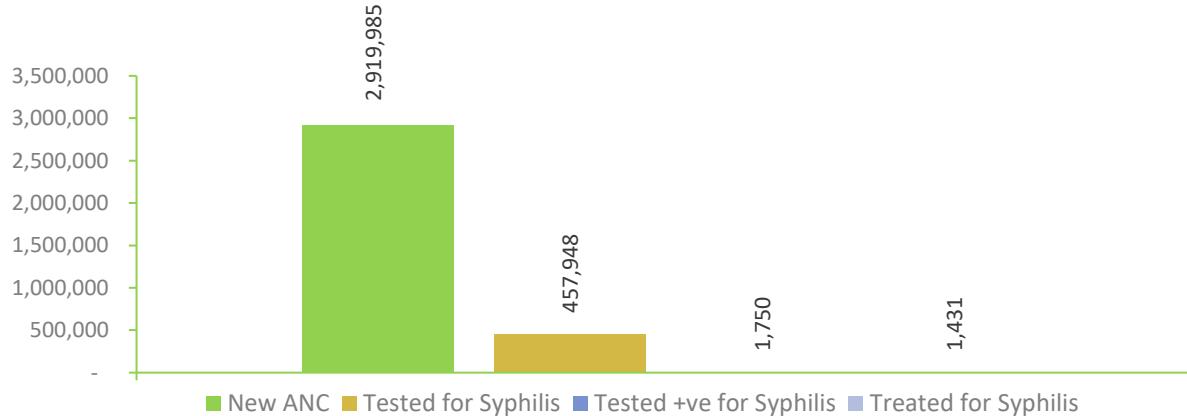
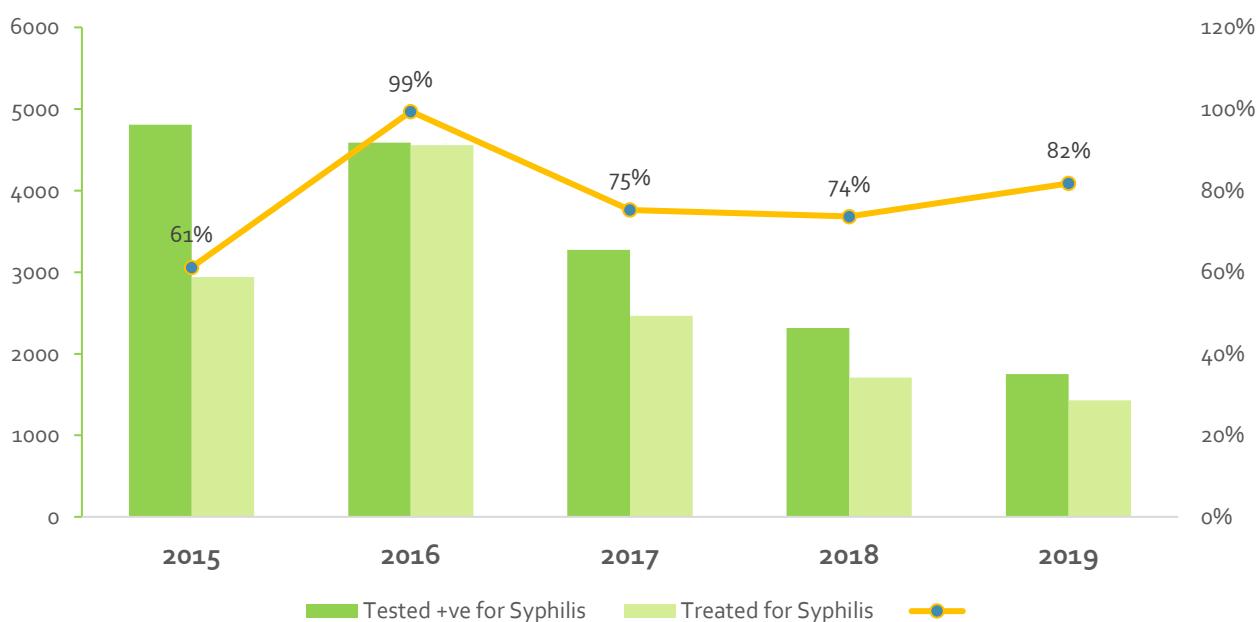


Figure 3.5.9: 2019 Syphilis Cascade



3.5.10 Trends in linkage to Syphilis Treatment at ANC

3.7 Challenges

- Low ANC service uptake due to user fees/out of pocket payment in healthcare facilities.
- Prolonged turnaround time of PCR test due to persistent challenge with DBS logistics and consumables.
- Low rates of facility delivery
- Low uptake of EID services
- Low PMTCT Coverage which stands at 43% as at 2019
 - Attitude of healthcare workers towards the client
 - Low literacy level on the importance of ANC/PMTCT services
 - Socio-cultural and religious beliefs

3.8 Recommendations and Best Practices

- Strengthening integration of PMTCT into RMNCAH+N services and improving on the community testing for pregnant women and linkage of PPW during MNCH week.
- Scale up PMTCT services in high burden states. Focus on improving ANC attendance, improve access to ARVs by all who test HIV positive, and prioritize Early infant Diagnosis
- Reinforce engagement and integrate community-based organizations/systems in raising PMTCT awareness at community level, provide adherence counselling and follow up of mother infant pair across the post natal follow up.
- Invest in community structures in order to increase awareness of PMTCT/EID, uptake of HIV testing among pregnant women
- The retention of mother infant pair in the program should be strengthened
- Strengthen Integrated Supportive Supervision by State Ministry of Health (SMOHs) across PMTCT sites.
- Improve and Strengthen follow up mechanism to ensure that all positive pregnant women who received PMTCT services deliver in the health facilities.
- High level advocacy for policy change for waiver of ANC User fee.
- Viral Load (VL) for positive pregnant women should also prioritized as part of the national interventions.

IMPACT STORIES

AKWA IBOM

Preserving generations with PMTCT

In Akwa Ibom state ,Southern Nigeria, there are challenges around ignorance about the availability of PMTCT services, stigma & discrimination as well as negative religious and social beliefs. Ignorance about HIV and PMTCT services was the case with Mrs. Rachael Ignatius, who was 33-year-old at the time of her diagnosis in 2011. Mrs. Ignatius was 3 months pregnant and had previously delivered 3 children in hospitals but had never heard of HIV infection or the need to protect her unborn children. During a routine visit to St. Luke's Hospital Anua in Uyo LGA in 2011, she was provided counselling and HIV test by a nurse. Nurse Margaret, she recalled, gently explained the need for the test and counseling which helped her deal with the shock of the positive result she was later to receive. She became worried for her pregnancy and the thoughts of danger to her life and family created moments of despair, but the counseling and information provided by the nurse helped her greatly. She was introduced to PMTCT program and told that the program offered support to mothers throughout the pregnancy, labor and breastfeeding of the child, provided information on safe childbirth practices and appropriate infant feeding including virology tests after birth and effective treatment to ensure her child could live a long happy normal life.

Her husband, who was subsequently tested, was also HIV positive and both commenced treatment immediately. *Mrs. Ignatius went on to deliver a set of twin daughters in November 2011 and they were immediately started on Nevirapine and a subsequent EID test returned negative for both babies.*

Knowing the benefit of PMTCT, she volunteered to work as a mentor mother in the hospital and in June 2014, went on to have another HIV negative baby. In 2015, Rachael joined the USAID funded program as a volunteer case manager and currently volunteers as a Ward Treatment Support focal person in Uruan L.G.A where she devotes time to manage HIV clients in care. She also continues mentoring mothers and promoting PMTCT as a viable intervention for pregnant women with HIV and supporting these mothers access care and treatment. She has worked with the project on PMTCT intervention to bring over an estimated 1,100 pregnant women to treatment and care supporting the birthing of over 1,350 HIV negative babies including several twins much like herself. Due to her passion and commitment to supporting positive pregnant women, she was appointed in 2018 and still serves as the Secretary of the Akwa Ibom State chapter of the Association of Women Living with HIV in Nigeria (ASHWAN). She is grateful for the access to good treatment and care and the opportunity to join USAID funded programs to close PMTCT uptake gaps.

SECTION 4





Thematic Area: **HIV Treatment**



Strategic Objective: All diagnosed people living with HIV (PLHIV) receive quality HIV treatment services, and at least 90% of those on antiretrovirals (ARV) achieve sustained virological suppression.

4.1 Background

Over the years, the National HIV Treatment programme and her key stakeholders have demonstrated concerted efforts in improving and expanding access to treatment for the different age groups of PLHIV. This is done by ensuring prompt initiation of identified PLHIV on treatment and retention in care resulting in viral suppression and improved quality of life. In 2019, substantial gains were recorded in the number of PLHIV on ART. The ART coverage has progressively increased from 55% in 2015 to 65% in 2019.

The different strategies for the HIV Treatment programme include; implementation of ‘test and treat all’ policy, Differentiated Service Delivery, management of Advanced HIV Diseases (AHD), use of Electronic Medical Records System for data management .

To further improve the quality of the national HIV programme, the country adopted Case Based Surveillance (CBS) and HIV mortality surveillance. However, there is still a gap in ART cascade. As at December 2019, about 89% of the diagnosed PLHIV were on treatment and only 71% of the PLHIV on treatment had their viral load test result. Of the population with Viral load test result, 78% were virally suppressed. Considering the 3rd 90, only 56% of PLHIV on treatment achieved viral suppression.



4.2 Access to ART Services

Timely access to ART services by all PLHIV is key to their survival, morbidity, mortality, and improved quality of life. As the world achieves the 90-90-90 UNAIDS global target and also moves in the direction of epidemic control, there is need to further improve access to HIV treatment.

4.2.1 PLHIV Burden in Nigeria

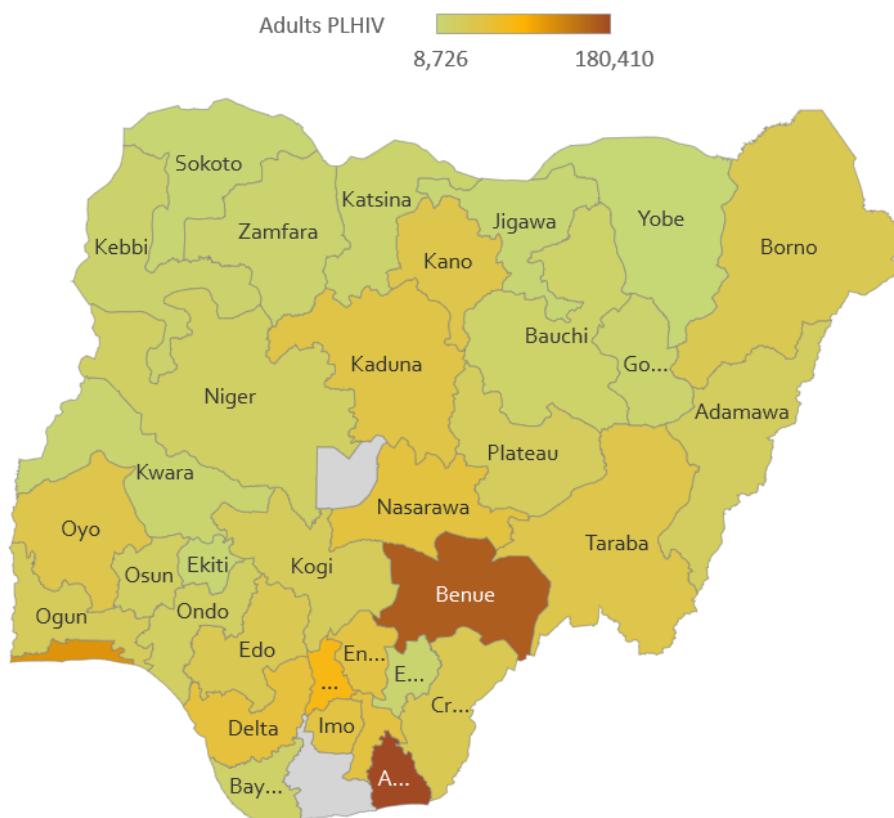


Figure 4.2.1: Map showing HIV burden by State (2019)

4.2.2 ART Sites in Nigeria

ART services are provided at comprehensive sites; the tertiary, secondary and few Primary Health Care centres based on the availability of minimum standard of care for an ART site.

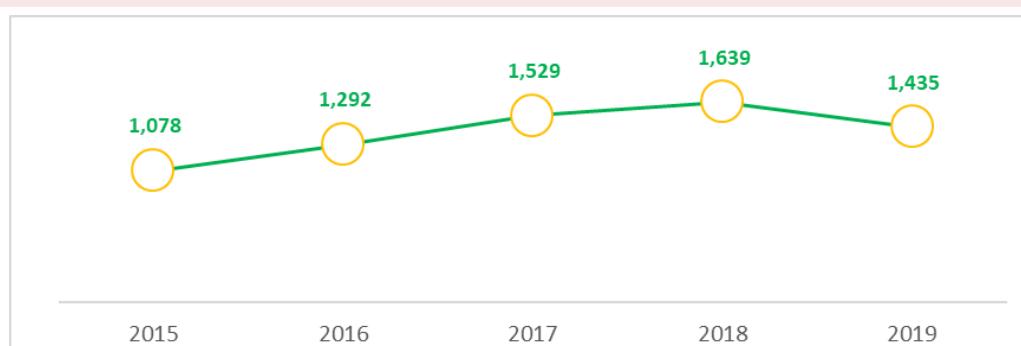
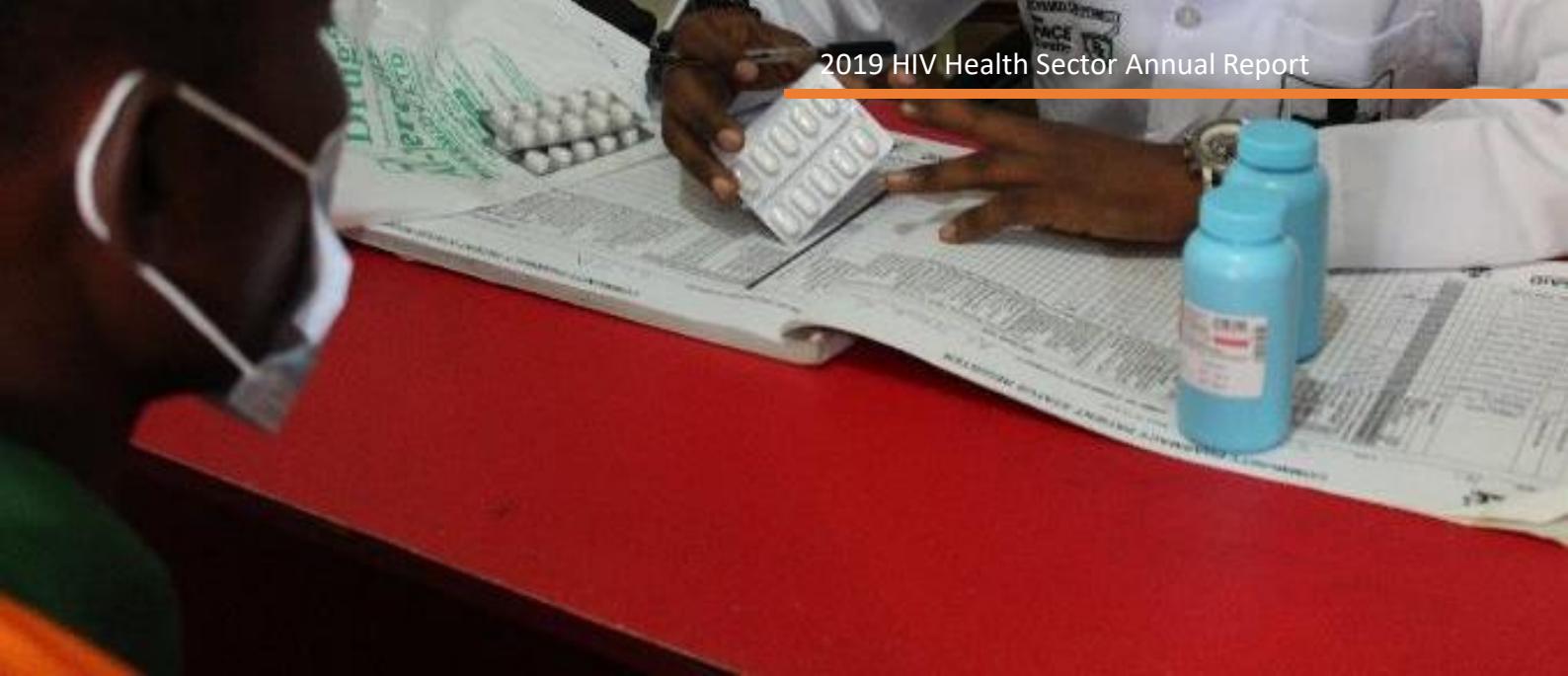


Figure 4.2.2 : Trend in the number of ART sites

The figure 4.2.2 above shows the progression in the number of ART sites from 2015 to 2018 with a slight decline in 2019.



PLHIV Newly Started on Treatment Disaggregated by Age & Sex

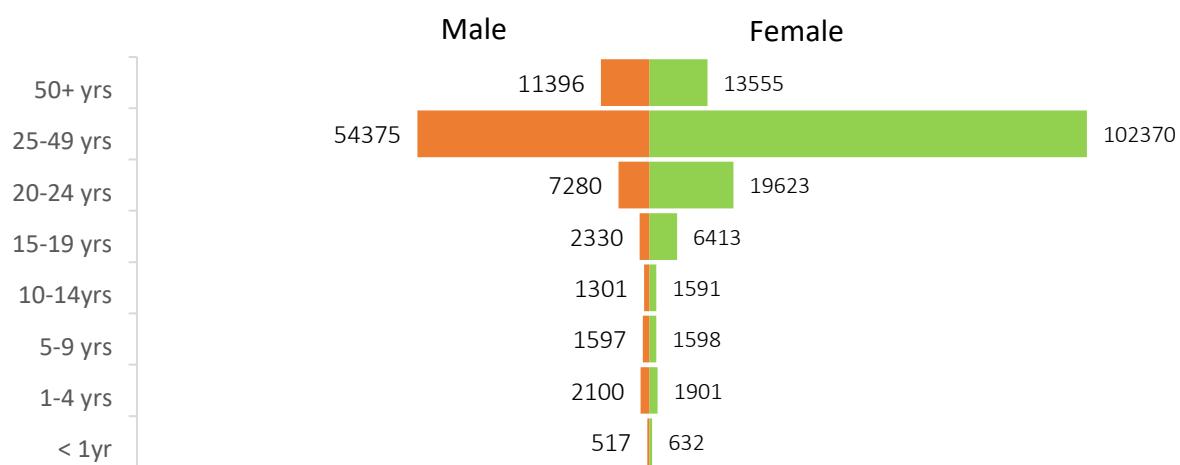


Figure 4.3.1: PLHIV Newly Started on Treatment Disaggregated by Age & Sex

In 2019 ; total PLHIV newly started on treatment is 228,579. The total number of people living with HIV currently on treatment is 1,146,720. Table 3.3 below shows the number of PLHIV newly started on treatment by sex and age group. Overall, females are more initiated on treatment than the males in the adult age group. In 2019, more PLHIV were initiated on treatment as compared with the other years as a result of the aggressive drive towards reaching epidemic control in the (Surge) states with highest unmet needs following the 2018 NAIIS. Figure 4.3.1 shows further disaggregation to finite Ages.

