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NATIONAL ACCELERATION PLAN FOR PAEDIATRIC & ADOLESCENT HIV TREATMENT AND CARE

2020-2022

FEDERAL MINISTRY OF HEALTH ABUJA, NIGERIA

FOREWORD

The revision of the 2016-2018 National Acceleration Plan for Paediatric HIV Treatment and Care further underscores government's commitment to the welfare of the Nigerian child and adolescent, and the need for urgent action to ensure that all children and adolescents living with HIV receive life-saving antiretroviral drugs. The revision and ultimate development of the 2020-2022 National Acceleration Plan for Paediatrics and Adolescent HIV Treatment and Care was largely informed by huge unmet needs as only 51,157 (36.5%) and 41, 363 (34%) of the estimated 140,000 and 121, 000 children and adolescents respectively living with HIV in Nigeria accessed ART in 2018. These recorded coverages were still very low compared to the UNAIDS 90:90:90 targets for case identification, linkage to treatment and viral suppression by the end of 2020. Hence if this status quo is maintained as a country, it will be impossible for our programme to attain the UNAIDS 95:95:95 targets by 2030.

The revised plan identifies the main factors that limit access to HIV services along the entire cascade for children and adolescents and recommends practical strategies for addressing them. It is concerned with factors related to the low coverage and poor uptake of services, as well as the quality of services. Broadly speaking, it recommends strategies that ensure that services are improved and sustained, and that communities are mobilized to access these services in a timely fashion.

I am particularly delighted about the deliberate focus on creating public awareness on paediatric and adolescent HIV services through the use of mass media and community based social mobilization strategies; and the innovative approaches proposed for intensified HIV case-finding among children and adolescents, with linkage to and retention in care. Inclusion of adolescent-specific interventions in this revised document is also laudable. I am confident that faithful implementation of the strategies in this plan will catapult the country forwards towards meeting the UNAIDS 95:95:95 targets by the year 2030.

As can be seen from the quality of the strategies set forth in this document, this plan is the product of painstaking work by expert stakeholders convened by the National AIDS/STIs Control Programme, and will serve as the national strategic document for acceleration of paediatrics and adolescent HIV treatment and care for the next three years.

I strongly recommend that all stakeholders at the National, State and LGA involved in the care of children and adolescents living with HIV participate actively in full implementation of the plan, with periodic evaluation towards ensuring we remain focused and on track till the end of the life span of the plan.



Dr. Osagie E. Ehanire MD, FWACS
Honorable Minister of Health

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Finally, I commend the NASCP staff under the leadership of the National Coordinator, and especially staff of the Treatment, Care and Support component of the programme that coordinated activities and meetings that ultimately culminated to the successful completion of this plan, who are also expected to render excellent coordination during the implementation of this three-year plan.



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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune-Deficiency Syndrome
AHD	Advanced HIV Disease
ALHIV	Adolescents Living with HIV
AMLSN	Association of Medical & Laboratory Scientist of Nigeria
ANC	Antenatal Care/Antenatal Clinic
APGMPN	Association of Private & General Medical Practitioners
APYIN	Association of Positive Youths Living with HIV in Nigeria
ART	Antiretroviral Therapy
ARV	Antiretrovirals
ASWHAN	Association of Women living with HIV/AIDS in Nigeria
AYP	Adolescents and Young People
CBOs	Community Based Organisations
Cd4+	Cluster of Differentiation 4
CDC	Centers for Disease Control and Prevention
CHEW	Community Health Extension Workers
CLHIV	Children Living with HIV
CMEs	Continuing Medical Education
CSOs	Civil Society Organizations
DBS	Dried Blood Spot
DHIS	District Health Information System
DNA	Deoxyribonucleic Acid
EID	Early Infant Diagnosis
EMRS	Electronic Medical Record System
EPI	Expanded Program on Immunization
FBOs	Faith Based Organizations
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GoN	Government of Nigeria
HCW	Healthcare Worker
HTS	HIV Testing Services
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMP	Infant-Mother Pair
IP	Implementing Partner
LTFU	Lost to Follow-up
LGAs	Local Government Areas
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MNCH	Maternal Newborn and Child Health
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NACA	National Agency for the Control of AIDS
NANNM	National Association of Nurses and Midwives of Nigeria
NASCP	National AIDS and STIs Control Programme