Table 3.3 : PLHIV Newly Started on Treatment Disaggregated by Age & Sex over three years

Age group	Trend in newly started on ART					
	2017		2018		2019	
Sex	Male	Female	Male	Female	Male	Female
Paediatrics (0-9 years)	3,955	4,320	3,656	3,581	4,214	4,131
Adolescent (10-19 years)	2,995	5,840	2,409	5,315	3,631	8,004
Adult (20 years and above)	55,046	113,585	50,269	100,720	73,051	135,548

4.4 ART Uptake - PLHIV currently on treatment

Figure 4.4.1: National Trend of Total PLHIV Currently on ART

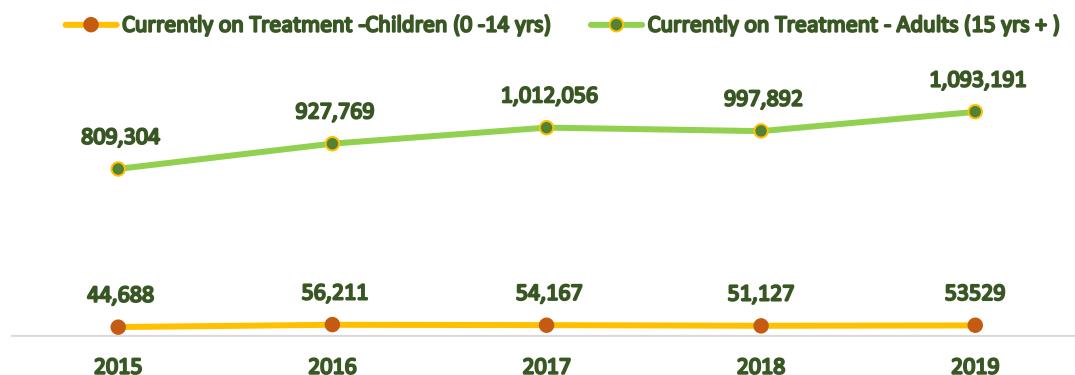


Figure 4.4.1: National Trend of Total PLHIV Currently on ART

Figure 4.4.1 above shows the number of PLHIV currently on ART in the last 5 years. Among the children, the number on ART increased by 4.7% between 2018 and 2019. Among the adults, the number on ART increased by 9.5% from 2018 to 2019. Overall, the National HIV Treatment programme is using different strategies and approaches to ensure that all PLHIV identified are promptly linked to care, initiated on treatment and retained in order to improve their clinical outcomes.

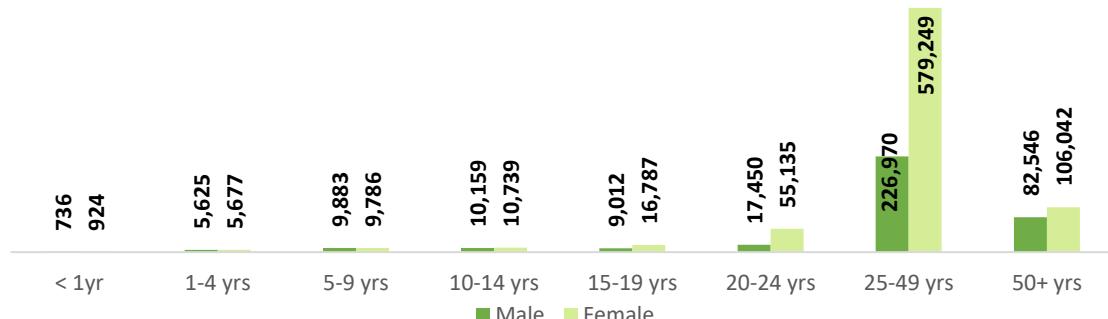


Figure 4.4.2: PLHIV Currently on Treatment Disaggregated by Age & Sex

Figure 4.4.2 above shows PLHIV currently on treatment disaggregated by Age & Sex. Adult females between the ages of 25-49 years are the largest age group currently on treatment. Across all age groups, there are more females on treatment than males. An increased focus on male involvement in the ART programs would ensure acceleration of coverage across the different age groups.

Currently on treatment disaggregated by age and regimen

	Age group	≤ 15 years		≥ 15 years		
		Male	Female	Male	Female	
Treatment Line	Sex					
	1 st line	25,188	25,998	325,171	734,660	1,111,017
	2 nd line	1,215	1,128	10,762	22,474	35,579
	3 rd line	0	79	0	45	124

Table 4.1: PLHIV Currently on Treatment disaggregated by Age, Sex and Regimen

The Table 4.1 above shows the number of persons currently on ART disaggregated by age, sex and regimen line which is an indicator of adherence to treatment & effectiveness of respective ARVs. The table shows that more adult females are on 1st & 2nd line regimens while no male is currently on 3rd line regimen.



Unmet Needs by State - Adults and Children

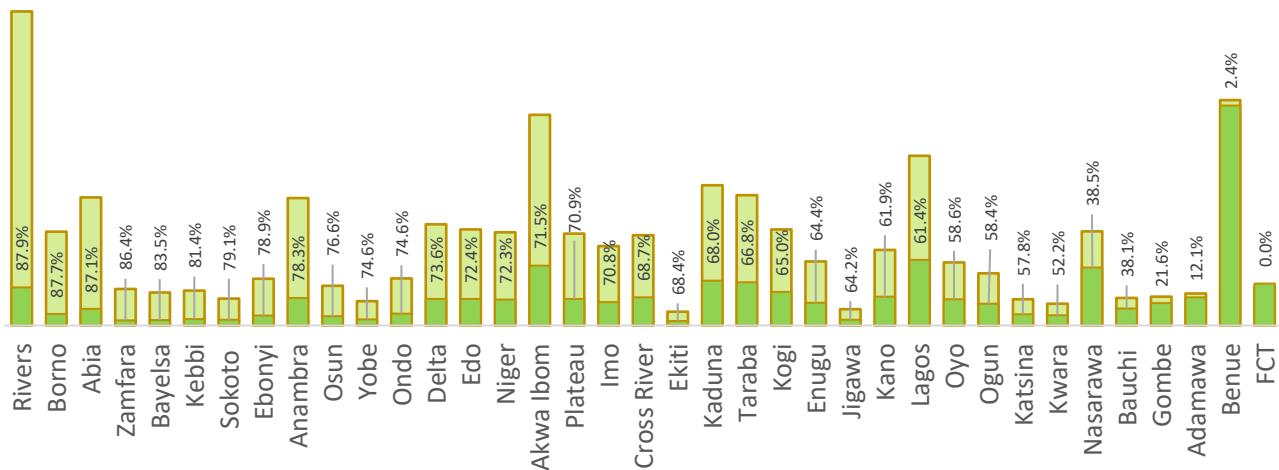


Figure 4.4.3: Percentage ART Unmet Needs among Children by State (2019)

Figure 4.4.3 above shows percentage ART unmet needs among children by state. This is highest in Rivers and lowest in Benue states while FCT had full coverage. Greater attention is being emphasized on ensuring children are not left behind within the ART programs especially as they transition into the adult treatment population.

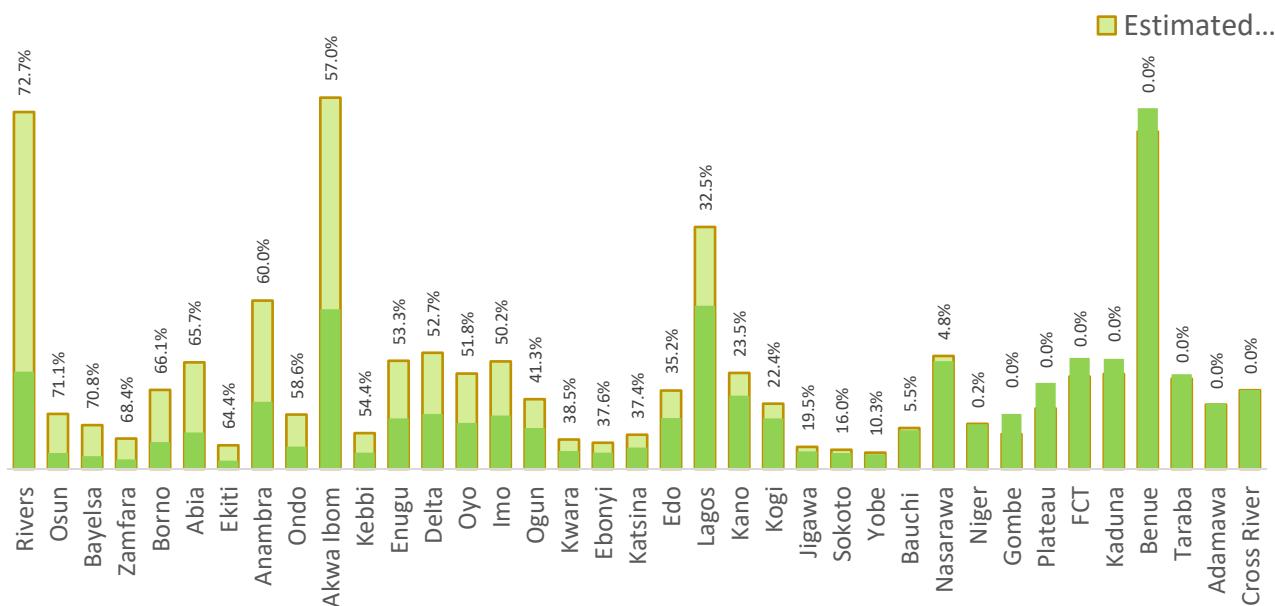


Figure 4.4.4: Percentage ART Unmet Need among Adults by State (2019)

The chart above shows the percentage ART unmet need among adults by state. This was highest in Rivers State, while Gombe, Plateau, FCT, Kaduna, Benue, Taraba and Adamawa States are saturated. The rapid scale up of the ART programme post NAIIS in states with higher unmet need such as Rivers, Akwa Ibom, Anambra & Lagos will suitably position the country to reduce unmet needs in ART coverage in the coming years.

4.5 ART Coverage and Retention -

National ART coverage

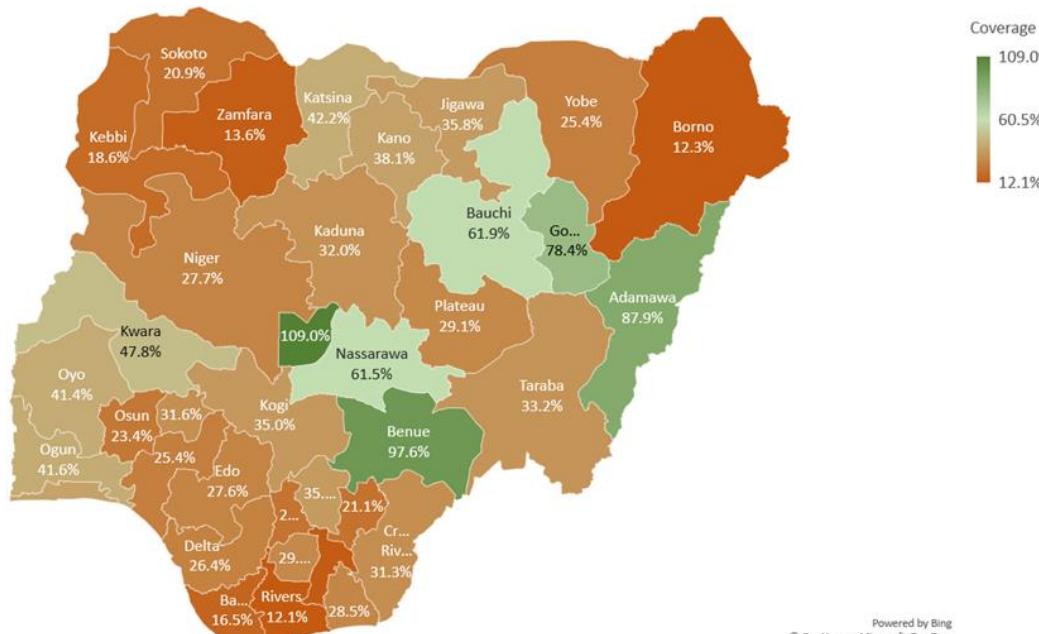


Figure 4.5.1: ART Coverage among Children by States (2019)

The ART coverage among children by States is shown in figure xx above. While ART coverage for children is lowest in Rivers, Abia and Borno states. The coverage is highest in FCT, Benue and Adamawa states..

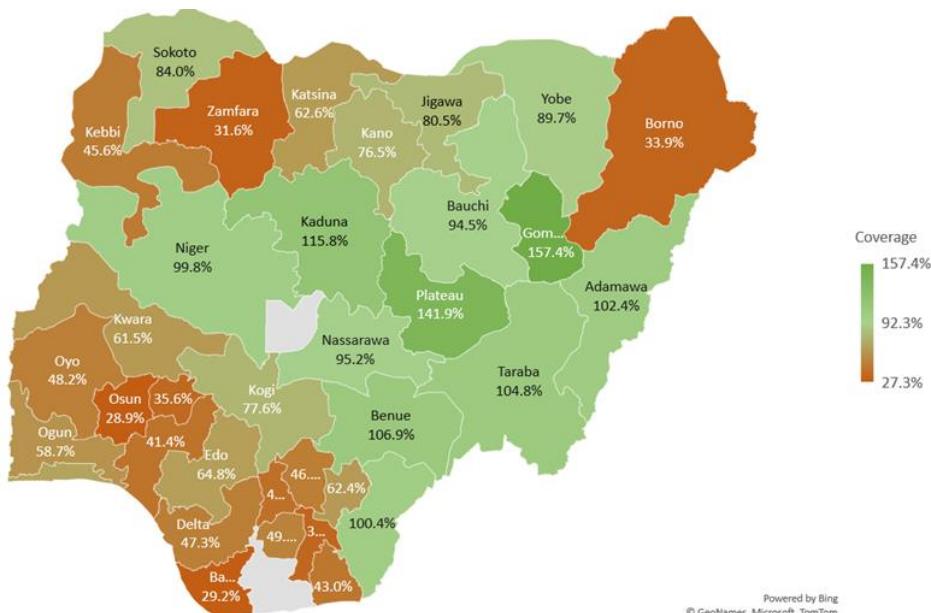


Figure 4.5.2: ART Coverage among Adults by State (2019)

The figures xx above shows ART coverage among adults by state in 2019. The coverage is highest in Plateau , Gombe , Adamawa and lowest in Rivers Bayelsa and Osun states. .

ART Coverage among pediatric and adolescent by age (0 – 19 years)



Figure 4.5.3: Chart showing ART Coverage among pediatric and adolescents

The figure 4.5.3 above shows the trend of ART coverage among children and adolescents from 2017 to 2019. Overall, ART coverage is sub-optimal. Worthy of note is the sharp decline among the adolescents (10 – 19 years) between the year 2017 and 2019.

Retention on ART Retention at 12 months after initiation

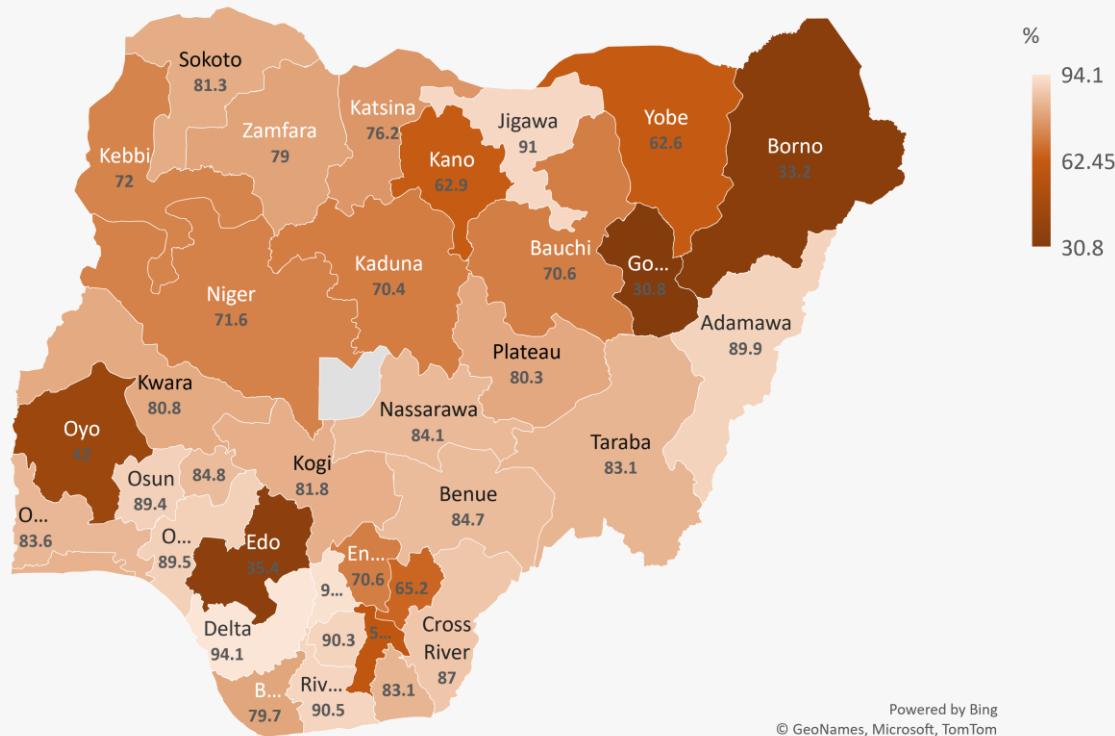


Figure 4.5.4 : Retention at 12 months after initiation on ART

The figure 4.5.4 above shows retention rate at 12 months after ART initiation. Retention rate is highest (94.1%) in Delta state and lowest (30.8%) in Gombe and Borno state. The low retention in these states could be linked to the insecurity being experienced by residents of these states.



Viral Load Testing Coverage and Suppression

2019 Viral Load Testing Coverage and Suppression rate

The National ART program recommends that all clients initiating ART should have viral load determined at 6- and 12-months following initiation of therapy and 12 monthly thereafter to determine the efficacy and suitability of the regimen for the individual client.

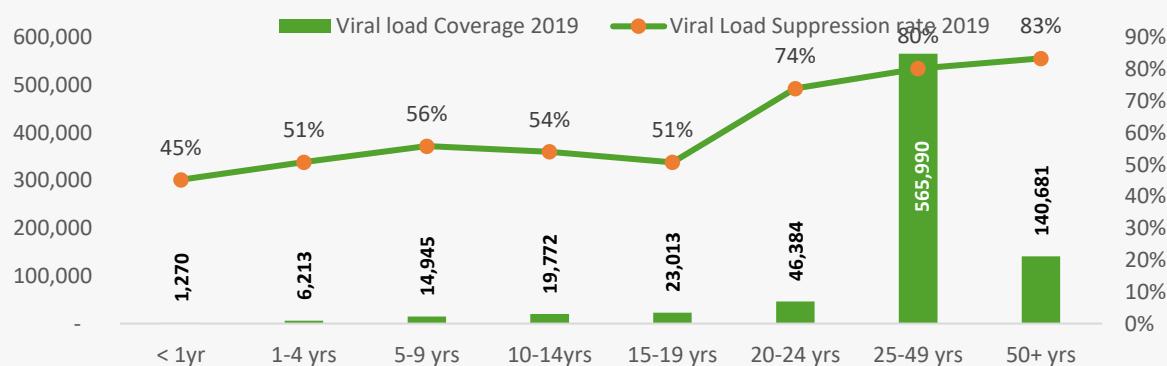


Figure 4.5.5 : Chart showing VL testing volumes and VL suppression rate by Age

The figures 4.5.5 above show Viral load testing volume and suppression rates across the age bands with Adults in ages 25-49 year having the highest volume of VL results and adults >50yrs with highest suppression rate of 83% while children ages 1-9years have the lowest volume of VL done and lowest supp rates.

2019 Viral Load Testing Coverage by State

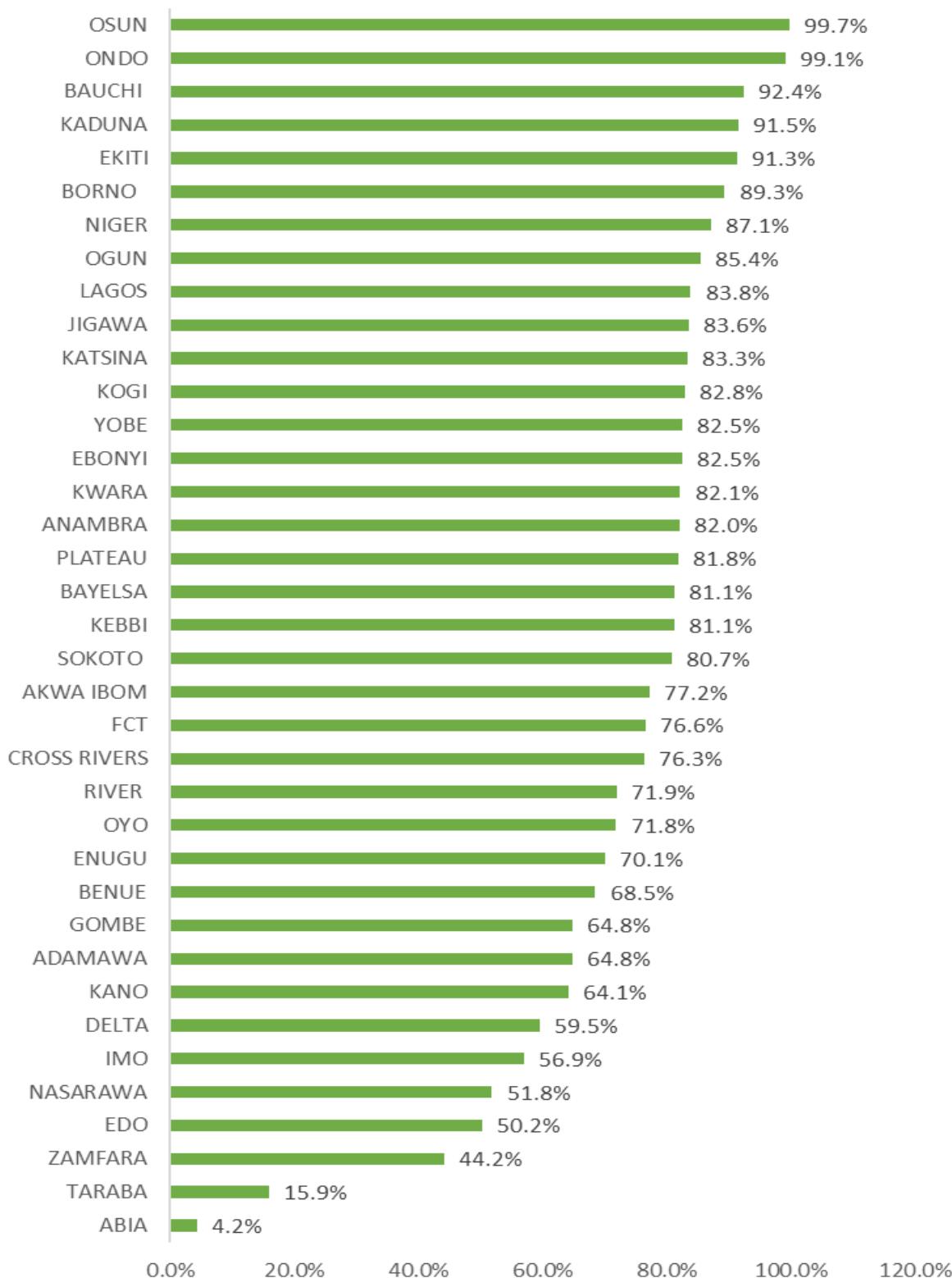


Figure 4.5.6 : Chart showing VL testing Coverage by States (2019)

The chart shows VL testing coverage is highest in Osun while the testing coverage is low in Abia state. The significant low VL coverage gives an indicator in the quality of ART programs and access to VL helps program & site managers provide timely intervention for PLHIV on ART.

2019 Viral Load Suppression rate by State

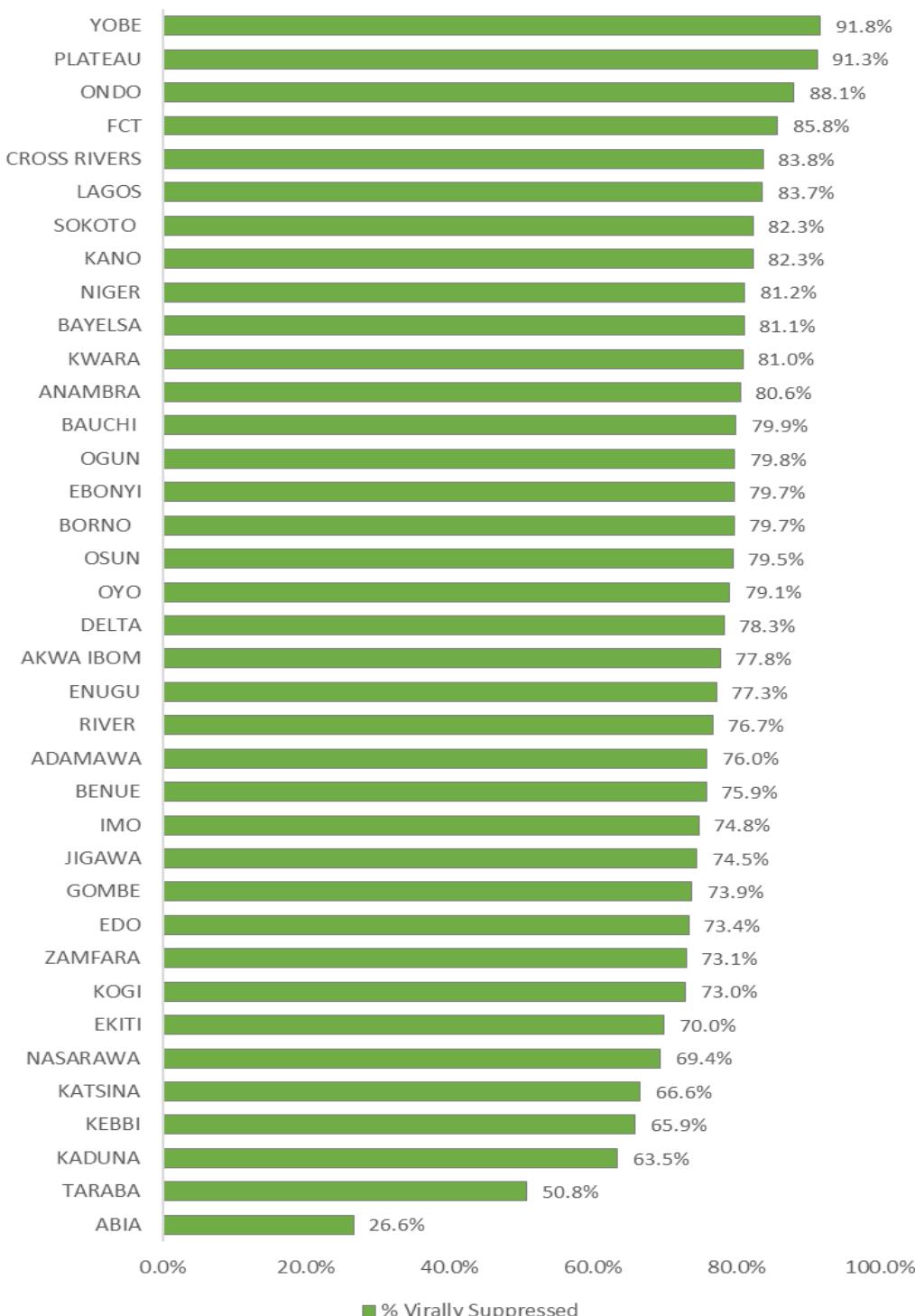


Figure 4.5.7: VL testing Suppression rate by States (2019)

The chart shows VL suppression rate is highest in Yobe while the suppression rate is low in Abia state. The significant low VL coverage gives an indicator in the quality of ART programs , level of treatment adherence and efficacy of treatment. High scrutiny into the ART programs with significant low VL suppression rates might be a good consideration.

2019 Viral Load Suppression rate by State

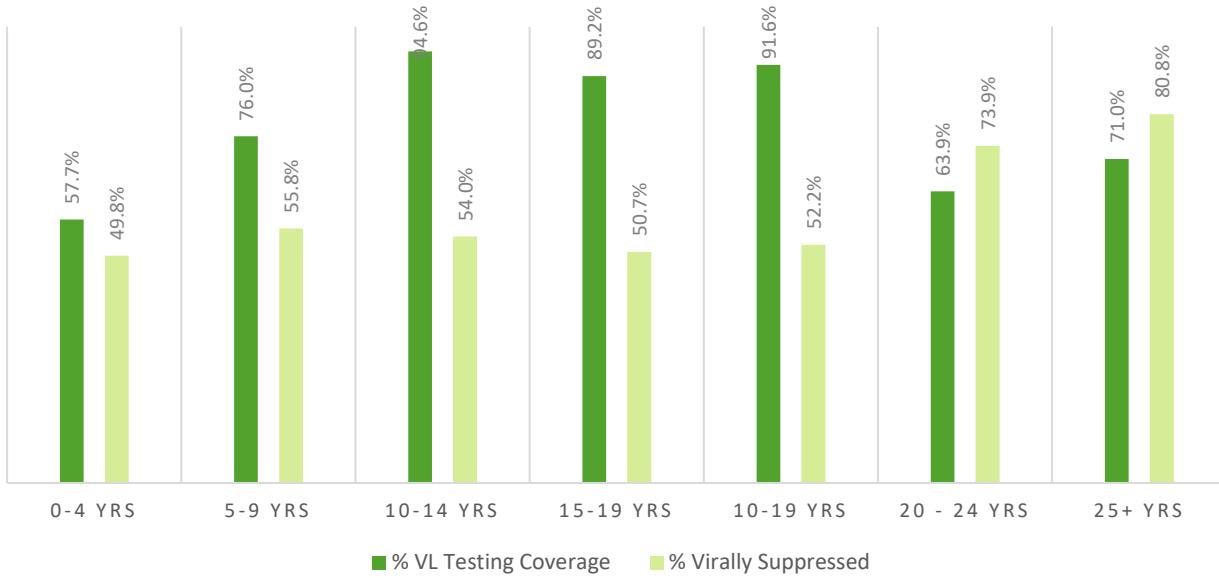


Figure 4.5.8 : Viral Load Testing and Suppression Coverage in Pediatrics & Adolescents

The chart shows Viral Load Testing and Suppression Coverage in Pediatrics & Adolescents. Viral load testing and coverage is lowest in the pediatric age groups mostly in 0-4years and 5-9years. Greater attention needs to be paid to classify pediatric clients on treatment as priority clients for Viral load testing and Suppression.

89% of the diagnosed PLHIV were on treatment as at December 2019



4.6 HIV Cascades.

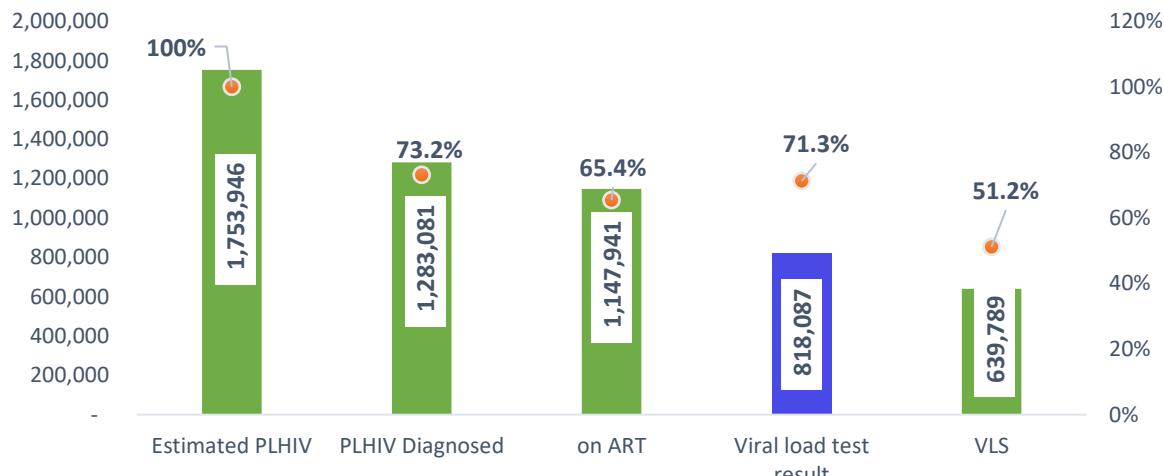


Figure 4.6.1a : Chart showing the HIV treatment Cascade

The chart above shows the country's status towards reaching HIV epidemic control. The HIV treatment cascade shows 73% of the estimated PLHIV know their HIV status and 65% of the estimated PLHIV were on ART. VL testing coverage (the proportion of routine VL tests done among PLHIV on ART) was 71% with Viral load suppression coverage among all PLHIV of 51.2% (*Please refer to 2020 Global AIDS Monitoring reporting guidelines page 38-39*).

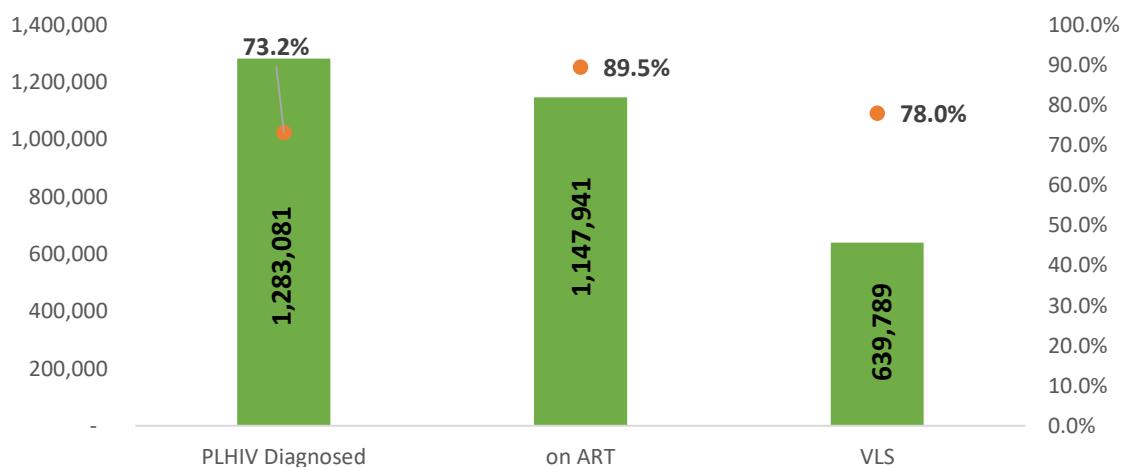


Figure 4.6.1b : Chart showing the 90-90-90 Cascade

The Chart above shows the country status towards the journey to reaching the UNAIDS 90:90:90 targets. The 90-90-90 cascade shows 1st 90 - 73% of the estimated PLHIV knew their HIV status , while 2nd 90 – 89.5% of PLHIV diagnosed were on ART with 3rd 90 – 78% of PLHIV on ART were virally suppressed. (*Please refer to 2020 Global AIDS Monitoring reporting guidelines page 38-39*). There is a need for concerted efforts to fill these gaps and double up the country's efforts of reaching the new targets of 95:95:95 by the end of 2030.

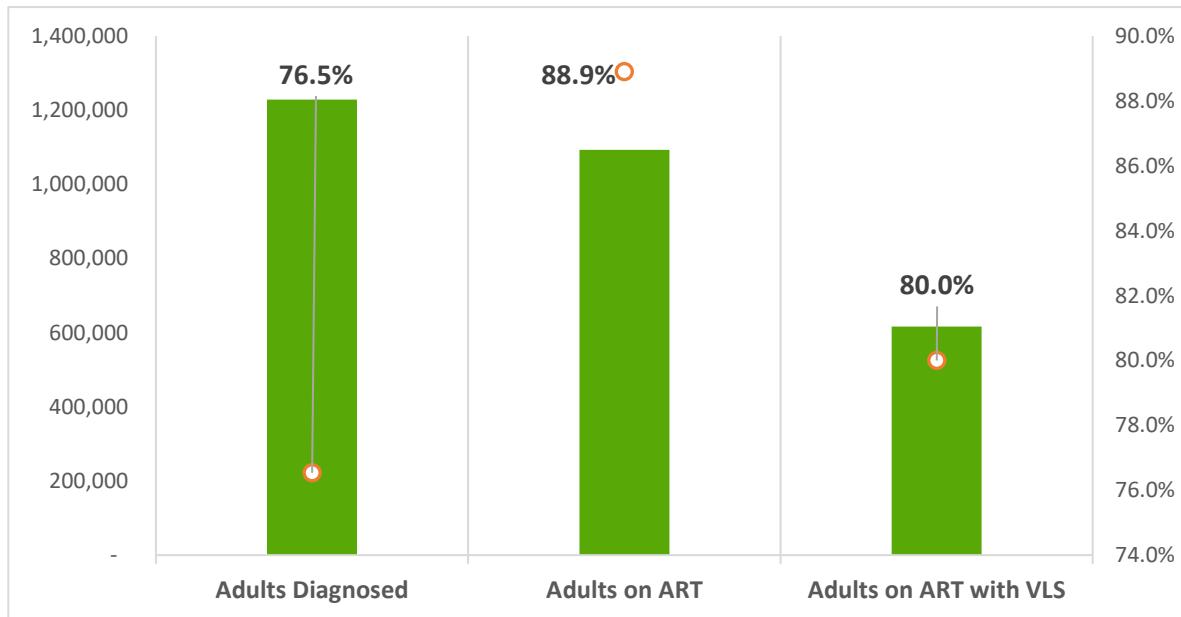


Figure 4.6.2 : 90-90-90 Cascade – Adults

The treatment cascade for adults shows 1st 90- 76.5% of the PLHIV estimated know their HIV status, while 2nd 90 – 88.9% are currently on ART with 3rd 90 – 80% are virally suppressed. (*Please refer to 2020 Global AIDS Monitoring reporting guidelines page 38-39*).