NBS	National Bureau of Statistics
NDHS	National Demographic and Health Survey
NDR	National Data Repository
NEPWHAN	Network of People Living with HIV in Nigeria
NGOs	Non-Governmental Organizations
NISRN	National Integrated Sample Referral network
NOP	National Operational Plan
NPHCDA	National Primary Health Care Development Agency
N-SDF	National Service Delivery Framework
NSP	National Strategic Plan
NTBLCP	National Tb and Leprosy Control Programme
NTTA	National Task Team on Antiretroviral Therapy
Ois	Opportunistic Infections
OTZ	Operation Triple Zero
OVC	Orphans and Vulnerable Children
PAN	Paediatric Association of Nigeria
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PMM	Patient Management and Monitoring
POC	Point of Care
PNT	Partner Notification Testing
PSM	Procurement and Supply Management
PSN	Pharmaceutical Society of Nigeria
SACA	State AIDS Control Agency
SASCP	State AIDS and STIs Control Programme
SCMS	Supply Chain Management System
SDF	Service Delivery Framework
SDGs	Sustainable Development Goals
SMOH	State Ministry of Health
SNT	Sexual Network Testing
SOP	Standard Operating Procedures
SPHCDA	State Primary Health Care Development Agency
STIs	Sexually Transmitted Infections
TAT	Turnaround Time
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TOC	Theory of Change
TWGs	Technical Working Groups
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Nigeria has the fourth-largest burden of HIV/AIDS globally (NAIIS 2018) and one of the highest rates of new infections in sub-Saharan Africa (UNAIDS, 2019). Despite low national prevalence of 1.3% (15 -64 years), based on the large country population, an estimated 1.8 million people are living with HIV. Of this number, 100,000 were estimated to be children (0-9 years), 40,000 young adolescents (10-14 years) and 82,000 older adolescents (15-19 years). Approximately 22,000 and 10,000 new infections occurred among children 0-14 years and 10-19 years, respectively. Only about 36.3% of children living with HIV (CLHIV) are currently accessing ART leaving an unmet treatment burden of almost 63.7% (FMOH 2019, HIV Health Sector Programme Data).

At the commencement of the national treatment programme in 2002, the initial target set by the Government was to place 10,000 adults and 5,000 children on ART in the first two years. Although, this was not achieved within the time frame, the number of children and adults now on ART have reached 53,553 and 1,229,528, respectively. The Government of Nigeria has committed to the global goal to end the AIDS epidemic by 2030. Creating an enabling policy environment through the formulation and dissemination of policy documents, including national guidelines for HIV/AIDS treatment and care, national HIV/AIDS strategic framework, national HIV/AIDS strategic plans among others remain key components of the response.

The first National Acceleration Plan for Paediatric HIV Treatment and Care (NAP) was developed in 2016 to address the poor progress in expanding paediatric HIV services. However, due to poor implementation, the plan which spanned three years (2016 - 2018) made minimal impact on the programme. By the end of 2019, HIV health sector programme data still showed a huge unmet need as only 53,533 (36.3%) and 46,697 (44%) of estimated 140,000 and 110,000 children and adolescents (respectively) living with HIV in Nigeria accessed ART. Significant gaps still exists in achieving the UNAIDS 90:90:90 targets by the year 2020. Without an acceleration of the current pace, it will be impossible to attain the UNAIDS 95:95:95 targets by 2030. The wide gap indicates that most children and adolescents living with HIV are still underserved, thus underscores the need for accelerated action and the revision of the 2020-2022 NAP.

This revised NAP (2020 – 2022) articulates strategic interventions which when implemented consistently and at scale would help achieve up to 95% ART coverage for eligible children and adolescents living with HIV in Nigeria. It recommends active case-finding using novel strategies, addresses demand-side barriers to uptake of HIV services by children, adolescents, and their families. It also recommends strategies that ensure that services are improved and sustained, and that communities are mobilized to access these services in a timely manner. This document provides the framework for concerted action by all stakeholders at all levels to close the perennial gap in HIV treatment for children and adolescents living with HIV. It ensures that children and adolescents are not left behind as Nigeria works towards achieving its targets.



Dr. Akudo Ikpeazu
National Coordinator

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1

INTRODUCTION



INTRODUCTION

1.1 COUNTRY PROFILE

The Federal Republic of Nigeria, located in West Africa, is the most populous country in Africa. The country has a projected population of 193 million inhabitants with an annual growth rate of 3.2% (National Bureau of Statistics NBS, 2016). Nigeria is comprised of 36 states and the Federal Capital Territory (FCT), grouped into six geo-political zones (North-East, North-West, North-Central, South-East, South-West and South-South) and has 774 Local Government Areas (LGAs). About 52% of the population are children and adolescents. Specifically, 30%, 11.5% and 10.6% of the entire population are children 0-9 years, young adolescent 10-14 years and older adolescent 15-19 years respectively (NBS 2016). The infant and under-5 mortality rates were 67 and 132 deaths per 1,000 live births respectively (National Demographic Health Statistics, NDHS, 2018).