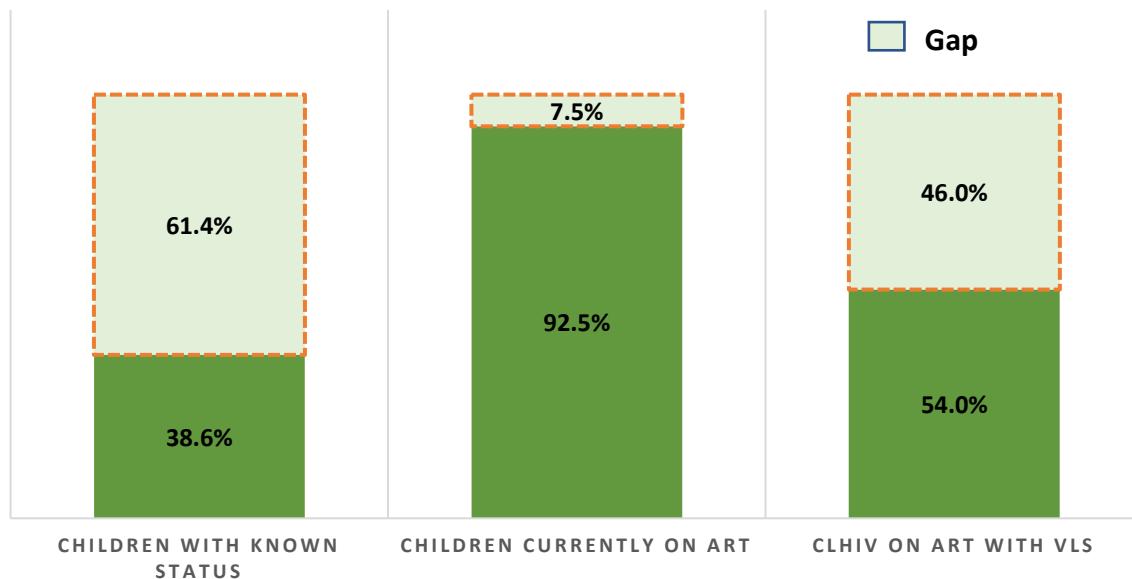


Figure 4.6.3 : 90-90-90 Cascade - Children

The treatment cascade for children shows 1st 90- 36.3% of the PLHIV estimated knew their HIV status, while 2nd 90 – 100% were on ART while 3rd 90 – 54% were virally suppressed. There is a need for intensified HIV case finding, linkage to care, prompt initiation to treatment and viral load testing to bridge the gap in the cascade.

4.7 TB/HIV integration -

Target 4: All PLHIV have access to TB services by 2021

TB HIV Cascade : from TB screening to diagnosis and Treatment

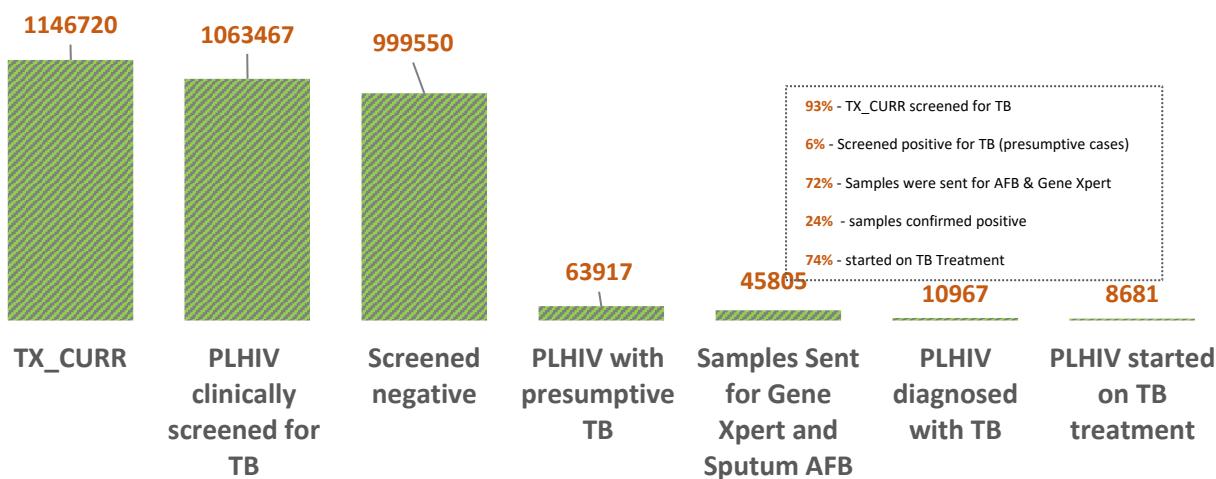


Figure 4.7.1 : TB HIV Cascade : from TB screening to diagnosis and Treatment

The figures 4.7.1 above TB HIV Cascade from TB screening to diagnosis and Treatment. 93% of all persons living with HIV currently on treatment screened for TB with a 6% presumptive case identification rate. Of these 72% had their sample sent for AFB and Gene expert testing. The TB case positivity for the year under review is indicated at 24% (i.e TB infectivity among PLHIV). While 74% of those were started on ART .

4.7.1 Other Opportunistic Infections (OI) indicators

Table 4.2 : Other OI Indicators performance from 2015-2019

Indicators	Year					
	2015	2016	2017	2018	2019	
Currently on Treatment	< 1 year	44,688	56,211	2,932	2,096	1,660
	1-4 years			10,110	11,792	11,302
	5-9 years			18,153	18,035	19,669
	10-14 years			22,972	19,204	20,898
	15-19 years	809,304	927,769	27,912	22,438	25,799
	20-24 years			81,166	68,127	72,585
	25-49 years			766,387	742,660	806,219
	50+ years			136,591	164,667	188,588
Total Number on ART		853,992	983,980	1,066,223	1,049,019	1,146,720
Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV		20.8	27.6	23.2		
Number of persons enrolled for HIV care who were placed on INH prophylaxis		40,885	62,781	91,873	111,262	168,355
Number of persons enrolled for HIV care who initiated CTX prophylaxis - (Children 0 -14 years)		28,284	38,770	70,565	97,223	219,307
Number of persons enrolled for HIV care who initiated CTX prophylaxis - (Adults > 15 years)		257,631	277,627	601,201	829,122	558,293
Number of persons on ART who are lost to follow		75,651	72,156	84,824	361,502	70,924
Total number of facilities providing ART services		1,078	1,292	1,529	1,639	1,435



4.9

Recommendations

- Promote integration and strengthen referral and linkages for HIV, TB, non-communicable diseases and other comorbidities
- Support full implementation of national task-shifting/task-sharing policy to address gaps in human resource available for the scale up and decentralization of HIV treatment services
- Institutionalize youth friendly services that target adolescents and young adults
- Scale-up of nationally identified differentiated models of patient centered care for stable and unstable patients (including in-facility and community-based models) to improve patient adherence and retention.
- Support pharmacovigilance and active management of adverse drug reactions
- Institute and strengthen quality management systems for treatment sites
- Improve the logistics and supply chain management for antiretroviral medicines and other related drugs
- Strengthen monitoring and evaluation platforms to support use of data for decision making.
- Conduct appropriate research to identify strategies that support increased access to HIV treatment services, viral suppression and improve quality of life
- Integrate non-traditional service delivery (faith-based organizations/maternities/traditional birth
- Develop a community component for keeping the persons on treatment, including community support, addressing user fees issues, inclusion of treatment costs in insurance mechanisms.
- Strengthen the national integrated sample referral network (NISRN).
- Integration of HIV services into routine health service provision.
- Scale up of the use of electronic health

IMPACT STORES

ADAMAWA

STATE

BUILDING A STRONG ADHERENCE STRATEGY

Establishing A Strong Relationship Between Case Managers And The Clients.

One fateful morning Abigail David was on phone with a case manager who normally called to render help in terms of service delivery and adherence for drugs taking. Pleasantries were exchanged and a request was placed on how to improve life expectancy of people living with HIV/AIDS. The clients responded with a lot of smiles in her face that it is indeed a good one since there are people out there thinking of them and how to help them improve and build a healthy life. She said it was a good one because life itself is full of challenges but with the support of love ones and the community at large it will be a success. The clients further said that they need shoulders to support in this struggle to survive which could be the work of the government or non-governmental organisations that support humanitarians as this pandemic wants to eradicate life gradually from the face of the earth, she further commented that if strong strategies for adherence to drugs and clinic visit days could be sorted out and encourage by the people or groups responsible, will help in combating the pandemic. The client therefore suggest that service providers and medical professionals that are responsible for taking care of the clients should show love and care to these clients as they could be their family members and loved ones, they should also encourage adherence by either phone calls or building support groups as they serve as reminders to client(s). She said that they depend much on the relationship between them and the service providers and the community at large as they encourage, support and remind them for adherence also strengthen discrimination, intimidation and segregation among the clients.



Victory over HIV: A viral suppression story

While poverty, ignorance, stigma, myths and misconceptions are among the factors that have militated against the achievement of viral suppression among PLHIV in Akwa Ibom & Nigeria at large, the intervention systematically provides solutions by ensuring accessibility to quality HIV care and treatment intervention in supported facilities and through the mobile community ART management strategy where over 80,000 persons are provided life-saving ARVs, information, other services (including Viral load services) & supported to remain on life-long ARV with outstanding results.

A case in point is that of 30-year Itoro, a seamstress and wife living in Oruko community in Urue Offong/Oruko LGA of Akwa Ibom state. Itoro was diagnosed with HIV at General Hospital, Oron in 2010 at the age of 22 during a routine Ante Natal Care (ANC) check-up following her first pregnancy. Itoro was totally devastated and refused initiation into care and further ANC services fearing her husband's reaction and stigma from her family. She rebuffed all entreaties to return to the hospital for delivery and lost the baby boy and a second baby in 2011, a few months after the birth of each child. The loss of two babies in 2 years caused Itoro to have a rethink and in 2012 when she was pregnant for the third time, she decided to register for ante-natal services at GH Oruko, another SIDHAS supported facility close to her home. There, she readily agreed to be initiated into care and consequent upon the robust counselling & support she received, she brought her husband and his other wife to the facility. Following couple counselling and testing , Victor and his first wife, Arit were also diagnosed with HIV.

While Victor took his treatment and care seriously, Arit refused and attributed her worsening health to witchcraft attack and died subsequently in 2017. Itoro, on the other hand adhered to her medication and through the PMTCT program in the facility, she delivered a healthy HIV negative baby girl and has gone ahead to deliver 3 more HIV negative children since then with the youngest being 8 months old.

According to Itoro, "I don't play with my drugs at all because I have seen what can happen if you don't take your drugs as you should. Also, I was tired of giving birth to children and they will be dying. That pain was too much; seeing my child die because of my own mistake. I did not want that to happen again so I have to take my drugs everyday as the nurses told me to take. Now I am very happy."

Following the advent of Viral Load (VL) testing services, Itoro had her first assay in March 2018 where she recorded <20copies of the virus /ml. Her most recent VL test done in May 2020, recorded "target not detectable". Victor's test done at the same time also had a similar result showing that she & her husband have achieved viral suppression which is the goal of every HIV treatment program. Itoro has not rested on her oars, instead she volunteers her time to counsel other pregnant PLHIV on the benefit of the PMTCT program and the need to achieve viral suppression.

Itoro and her husband are just two of the over 87% of persons living with HIV in Akwa Ibom state who have achieved viral suppression through the USAID intervention and have ensured that an AIDS free generation is attainable with the birth of 4 HIV negative children.

SECTION 5



Nigeria Estimates and Projection



5.1 Background

The Government of Nigeria with the support of UNAIDS has been using estimations and projections to provide information on HIV/AIDS indicators that cannot be obtained from other sources. The estimation and projections method uses demographic, program, surveillance and survey data as key inputs. UNAIDS has been supporting countries to do these estimations using the Spectrum software developed by Avenir health. Spectrum is a suite of several software models used by policy makers to support program planning and decision making.

The AIDS Impact Model (AIM) is the Spectrum model widely used for producing HIV estimates both for national and sub-national epidemics. Spectrum outputs include a range of HIV indicators that can be used by program managers and policy makers involved in HIV programming. These outputs include the population living with HIV, new HIV infections, AIDS related deaths, need for ART and PMTCT, and the impact of ART and PMTCT programs.

Increasingly, program managers and policy makers require HIV indicators at the subnational level because of differences in the population dynamics, depleting resources and competing priorities within subnational regions. Subnational monitoring of the epidemic is also required to measure progress in subnational HIV prevention activities. Globally, there have been efforts to move towards characterizing HIV epidemics at subnational levels. UNAIDS introduced the location population approach in 2013 and has been working with countries to produce their sub-national HIV estimates to address the heterogeneity in sub national epidemics in many countries. This approach serves to identify locations that have the greatest need for services and consequently direct resources and attention to these areas.

In 2013, Nigeria commenced subnational HIV estimates and projections for all its 36 states and the Federal Capital Territory (FCT) using the Spectrum software. The 2018 Nigeria Spectrum estimations and projections is the fifth iteration of subnational estimations. This chapter describes the process of generating estimates, presents the findings, as well as discusses the policy implications of observed estimates and trends. To inform planning at the lowest level of administration in Nigeria, Local Government

Area (LGA) level estimates are also required. In 2019, a new module was added to the Spectrum software for computation of LGA level estimates. This module uses the HIV positivity rates from the national PMTCT program as a proxy for prevalence as well as the population of each LGA to estimate the HIV burden. The Nigeria estimates team used this module to attempt LGA level estimation. The outputs from this effort will also be presented in this report.

5.2 Methodology

The National HIV/AIDS estimates is generated annually through the collaboration of various stakeholders. The process involves reviewing population figures, updating PMTCT and ART (Adult and children) program data, recalculating targets where required, reviewing surveillance and survey data in the files and then fitting the curves using the Estimates and Projection Package (EPP) part of the software.

Updates to the 2020 Spectrum Software and Estimation Process include the;

- 01  Review of state populations to align with population figures used in the 2018 NAIIS survey
- 02  Replacement of the NARHS data with the NAIIS prevalence data
- 03  Use of the new 'Knowledge of Status' tab
- 04  Use of the 'Shiny 90' app to estimate 1st 90.
- 05  Use of the new 'Viral Suppression' tab to input viral load data.
- 06  Inclusion of 'Treatment Cascade' in the ART results.
- 07  Introduction of the 'District Estimates Tool'.

The national and state files were updated with the final national validated data in March 2020 and submitted to UNAIDS for review and the final estimate was used in the UNAIDS 2020 Global AIDS report.

5.3 Data Sources for HIV Estimates and Projections

A number of data sources were used as input in the Spectrum software. These include:

- a.) Demographic data from the UN population Division and the National population Commission (NPC): These sources provide population data which form the base of the model.
- b.) Nigeria Demographic and Health Survey (DHS) - (1989, 1995, 2001, 2006, 2011, 2013). This survey provides demographic data such as breastfeeding practices with which the model calculates disease transmission probabilities.
- c.) HIV sentinel surveillance system i.e. Antenatal HIV Surveillance System among pregnant women. This survey provides prevalence among pregnant women which is used to project the trends of HIV prevalence in the module.
- d.) Routine Program M&E: The Spectrum model uses program data on ART (adult and children) and PMTCT to provide numerators for computing coverages and targets. The key indicators required are:
 - i. The number of adults and children receiving ART
 - ii. The number of adults newly placed on ART
 - iii. The number of children receiving cotrimoxazole
 - iv. The number of pregnant women who received ART for PMTCT by type of regimen
- e.) The National AIDS and Reproductive Health Survey (NARHS): This survey provides data on HIV prevalence in the general population. In place of the NARHS, the Nigeria AIDS Indicator and Impact Survey (NAIIS) was used in the 2019 round of estimates thereby re-calibrating the model going forward.

Map of HIV prevalence estimates among 15-49 population from NAIIS

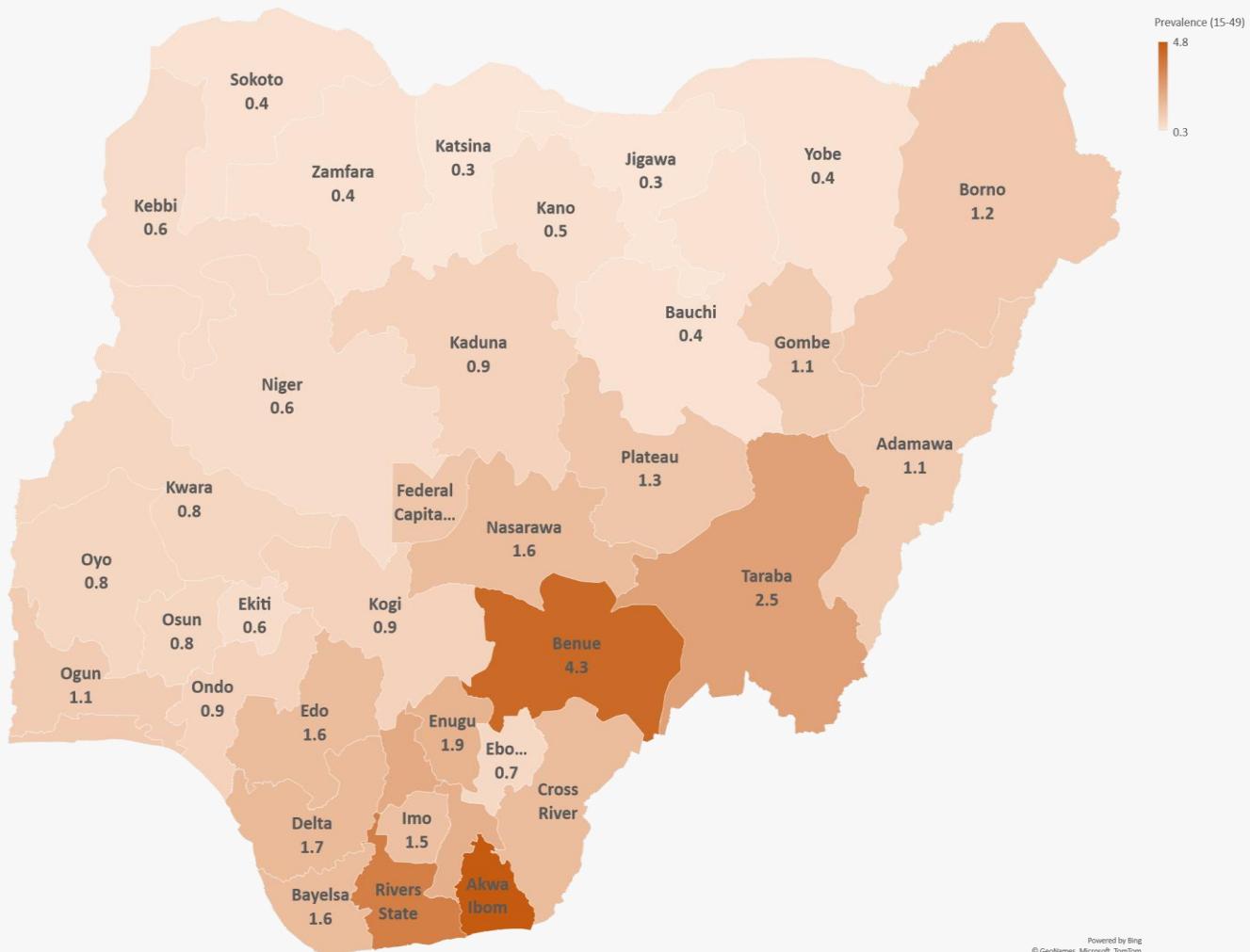


Figure 5.3.1: Map of HIV prevalence estimates among 15-49 population from NAIIS

The figure 5.3.1 above shows the 2018 NAIIS prevalence by state. The national HIV prevalence among adults aged 15-64 years is 1.4% and 1.3% among adults aged 15-49 years. The highest and lowest HIV prevalence were recorded in Akwa Ibom (4.8%) and Jigawa (0.3%)/Katsina (0.3%) states, respectively.

HIV prevalence estimates among 15-49 population from NAIIS

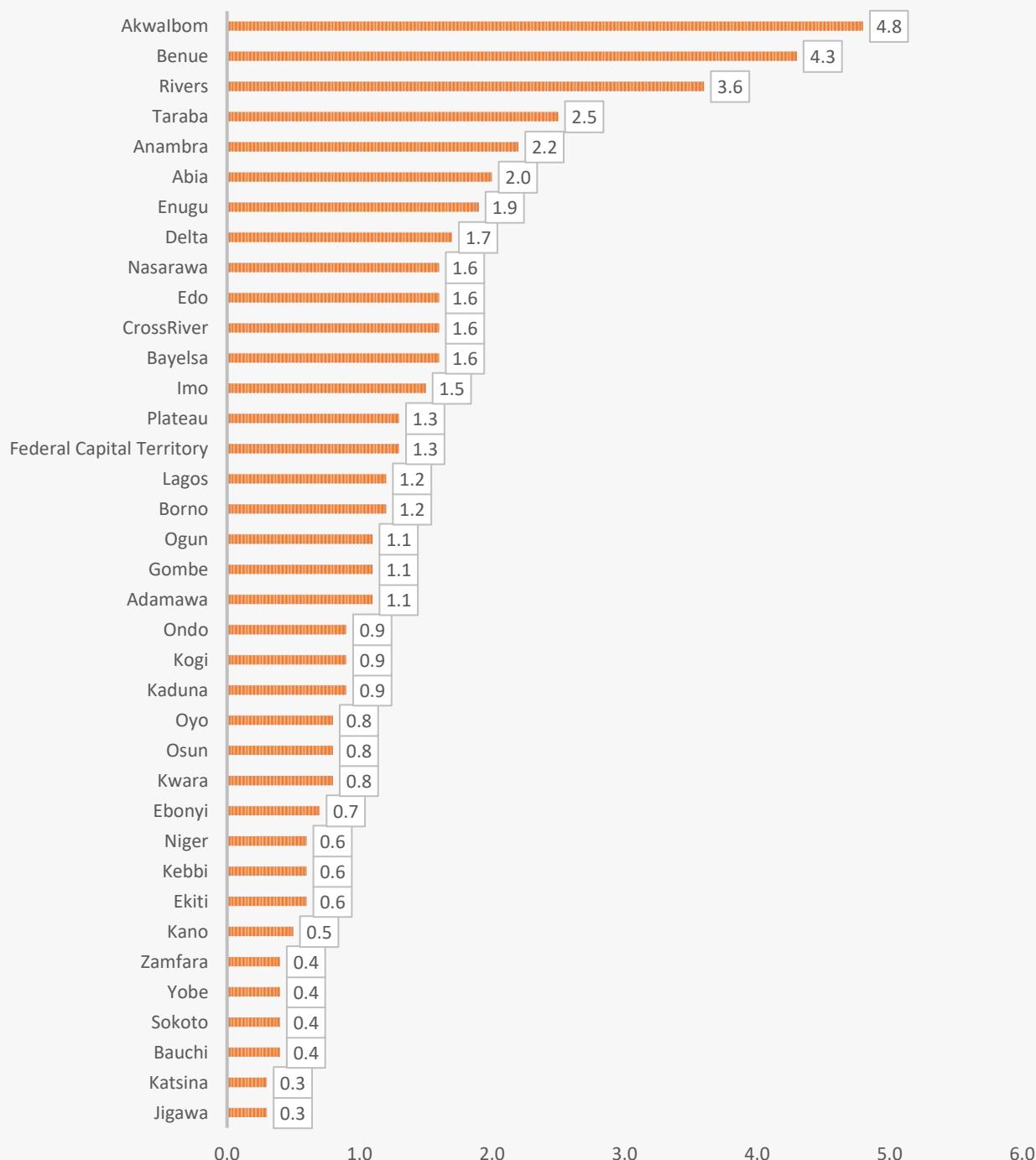


Figure 5.3.2 : HIV Prevalence by State

The figure 5.3.2 above shows the 2018 NAIIS prevalence by state. The national HIV prevalence is 1.4%. The highest and lowest HIV prevalence were recorded in Akwa Ibom (4.8%) and Jigawa (0.3%)/Katsina (0.3%) states, respectively.

5.4 OUTPUTS

5.4.1 NUMBER OF PEOPLE LIVING WITH HIV, ALL AGES

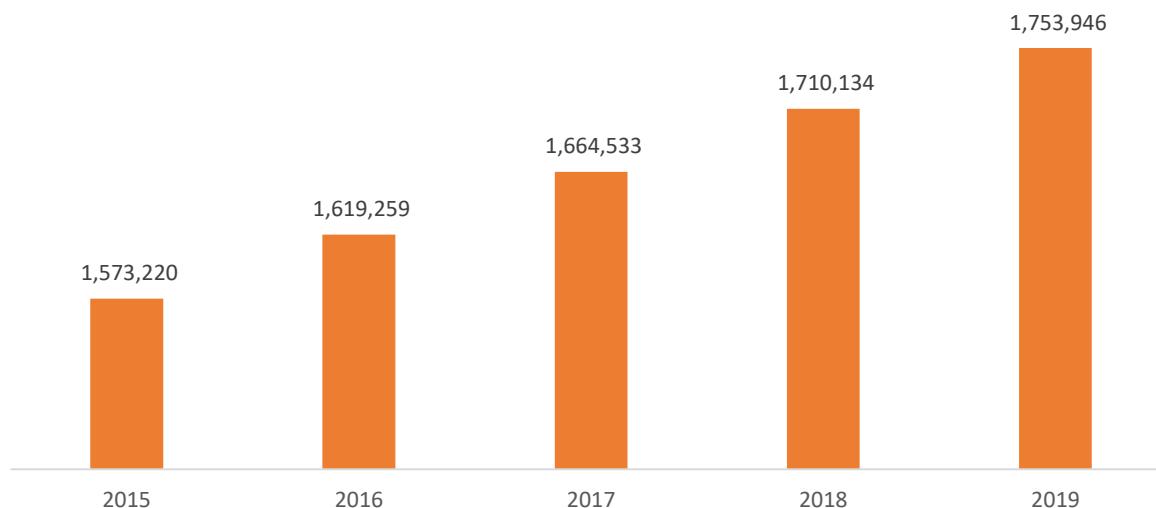


Figure 5.4.1: Trend in the Number of PLHIV -All Ages

Figure 5.4.1 above shows the estimated number of PLHIV from 2015 to 2019. Generally, there was a 10% increase in the PLHIV population estimates between 2015 and 2019. The PLHIV population is dependent on the interplay between the change in total population, new infections as well as AIDS related deaths. About 1.8 million (1.4 million-2.6 million) people were estimated to be living with HIV in Nigeria in 2019 and 92% of these were adults above 15 years. Among the adult PLHIV, 55% were women.

5.4.2 NUMBER OF CHILDREN (0-14 YEARS) LIVING WITH HIV



Figure 5.4.2 : Trend in the Number of Children Living with HIV

Figure 5.4.2 above shows trend in the number of children living with HIV in Nigeria in the last five years. There was a 4% decline within this period. As at 2019, an estimated 150,000 (91,000-220,000) children (0-14 years) were living with HIV in Nigeria. This accounts for about 8% of the total number of PLHIV in Nigeria.

5.4.3 NUMBER OF PEOPLE LIVING WITH HIV, ALL AGES

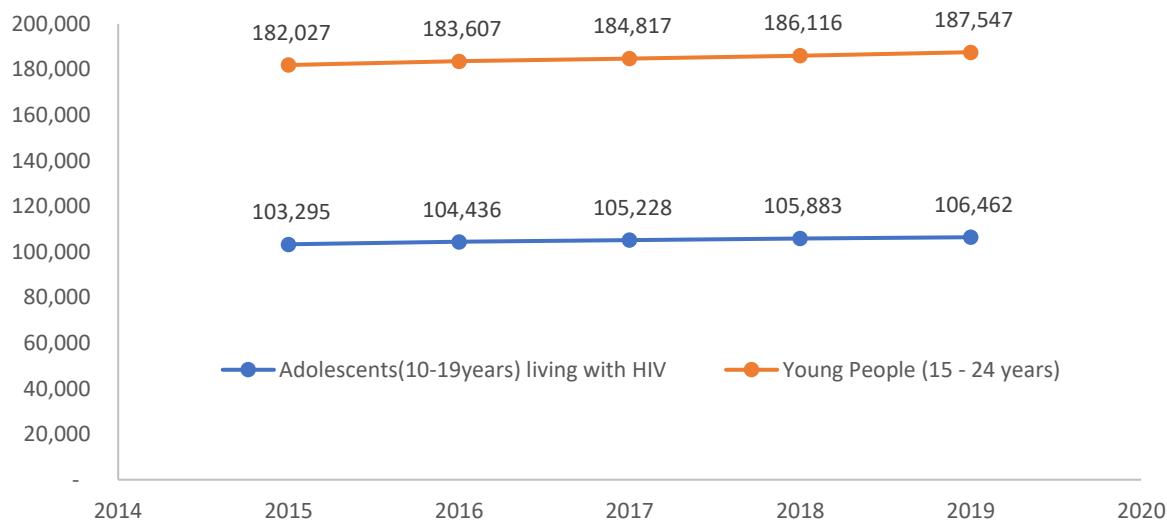
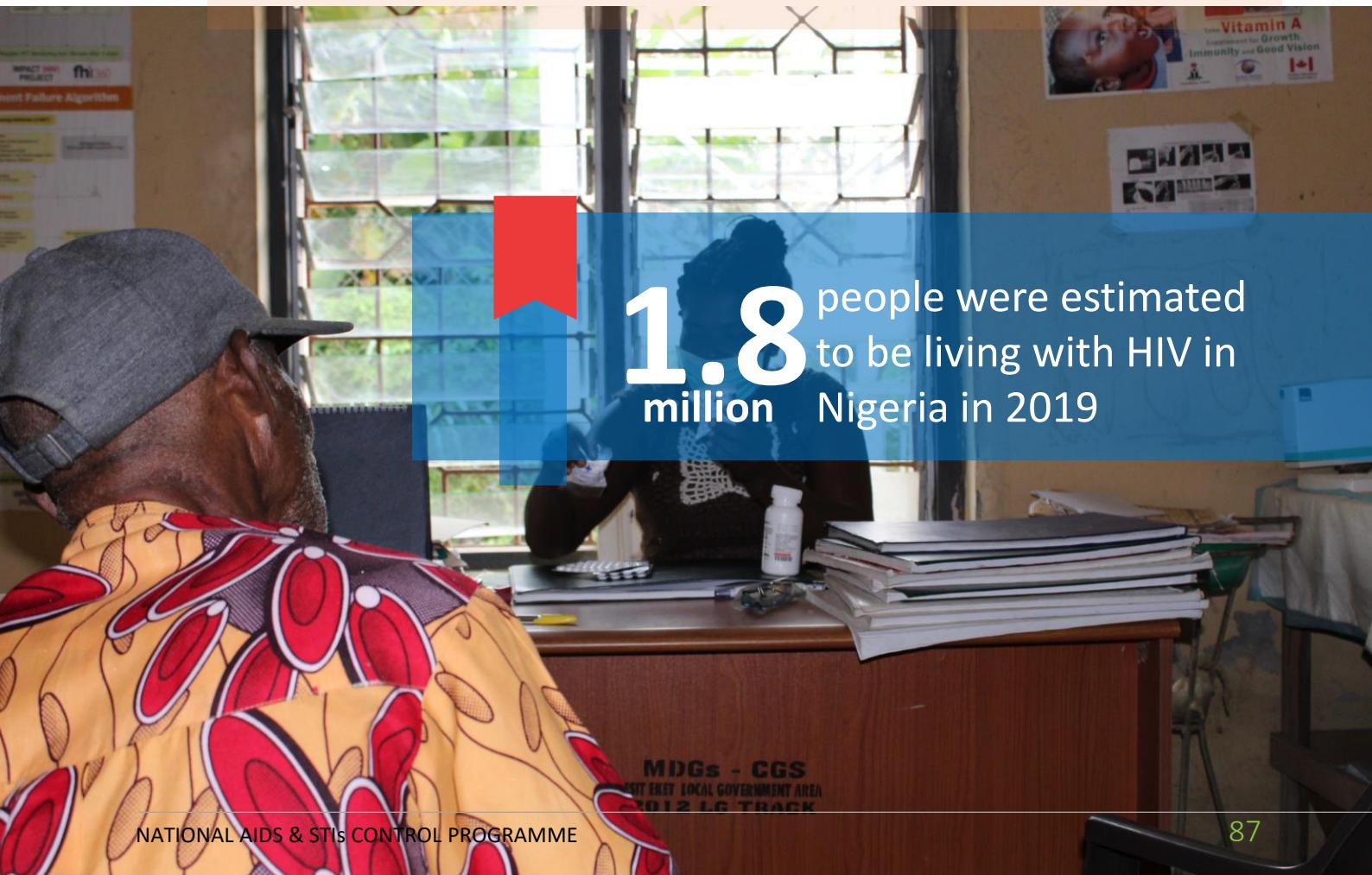


Figure 5.4.3: Number of Adolescents (10-19 yrs) and Young people (15 – 24 yrs.) Living with HIV.

Figs 5.4.3 above shows the trend in the estimated number of adolescents and young people (AYP) Living with HIV from the year 2015 to 2019. A similar trend was observed among the two populations. In 2019, adolescents and young people constituted about 6% and 11% of PLHIV respectively.



5.4.4 Number of People living with HIV by State

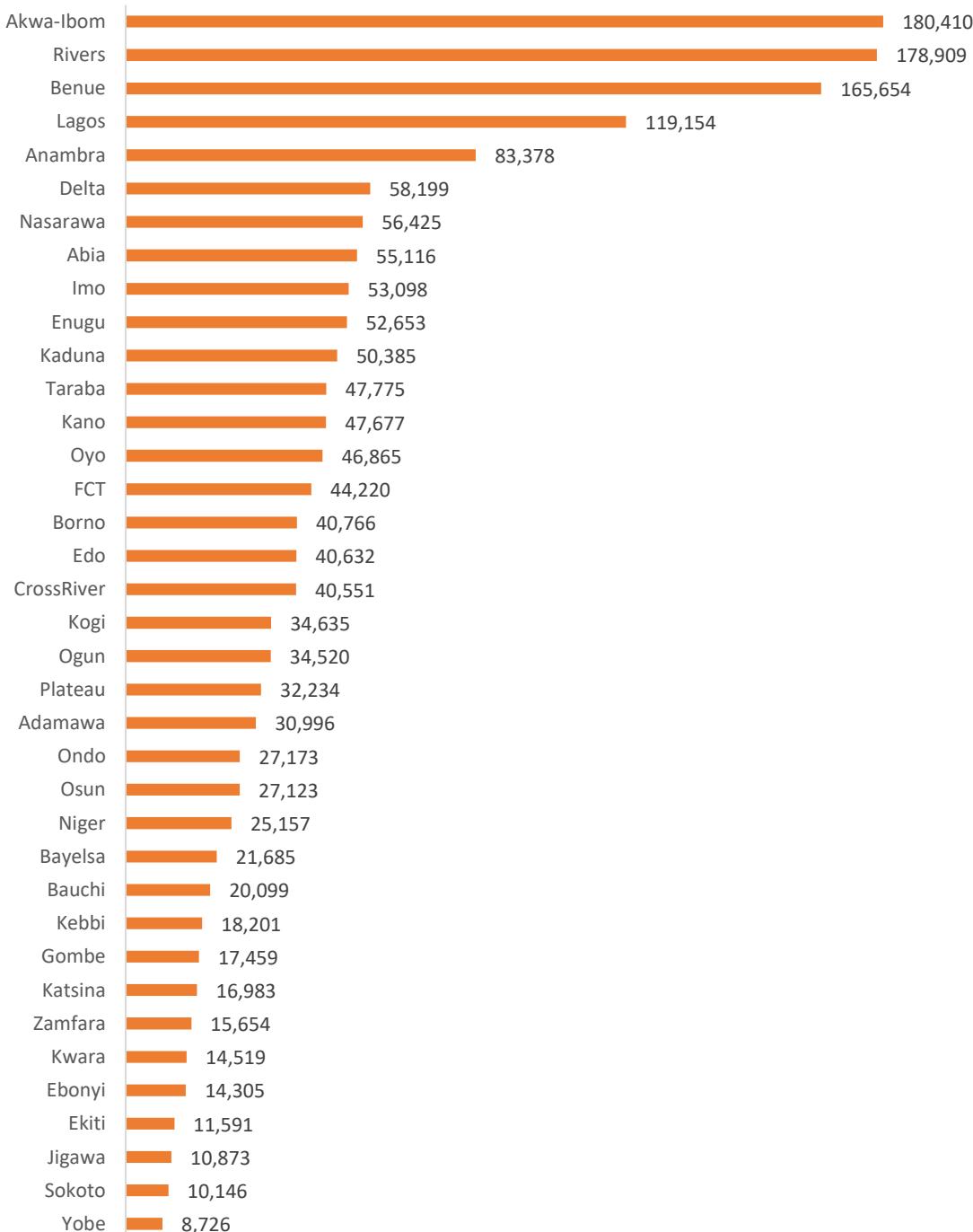


Figure 5.44: Burden of HIV

Fig 5.4.4 shows state level disaggregation of PLHIV in Nigeria. The figure is highest in Akwa Ibom (180,410) and lowest in Yobe state (8,726). Akwa Ibom, Rivers, Benue, Lagos and Anambra and Delta states account for almost half of the national HIV burden.