1.2 PAEDIATRIC AND ADOLESCENT HIV BURDEN IN NIGERIA

Nigeria has the fourth-largest burden of HIV/AIDS globally (NAIIS) and one of the highest rates of new infections in sub-Saharan Africa (UNAIDS, 2019). Although the National prevalence is low (1.3%), the populous nature of the country makes it such that an estimated 1.9 million persons are living with HIV (PLHIV). About 100,000 were estimated to be children (0-9years), 40,000 are young adolescents (10-14years) and 82,000 are older adolescents (15-19years).

Approximately 24,000 and 19,000 new infections occurred among children 0-14 years and 10-19 years respectively. There were an estimated 14,000 AIDS-related deaths in children aged 0-14years (UNAIDS, 2019). Only about 36% of children living with HIV (CLHIV) are presently accessing ART leaving the country with an unmet treatment burden of almost 64% (FMOH 2018, HIV Health Sector Programme Statistics).

There has been modest progress in antiretroviral coverage for pregnant women living with HIV, from 21% in 2015 to 44% in 2018. However, vertical transmission remains a major contributor to pediatric HIV burden with Mother to Child Transmission (MTCT) rates of 13% and 24% at six weeks and 18 months respectively (UNAIDS 2019). Also, national Early Infant Diagnosis (EID) coverage remains low at 23% (FMOH HIV Program data 2018).

Antenatal care (ANC) by a skilled provider serves as an entry point for the Prevention of Mother to Child Transmission (PMTCT). This is important to improve pregnancy outcomes and reduce mother to child transmission. Despite the first ANC uptake of 67%, only about 39% of deliveries occurred in the health facility (NDHS 2018). This implies PMTCT uptake and outcome, as the PMTCT ART coverage as of December 2018 is 44%, while health-facility based delivery for HIV positive pregnant women is 25%. Poor health care-seeking behavior and the shortage of skilled health providers for the care of children and adolescents living with HIV further contribute to the high burden of HIV among these sub-groups of PLHIV.

1.3 NATIONAL RESPONSE TO PAEDIATRIC AND ADOLESCENT HIV/AIDS

The National response to pediatric HIV/AIDS commenced effectively in 2002 at the same time, the country started providing treatment for adults living with HIV. The initial target for the Government was to place 10,000 adults and 5,000 children on ART in the first two years. Although, this was not achieved within the time frame, however, the national response got a major boost in 2004/2005 with the emergence of PEPFAR and Global Fund support.

Since then, the government has worked closely with her partners to establish systems for the effective delivery of pediatric and adolescent ART services. Notable amongst the efforts made is the creation of an enabling policy environment through the formulation and dissemination of policy documents, including several editions of national guidelines for HIV/AIDS treatment and care, national HIV/AIDS strategic framework, national HIV/AIDS strategic plan among others. Also, worthy of note are the interventions/ programs rolled out to bring pediatric HIV services to scale all over the country. Presently there are about 1,639 ART centers spread across the country.

Over the years, NASCP inaugurated and operated a national Task Team on ART with a subcommittee on pediatric ART. In keeping with its mandate, it has coordinated the health sector response to HIV/AIDS and continues to support the scale-up of novel strategies aimed at improving pediatric and adolescent ART services.

1.3.1 SCOPE OF PAEDIATRIC AND ADOLESCENT HIV SERVICES IN NIGERIA

Pediatric and adolescent HIV services currently available in the country as outlined in the National Guidelines for HIV Prevention, Treatment and Care (2016) and the approved updates on the use of antiretroviral drugs for treating and preventing HIV infection in Nigeria (March 2020) include: Early identification of HIV infected children and adolescents through DNA polymerase chain reaction (PCR) at six weeks of life and 3 months after cessation of breastfeeding, HIV rapid testing for children at 18months of age and above, Early initiation of ART for confirmed HIV positive infants, children, and adolescents (test and treat) and routine follow-up and monitoring of HIV exposed Infants using the National Patient Management & Monitoring (PMM) tools. Other services include laboratory monitoring of children on ART, TB screening and preventive therapy, post-exposure prophylaxis, nutritional support, prevention, and management of opportunistic infections (OIs) and orphans and vulnerable children (OVC) packages. The National ART programme has also recently developed the AHD package of care for adults, adolescents and children and its implementation is planned in a phased manner for some selected facilities across the country. In line with WHO, AHD in adults, adolescents, and children older than five years is defined as CD4 cell count <200cells/mm³ or WHO stage 3 or 4 disease. All children younger than five years old with HIV are considered as having advanced HIV disease.