5.4.5 NEW HIV INFECTIONS



Figure 5.4.5 : Trend in new HIV Infections

5.4.6 a NEW HIV INFECTIONS - CHILDREN (0 – 4 YEARS)

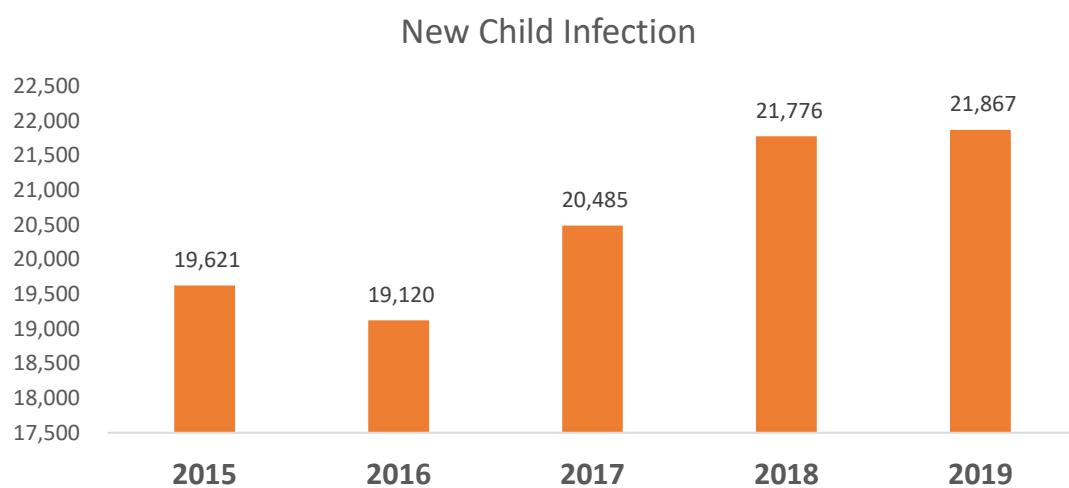


Figure 5.4.6 : Number of Children Living with HIV

Figs 5.4.5 and 5.4.6a show the estimated number of new HIV infections among children (0 – 4 years). Overall, new infections assumed an upward trend from 2017 . This calls for a re-focusing of the response on HIV prevention.

5.4.6b MTCT by Source : Number of Pregnant Women

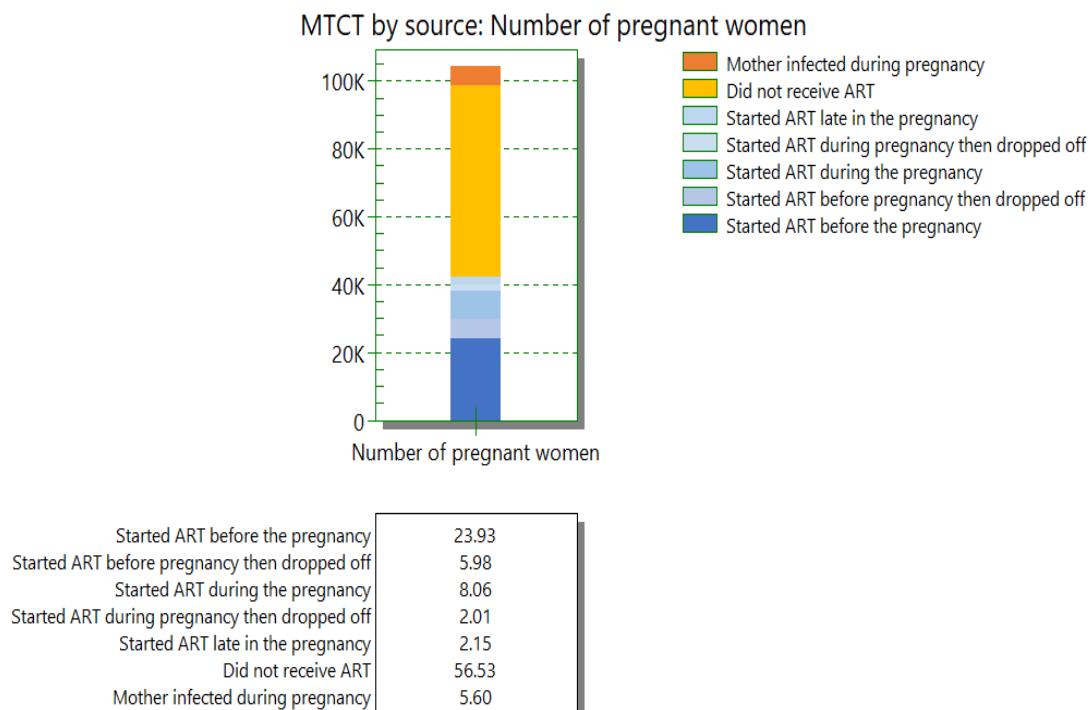


Figure 5.4.6b : MTCT by Source : Number of Pregnant Women

Figs 5.4.6b show the estimated number of new HIV infections among pregnant women by source . This shows over half of estimated HIV positive pregnant women did not receive ART. It also shows about 8% drop-offs among pregnant women after commencing ARVs. More effort is needed to reduce drop-offs and to identify HIV positive women and place them on ART before they present with pregnancy to reduce MTCT.

5.4.6c Sources of New Child Infections

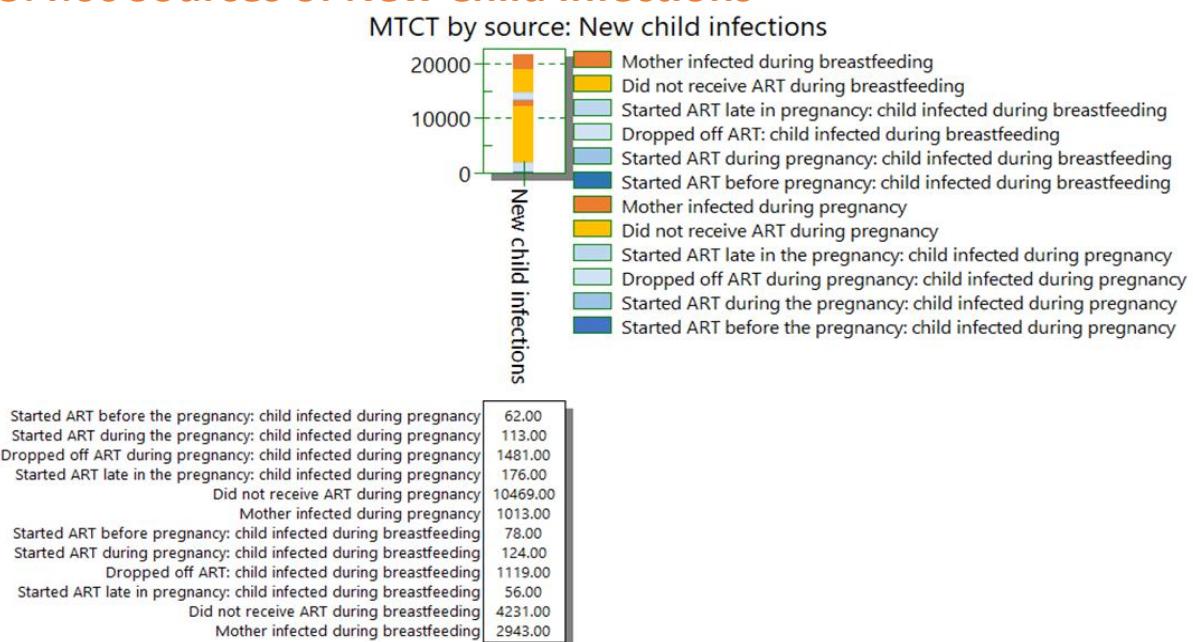


Figure 5.4.6c : MTCT by Source : New Child Infections

Figs 5.4.6c show the estimated number of new HIV infections occurring through MTCT . This shows highest number of estimated new infections among children (10,469) are from mothers who did not receive ART during pregnancy. About 20% of infections (4,231) are due to mothers who did not receive ART during breastfeeding.

5.4.7 NEW HIV INFECTIONS BY STATE

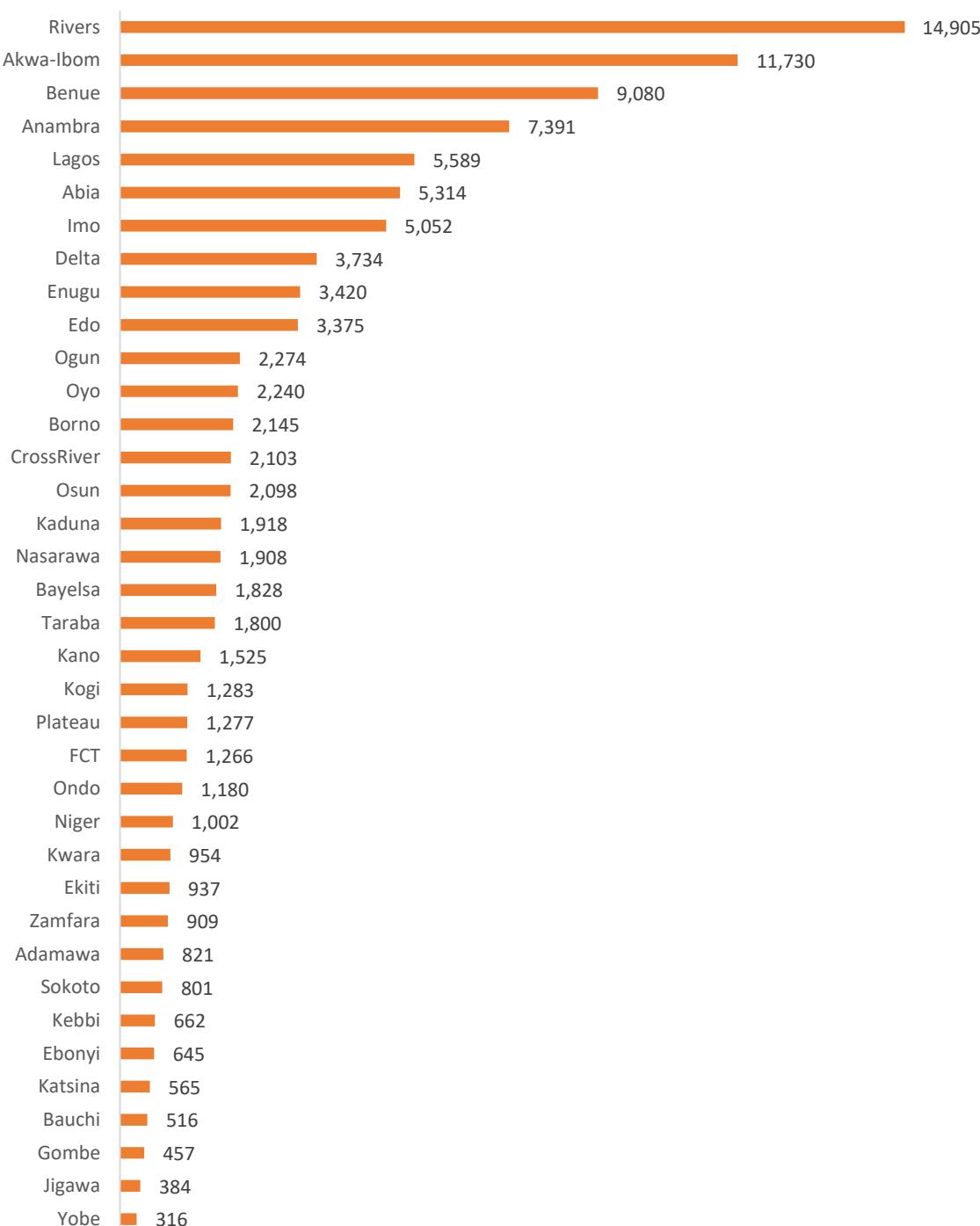


Figure 5. 4.7 : Number of New HIV Infections

Figure 5.4.5 and 5.4.6 above shows a trend in new HIV infections from 2015 to 2019. There was a marginal increase of 0.4% between 2018 and 2019 (figure 5.4.7). Akwa Ibom, Rivers, Benue, Lagos and Anambra state which contributed significantly to the national HIV burden, also accounted for about 50% of new HIV infections in 2019. This high number of new infections and high HIV burden as well as high unmet need formed the basis of selection of the 7 ‘surge’ states in the country. Ongoing efforts in these surge states will be sustained.

5.4.8 AIDS-RELATED DEATHS



Figure 5.4.8 : Estimated annual AIDS deaths

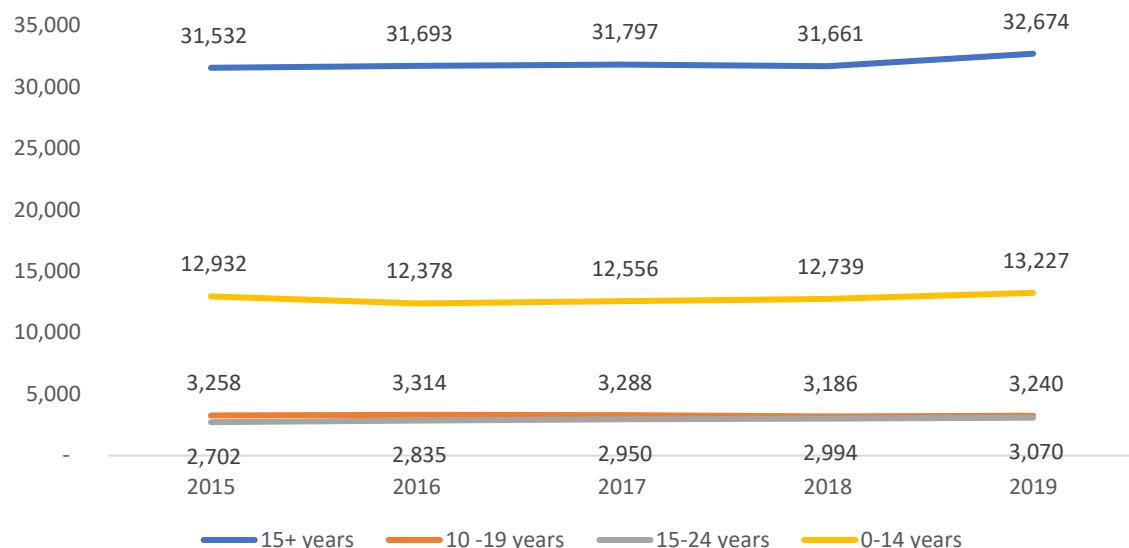


Figure 5.4.9 : AIDS related deaths disaggregated by age

Figures 5.4.8 and 5.4.9 show the estimated number of annual AIDS related deaths and AIDS related deaths disaggregated by age respectively. AIDS related deaths have assumed an upward trend since 2017. To reduce this trend, there is a need to strengthen treatment program to ensure adherence to treatment and aggressive monitoring of treatment failure. Over a quarter (26%) of the deaths were among children 0 -14 years emphasizing the need to strengthen the PMTCT program.

Table 5.1 Estimated AIDS Related Deaths by State

State	2015	2016	2017	2018	2019
Abia	686	688	746	824	938
Adamawa	329	369	382	364	333
Akwa Ibom	4368	5459	5508	5532	6222
Anambra	1003	961	1090	1232	1399
Bauchi	249	221	220	249	242
Bayelsa	658	606	610	594	621
Benue	2113	2024	1797	1589	1546
Borno	496	449	473	538	650
Cross River	470	477	453	481	509
Delta	969	996	1050	1104	1146
Ebonyi	310	292	294	288	277
Edo	390	426	473	511	536
Ekiti	252	260	273	288	314
Enugu	1120	1055	1056	1071	1023
FCT	409	447	429	397	384
Gombe	251	213	166	153	148
Imo	562	508	597	727	852
Jigawa	184	179	185	167	150
Kaduna	868	759	687	623	597
Kano	707	677	700	687	658
Katsina	224	208	197	179	175
Kebbi	215	249	304	355	385
Kogi	902	861	834	798	762
Kwara	199	189	192	195	197
Lagos	1514	1518	1609	1556	1510
Nasarawa	1175	1083	976	690	607
Niger	355	304	287	279	274
Ogun	559	553	571	585	612
Ondo	1294	1258	1219	1169	1102
Osun	871	880	915	938	956
Oyo	1097	1151	1218	1185	1147
Plateau	365	347	317	306	302
Rivers	5244	5043	5039	5047	5067
Sokoto	105	102	91	80	81
Taraba	569	518	489	472	471
Yobe	107	124	109	99	94
Zamfara	345	241	242	309	388

Table 5.1 shows AIDS related death disaggregated by states; this was mostly observed at Akwa Ibom state recording the highest number of deaths and Sokoto state recording the lowest

5.5 PMTCT

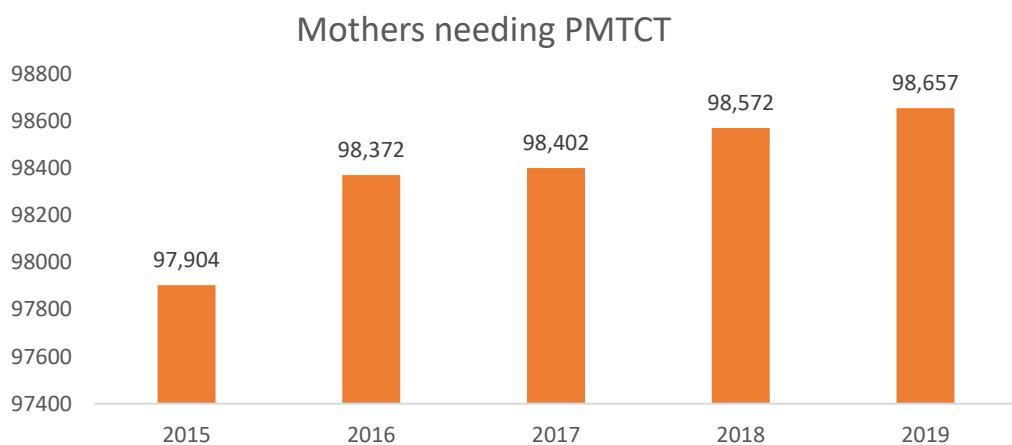


Figure 5.5.1: Estimated Women Needing PMTCT

Fig 5.12 shows an increase in the number of HIV positive pregnant women who required prevention of mother-to-child transmission from 2015 to 2019. This may be attributable in part to high fertility rates and calls for strengthening of PMTCT prongs 1 and 2. There is also an upward trend in the estimated MTCT rate at 6 weeks as reflected in figure 5.13. Concerted efforts need to be intensified to ensure effective PMTCT programming.

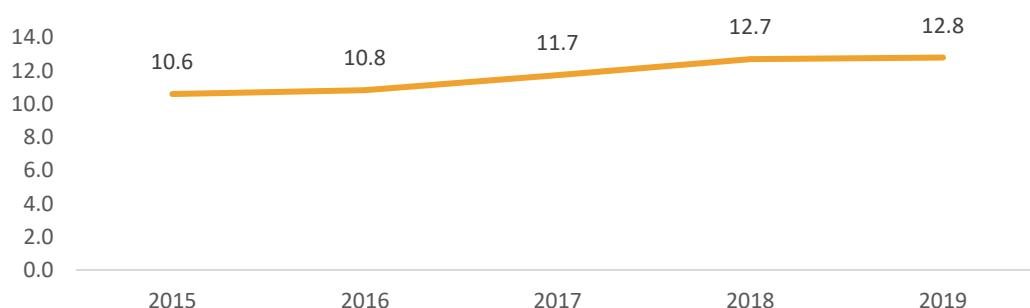


Figure 5.5.2: MTCT Rate at 6 weeks (%)

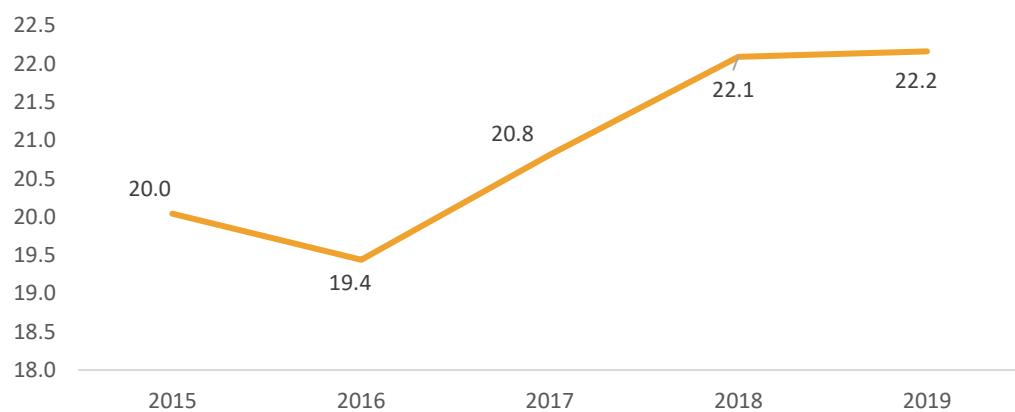


Figure 5.5.3 : Final Transmission Rate



SECTION 6



Summary & Conclusion

6.0 Synopsis of Data

The 2019 HIV health sector reports provides a brief description of NASCP mandate, roles, strategic direction and achievements across the various thematic areas. Progressive improved performance was seen in the total number of persons tested positive, number of PLHIV with known status, early infant diagnosis, linkage to syphilis treatment at ANC, number of persons on treatment and suppressed. However, there are gaps in the percentage attending 1st ANC, PMTCT ARV uptake, MTCT rate among others.



HIV Testing



There is a decrease in the number of persons counselled tested and received result despite the increase in the number of HTS sites. There was an increase in the number of PLHIV who know their status overall while the number of diagnosed children living with HIV remains low, and this shows the need for a state specific testing strategy that is reflective of the HIV typology to identify this population of PLHIV. Due to the low prevalence of HIV among children and limited resources for testing, strategies such as HIV risk stratification, index case testing should be deployed for an effective testing yield.

There was an increase in HIV positivity rate as compared with year 2018 despite the fact that less number of people were tested in 2019. HIV positivity was highest among those aged 35 – 39 years while the age group 25 – 29 years females contributed most (14.8%) to the total positives. This shows the need for the country to strengthen the integration of reproductive health services into HIV services while ensuring proper linkage of persons diagnosed to care. This also call for an operation research to determine the drivers of HIV disease in this age group and the development of effective strategies to mitigate the drivers. In addition, best practices might be adapted from other African countries with success story to suit country need.

Studies have shown tuberculosis to be the commonest cause of death among the PLHIV. The World Health Organization also recommended screening for TB when providing HTS services. However, uptake of TB screening in HTS setting is still low at 44%. This could be as a result of poor documentation of this service. There is need to educate the HCWs on the importance of TB screening while providing HTS services, emphasis should also be made on the importance of documentation for every services provided. Furthermore, uptake of services for other co-infections such as Syphilis and Hepatitis testing at HTS setting was very low.



Thematic Area:

HIV Testing Service

Prevention of Mother-to-Child Transmission



The National PMTCT program deploys strategies and evidence-based approaches to improve PMTCT uptake among pregnant women. However, ANC attendance at HIV delivery sites, one of the entry points to PMTCT is still sub-optimal. This necessitates engagement of all key stakeholders including the Traditional Birth centres, the religion leaders, private health care providers, Faith-based medical centres for a concerted effort in scaling up ANC uptake.

There is progressive decline in positivity rate among pregnant women over the years. It was highest among those who came during post-partum period, thus, posing more risk to the HIV Exposed Babies. PMTCT coverage also remains sub-optimal and requires interventions to improve the coverage in order to eliminate maternal to child transmission of HIV.



Thematic Area:

**Elimination of
Mother-to-Child
transmission
of HIV**

Antiretroviral Treatment Program



The concerted efforts of the National treatment program and all the stakeholders has significantly improved HIV continuum of care from initiation on treatment to the point of viral load suppression. This has led to gains in the last two '90s' of the UNAIDS Global target. At the state level, there was still ART unmet need mostly among children, and adults. This was highest in Rivers state for both children and adults (87.5% and 72.7% respectively). This further reflects the gap in HIV diagnosis among the estimated PLHIV in Rivers state (54.5% are yet to be diagnosed) and necessitates the need to re-strategize using approaches that will provide more yield in the number of persons diagnosed to be living with HIV, strengthen linkage and retention in treatment.

Findings from the National HIV Cascade Study and Survival Analysis conducted in 2019 showed that retention at 1 year after initiation on treatment was 76%. Retention was highest and lowest in Delta and Gombe states respectively. Further studies may be conducted to determine the factors influencing retention in order to strengthen ART program. Viral load testing has been recommended by the WHO has the gold standard for monitoring PLHIV on treatment, however, there was still gap in the 3rd 90. The viral load testing coverage was suboptimal even though it has progressively improved over the years. Viral load testing coverage was lowest among children ages 1-9 years while suppression rate was also found lowest among children <15 years. It is very key for the country to deploy measures to improve access to viral load testing, reduce the turnaround time and also strengthen the laboratory network in Nigeria. This will further improve the quality of life of PLHIV, reduce HIV transmission and new infections.

Thematic Area:
HIV Treatment

Conclusion

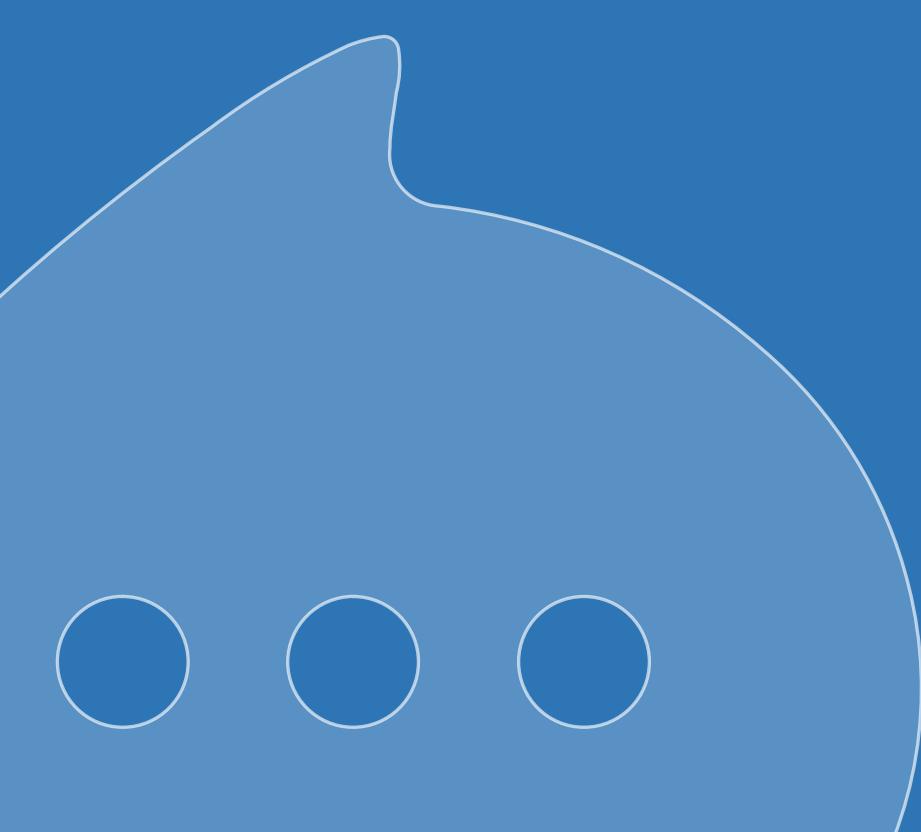
In conclusion, the 2019 HIV Health Sector report showed programme performance, highlighting the achievements, success stories and gaps in the National HIV program. The gains in all the thematic areas should be sustained and improved while the targeted strategies are to be developed to bridge the gaps in HIV diagnosis, PMTCT and treatment coverages.

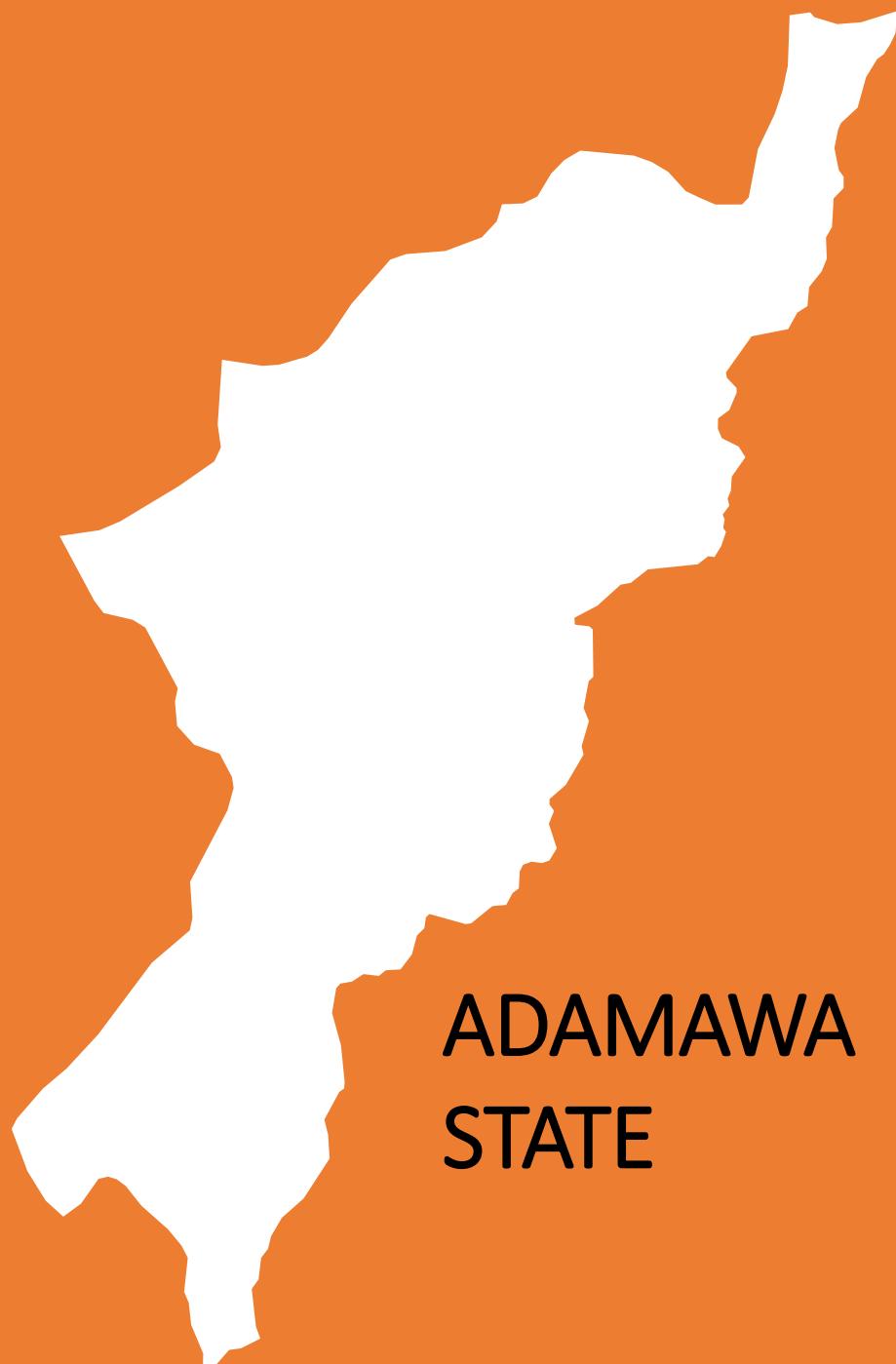
appendix

APPENDIX



IMPACT STORIES





ADAMAWA STATE

How we became **Friends!**

It wouldn't have mattered if the patients would just come on the scheduled day to pick their drugs. Getting their phone numbers was a major challenge as most of them gave out wrong information, some who gave out the right numbers, won't give u listening ears even if they managed to do, they were quick to get over with the calls. It wasn't an easy task forming a rapport with them not to mention reminding them of their pick-up date. Not everyone would want to let you in so as to avoid stigma. Managing some clients proved difficult but along the line I found a way around the situation which now makes the work run smoothly.

Meet Zainab Muhammad aged 33 who lives at Ngurore in Yola town. The first time I called her, she wouldn't just listen to me, all she wanted to know was how I got her phone number. After much explanation she concluded the conversation saying she was not dumb, so no need calling to keep up with her. That she would remember to come pick up her drugs, but her history shows she always missed her appointments and would come months later. I couldn't just let her go! I used a different approach not simply calling to remind her of pick-up dates but I called as a "friend" just to check on her, then I'll stylishly remind her of the date. It wasn't a smooth sail at first but with time everything turned out fine

When I finally met her, I got to understand her kind of person, she's a lady with so many sad tales on how family abandoned her after finding out she was living with HIV. I had to do a little counseling and told her she wasn't alone in this journey. She left happier than she came simply because she knew that someone cared.

Zainab Muhammad is just a case amongst thousands whom family have abandoned simply because they live with the virus.

I recommend that more awareness be created in every nook and cranny to let the world know that they are just like everyone else and need to be shown love.

Defeating Discrimination: The freedom to live HIV positive.

Binta is awakened by the knock on her door one morning. She responds faintly by inquiring the identity of her guest while trying to get a veil to cover herself. To her surprise a man replies, "My name is Josh and I am from the hospital. Please can I come in"? Being so weak to reach for the door she leaned her back on a pillow as she said "the door is not locked help yourself in".

Binta started falling sick more often than normal shortly after her husband Musa passed away due to a brief illness in 2005. As her health declined she was admitted to the General hospital in Mubi, Adamawa State, where she was tested and confirmed HIV positive. For Binta this was all new, having no prior information about HIV and the stigma that plagues people living with HIV and AIDS. She did not know that the news she had just received from the nurse was in her culture a death sentence. Binta reaches out to her family for support and in so doing she tells them her diagnosis. To her surprise, a family meeting was held the next day with her being the subject of discussion. Afterwards, her troubles began. In her father's house where she lived, she was

isolated and quarantined from the rest of the family. She was moved to the garage as her new room and given a mat to sleep on in the place of a comfortable bed. Binta was horrified and began to get depressed. She contemplated suicide a couple of times but failed to pull it through.

Finally, she sees an opportunity and escapes from her father's house to the slum. She gets a small room in a brothel and becomes a sex worker. As is the case of Binta, the stigma attached to persons living with HIV and AIDS is ugly and has become a major hindrance to the decline of the pandemic in Nigeria. According to a report from the National population Commission on a research conducted called Nigeria demographic and health survey, over half of the country's population (70 million people) subscribe to discrimination. There is a high level of stigmatization and discrimination against PLWHA (people living with HIV and AIDS).

Discrimination and stigmatization of PLWHA began to decline with a positive change in behaviour towards treatment on the increase with tremendous effort in providing regular health care for PLWHA in communities around Northeast Nigeria, with an inspiring testimony of reaching over 20 million Nigerians with different programs in a space of 30 years.

HIV/AIDS pandemic on the Nigerian population. For Binta, life became better the morning Josh walked into her room. Josh, a case manager volunteering for FHI360 under the SIDHAS project, tracked down Binta who had long defaulted from her anti-retroviral treatment (ART). Josh began to help Binta see the benefits of maintaining her treatment. He was able to discern Binta's fears thereby getting to the root cause of her defaulting treatment. The root cause being the discrimination and stigmatization she experienced from her family making her feel betrayed. Josh immediately encouraged Binta to join a support group in her community called Friends for Friends, where she was able to overcome her fear of rejection and develop the right self-esteem to continue her treatment. Binta reconciled with her family and she is accepted without an iota of discrimination or stigmatization.

Also, through the Friends for Friends platform in partnership with some religious organizations, Binta now educates her community on the HIV and AIDS and encourages her community to accept people living with HIV and AIDS. She also volunteered as a case manager with FHI 360 in her community. In 2016, Binta was recognized by the This day newspaper as a patriotic Nigerian inspiring change against discrimination and stigmatization. In an interview with This day newspaper, Binta was quoted saying " we are all affected by HIV, it is not an individual challenge, it is a global challenge, and the solution will come when we all come to understand, that people living with HIV and AIDS are not less human but are perfectly human."