Whereas pediatric HIV services are available at all levels of the healthcare system in the country, the scope of services delivered depends on the level of care. Services available in the primary health centers (PHCs) include HIV testing services, ARV prophylaxis offered as part of PMTCT services and referrals. With requisite training, the collection of dried blood spots (DBS) for PCR tests is done at all levels of the health care system. All tertiary and a significant proportion of secondary health facilities offer a full range of pediatric HIV services including clinical monitoring, CD4 count/CD4% estimation, EID, viral load estimation, hematological, chemistry tests, as well as adherence counseling.

1.4 GAP ANALYSIS OF THE PAEDIATRIC AND ADOLESCENT HIV RESPONSE

1.4.1 CASE IDENTIFICATION

Case identification through HIV testing is the gateway to HIV treatment, care, and support for children and adolescents. However, many children and adolescents living with HIV remain unidentified. This limits the early initiation of antiretroviral therapy, the survival of HIV-infected children and adolescents. An increase has been recorded in the number of sites providing HIV testing services (HTS) from 8,114 in 2014 to 8,373 in 2018. This has contributed to about 60% increase in the number of identified children and adolescents living with HIV. However, this is far below the 23,600 sites required to provide full coverage (desk review of NSP 2010-2015). A huge gap still exists in the identification of children and adolescents living with HIV, which must be addressed to increase access to life-saving treatment and care.

Factors that may militate against case identification include poor health care-seeking behavior, limited health care providers and training, limited access to appropriate HIV diagnostic services, and less than optimal PMTCT services coverage. Additionally, a shortage of test kits and lower prevalence than the larger adult group requires more targeted, innovative case-finding strategies both at facility and community levels.

1.4.2 LINKAGE TO CARE AND TREATMENT

The diagnosis of HIV is of no benefit to the child or adolescent in the absence of appropriate linkage to treatment and care. Non-linkage to HIV treatment and care services continues to erode the gains of improved HIV case identification among children and adolescents over the years. In 2018, the linkage of children and adolescents identified to be HIV positive occurred in 33.7%, 49.1%, 23.9% and 79.1% of children and adolescents aged 1-4 years, 5 – 9 years, 10 – 14 years and 15 – 19 years respectively. This translates to a wide gap in linkage to care as seen in *Figure 1*.

The Adoption of the “Test and Treat” strategy in 2016 has contributed to an improvement in the number of HIV-positive children 0-14 years initiated on ART. Despite these improvements, some barriers continue to militate against effective linkage to care and initiation on treatment. These include long turnaround times for diagnostic, baseline tests and treatment, users' fees, lack of efficient mother-infant pair tracking systems, stigma and discrimination, socio-cultural & religious beliefs, poor attitude of healthcare workers, parents/caregivers' issues, dysfunctional family, single parenthood, lack of transportation, disclosures issues and inadequate human resource capacity for the children and adolescent population.