IMPACT

STORIES



RIVERS

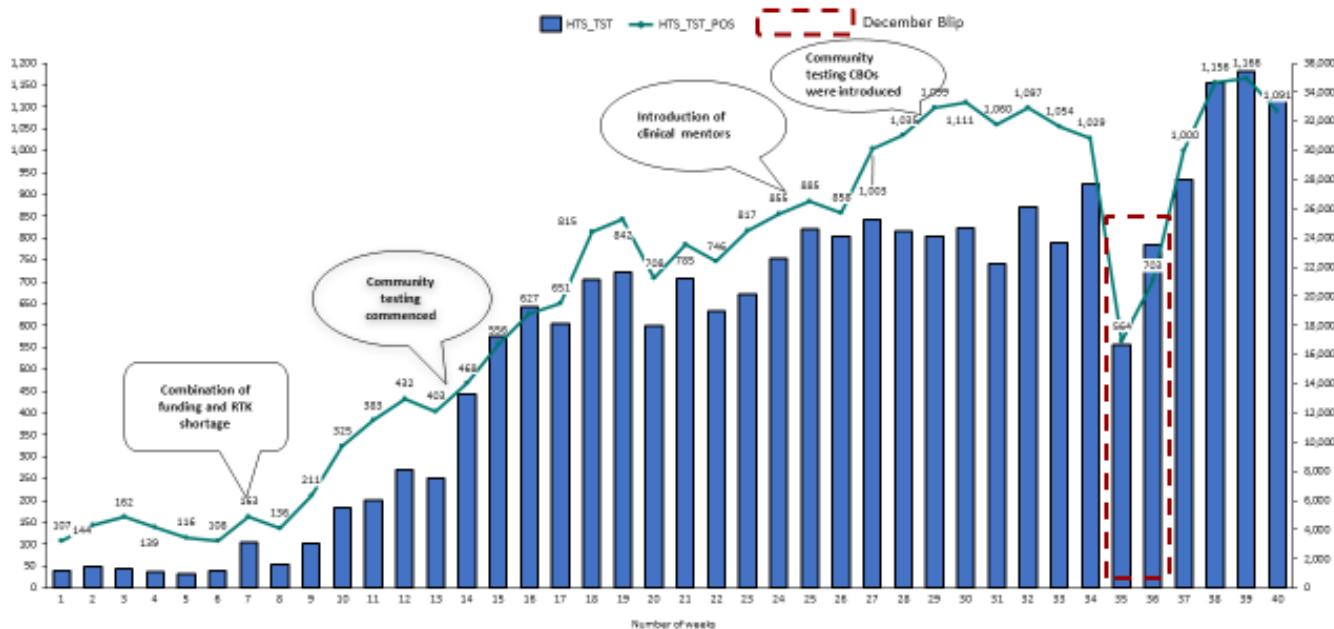
HIV SURGE SNEAK PEEK

1. Program Impact – *Magnitude of change*

Summary of New Positives

104 week 1 in April 2019 to 1091 week 40 in January 2020

1ST 95: WEEKLY HTS_TST AND HTS_TST_POS ACHIEVEMENT

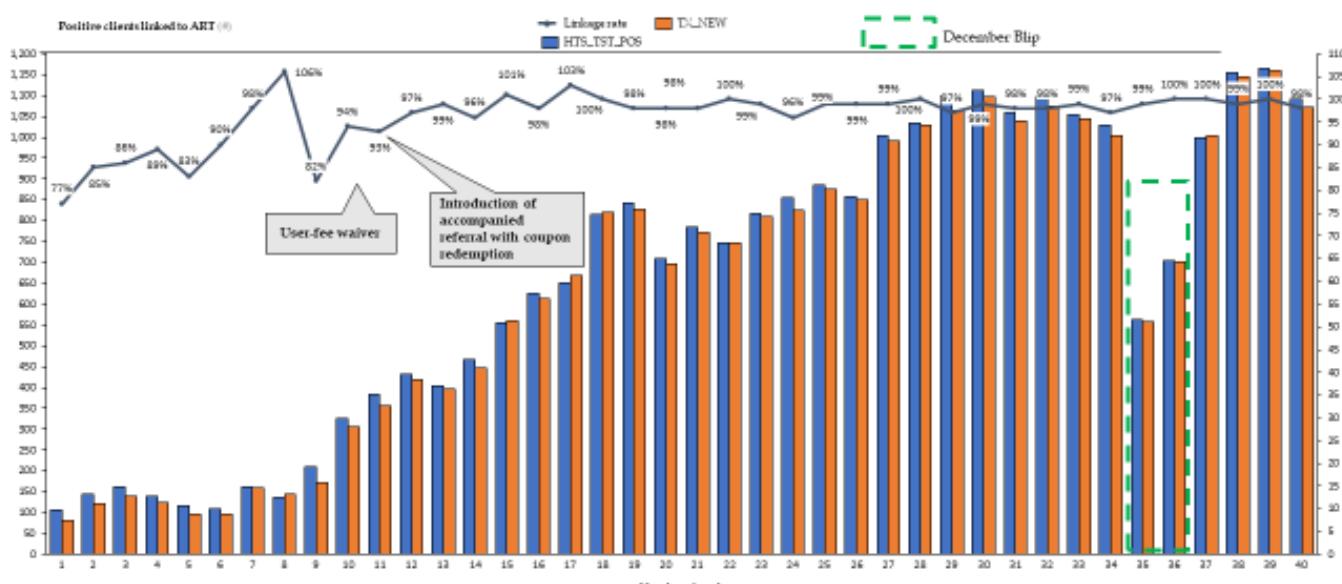


2nd 95

LINKAGE TO CARE/RETENTION

Abolition of user fees in Rivers State was also a turning point in the return of clients Lost-to-follow up back into care, increasing the retention.

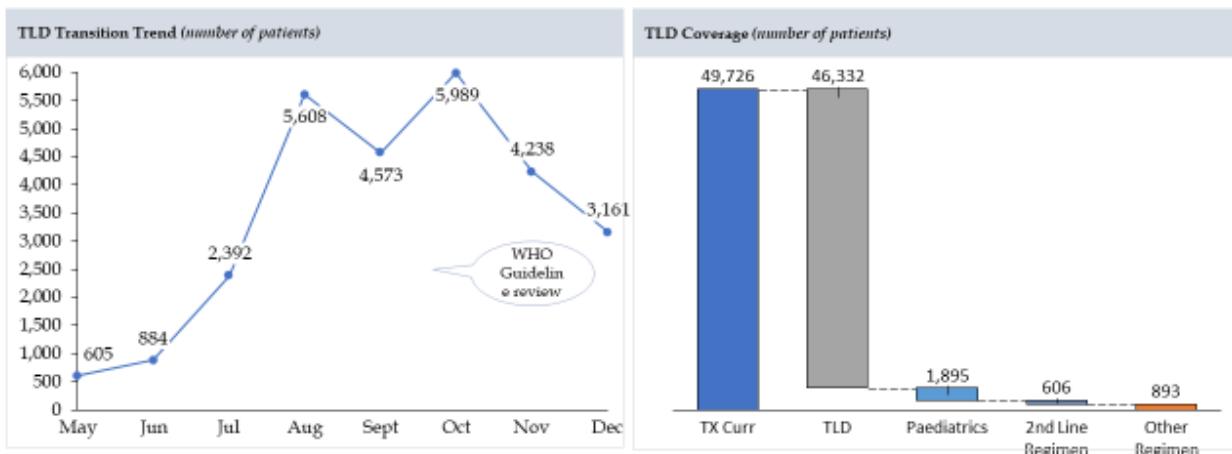
2ND 95: HTS_TST_POS AND TX_NEW



Adult and Pediatrics/Adolescent

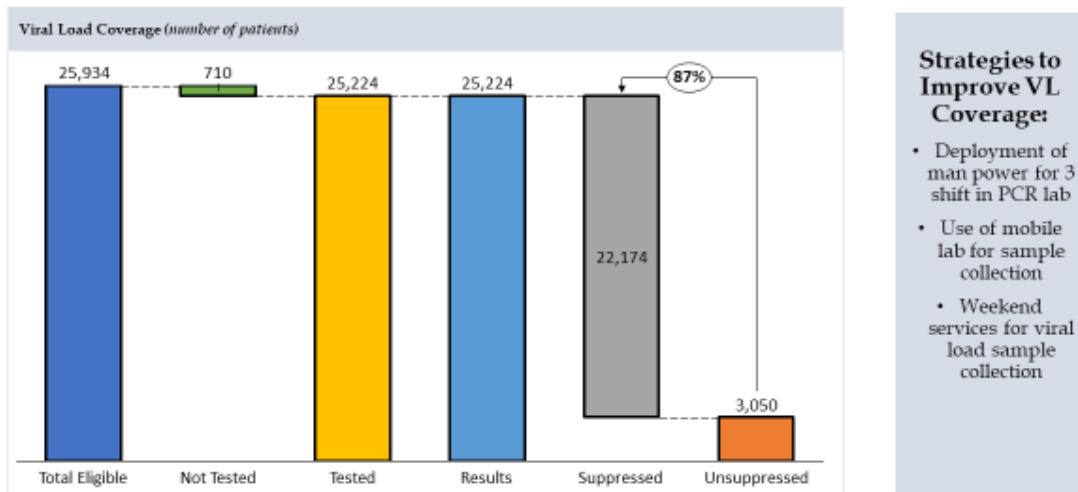
In a bid to deploy sustainable strategies to link and retain new cases identified in the SURGE Rivers project, a multi-faceted, multi-sectoral approach has been domesticated. Focus has been on optimizing same-day initiation, and linkage to ART for every new case identified both adult and paediatrics.

2ND 95: TLD TRANSITIONING/COVERAGE



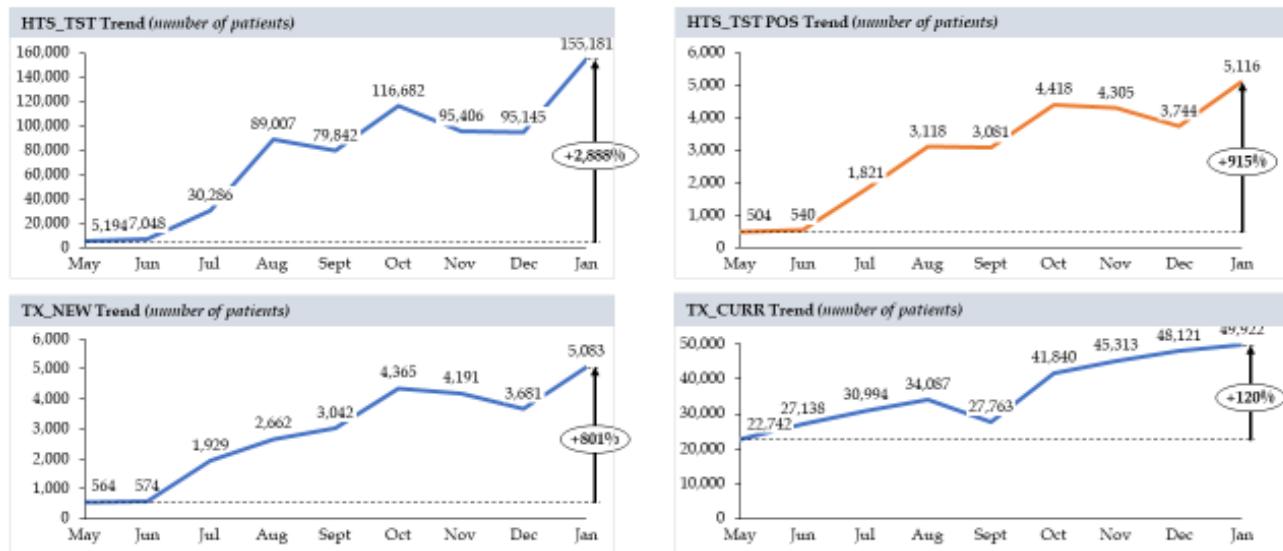
The Human Resource is enhanced by having three full-time Partner staff dedicated to the lab to ensure all forms are logged into LIMS to fasten samples processing and extended work hours (24 Hours) operation by the facility PCR Staff is facilitated by partner. This has reduced the TAT to 3-4 days.

3RD 95: VIRAL LOAD CASCADE (APRIL 2019 TO DECEMBER 2019)

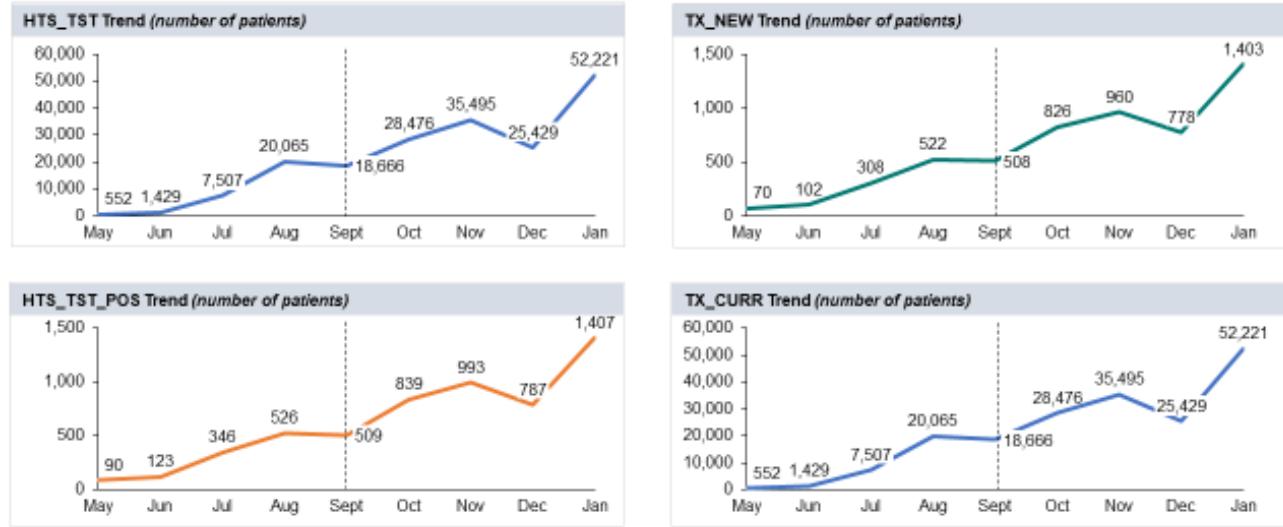


Overview of Rivers SURGE Key Performance Indicators

STATE WIDE SURGE PERFORMANCE OVERVIEW OF KEY INDICATORS FROM MAY TO JANUARY 2020



7 FOCUS LGAS SURGE PERFORMANCE OVERVIEW OF KEY INDICATORS FROM MAY TO JANUARY 2020



The Surge community peer educators (CPE) have reached Seven Thousand One Hundred and Twenty-Seven (7127) persons with HIV related sensitization messages with referrals to facilities for health access while the Adherence Counsellors counselled and enrolled Ten Thousand Five Hundred and Thirty-Four (10,534) clients into treatment following sufficient treatment preparation with consent and promise of adherence to medication.

Between April and September of 2019, 13,723 pregnant women were offered HTS, with identification of 513 positive pregnant women (including Previously known cases) with 98% (502) PMTCT_ART uptake. Mentor mothers facilitated 351 PMTCT_EIDs and tracked 216 previously missed EID opportunities giving a total of 612 samples collected and assayed.

○ **The abolition of “USER FEES”**

The abolition of “USER FEES” for PLHIVs by His Excellency, the Executive Governor of Rivers State, Chief Barrister Nyesom Wike following a high delegation visit to the government house by Donor & Partner led joint team opened the door to optimal care continuum in Rivers state with improved and increased access to HIV care and treatment. This opened the floodgates for fee abolition in other neighboring States.

- All clients booked for Enhanced Adherence Counselling (EAC) at Rivers State University Teaching Hospital (RSUTH) at the beginning of the project had their repeat viral load test, and all are now virally suppressed- 100% conversion to Viral Load Suppression.
- The surge project has seen the inauguration of facility-based support groups, one in MPH Churchill and another upcoming one in MPH in Agbonchia, Eleme LGA.
- Income Generating Activities (IGA) of NEPWHAN in the state has made available innovative funding schemes to support group members. Fifteen (15) of Forty-Five (45) existing support groups have cashed out from the IGA fund.



2. Future Potential – How the program is continuing the good work

- Index Case Finding, ICT

With a yield of 1:3 index case finding, ICT promises to be the trump card in the final push to identifying positives. Once biological, sexual or generational index case finding is pursued logically, the State would be saturated in terms of coverage and uptake of anti-retroviral therapy.

- Potential for reaching Epidemic control of HIV in Akwa Ibom & Rivers State.

APPENDIX

HIV Positivity Rate across the 36 States

State	Positivity Rate Across 36 states plus FCT		
	Pregnant Women CTRR	No Tested Positive	Positivity Rate
Benue	72,990	7890	10.8%
Akwa ibom	39,209	2673	6.8%
River	32,336	1512	4.7%
Abia	39,469	1819	4.6%
Delta	55,037	2404	4.4%
Edo	26,852	1140	4.2%
Enugu	30,167	1265	4.2%
Taraba	47,048	1827	3.9%
Plateau	26,181	1003	3.8%
Kogi	43,541	1584	3.6%
Bayelsa	13,930	449	3.2%
Ondo	34,434	1017	3.0%
Nasarawa	74,048	2065	2.8%
Fct	84,025	2244	2.7%
Cross rivers	55,829	1374	2.5%
Imo	41,757	987	2.4%
Lagos	75,782	1749	2.3%
Ogun	31,778	657	2.1%
Anambra	78,481	1385	1.8%
Ebonyi	36,419	638	1.8%
Kwara	27,137	439	1.6%
Ekiti	13,345	174	1.3%
Osun	24,230	310	1.3%
Niger	86,719	979	1.1%
Kaduna	303,151	3075	1.0%
Adamawa	93,097	895	1.0%
Kebbi	24,932	199	0.8%
Gombe	126,212	908	0.7%
Yobe	72,739	503	0.7%
Borno	97,894	669	0.7%
Oyo	194,412	1262	0.6%
Sokoto	31,964	207	0.6%
Katsina	130,588	466	0.4%
Jigawa	105,053	359	0.3%
Zamfara	58,959	194	0.3%
Kano	299,544	772	0.3%
Bauchi	246,758	496	0.2%
	2,876,047		1.7%
		47,589	

APPENDIX

ANC Coverage by States

State	Estimated Pregnancy	New ANC Attendees	% Attending 1st ANC (PMTCT sites)
Edo	278,931	27,173	9.70%
River	285,879	29,131	10.20%
Kebbi	162,184	17,908	11.00%
Lagos	540,912	76,308	14.10%
Ekiti	97,262	14,398	14.80%
Ogun	203,829	30,139	14.80%
Osun	160,999	25,368	15.80%
Bayelsa	73,851	12,394	16.80%
Plateau	163,499	27,710	16.90%
Ondo	182,540	32,421	17.80%
Sokoto	160,523	28,920	18.00%
Imo	198,313	40,988	20.70%
Delta	242,668	52,410	21.60%
Enugu	127,433	29,691	23.30%
Akwa ibom	164,904	39,993	24.30%
Kwara	109,382	29,734	27.20%
Kogi	138,711	41,607	30.00%
Cross rivers	155,686	49,796	32.00%
Zamfara	156,985	50,768	32.30%
Fct	266,290	87,136	32.70%
Benue	230,796	76,117	33.00%
Nasarawa	215,915	71,188	33.00%
Ebonyi	106,555	35,355	33.20%
Abia	108,273	36,276	33.50%
Katsina	336,691	118,563	35.20%
Anambra	215,337	78,705	36.50%
Jigawa	221,438	89,666	40.50%
Borno	234,720	100,979	43.00%
Niger	198,024	88,209	44.50%
Taraba	107,002	48,852	45.70%
Kano	560,365	312,194	55.70%
Oyo	282,662	168,526	59.60%
Adamawa	153,132	92,885	60.70%
Yobe	99,438	84,052	84.50%
Bauchi	278,097	268,591	96.60%
Gombe	124,095	129,688	104.50%
Kaduna	281,707	376,146	133.50%
National	7,625,028	2,919,985	38.3%

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