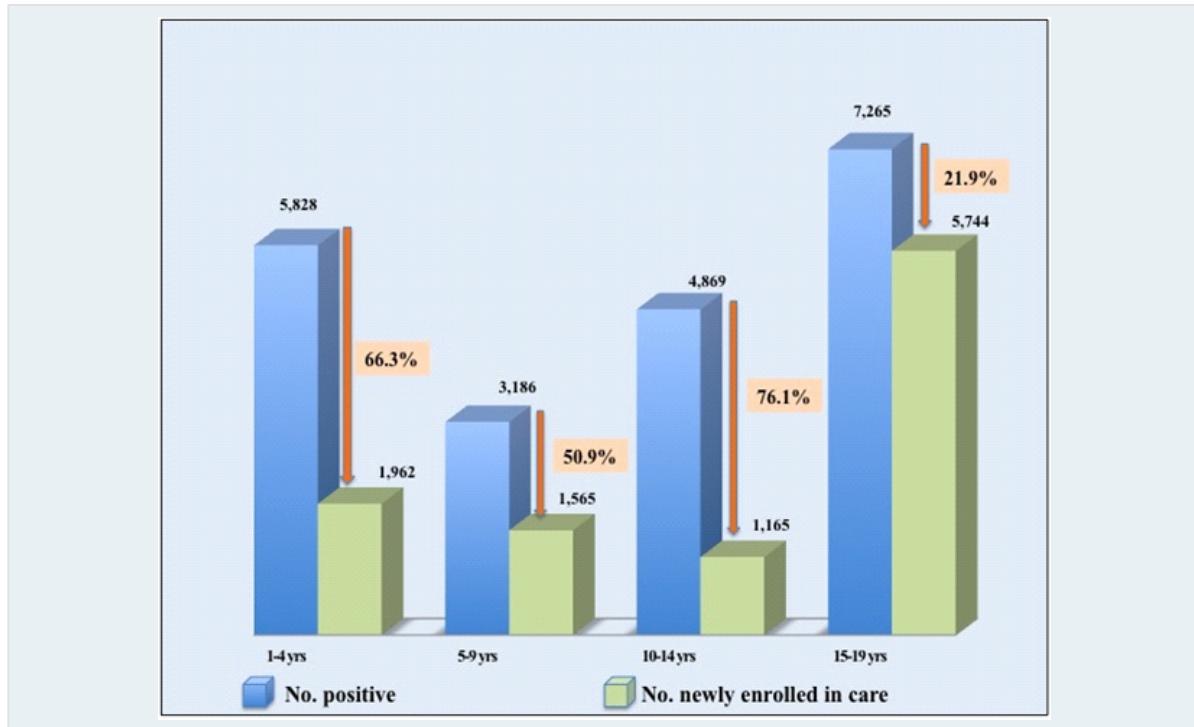


Figure 1: Linkage to Care and percentage gap among Children and Adolescents living with HIV. NASCP, 2018 HIV program data

1.4.3 HIV TREATMENT

The current trend analysis for ART coverage shows that paediatric ART (0-14years) coverage is 35.7% in contrast to adult ART coverage of 67.5% (Figure 2). Factors contributing to the low coverage include the limited capacity to provide paediatric ART services, inadequate child and adolescent-friendly ART services and shortage of paediatric ARV formulations.

The Rapid Advice on ART recommendations released in 2018 (FMOH 2018) addressed optimal first-line antiretroviral therapy for children and adolescents living with HIV in Nigeria. However, the non-availability of the newly recommended paediatric ART drugs and formulations due to procurement challenges & non approval has persisted and continues to adversely affect the rollout of the optimized regimen.

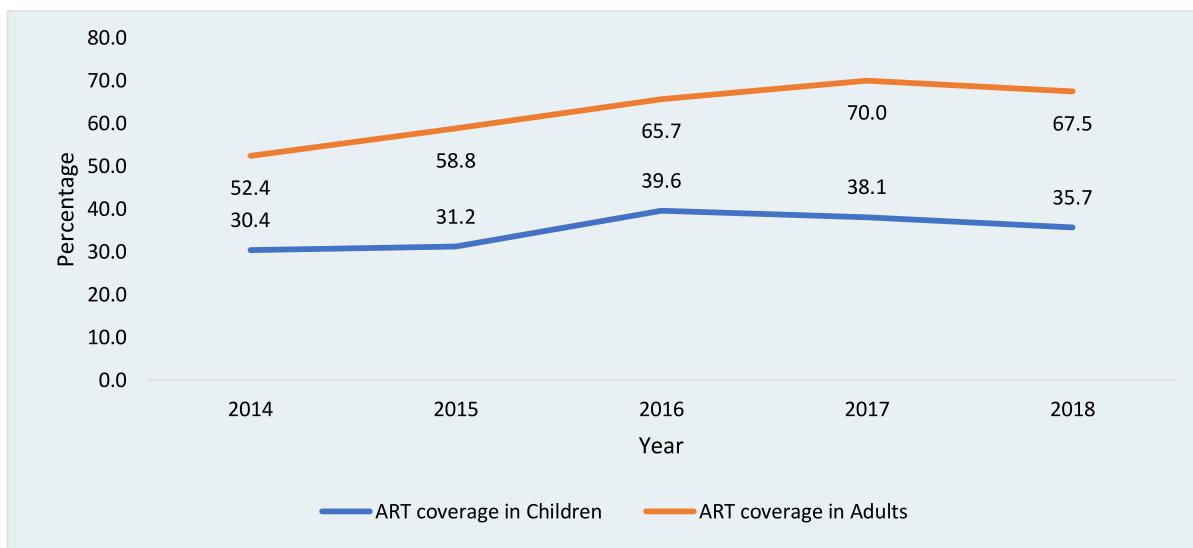


Figure 2. ART Coverage trend from 2014-2018 Nigeria NASCP, 2018

1.4.4 RETENTION IN CARE AND VIRAL SUPPRESSION

The National HIV Service Cascade Assessment and Survival Analysis study conducted in 2019 showed a one-year retention rate of 76% among children initiated on ART. Some of the challenges of retention in care include caregivers' apathy, lack of synchronization of clinic appointments of mother-child pair, pill burden, lack of disclosure to children and adolescents about their HIV status, fear of stigma and discrimination, and limited adolescent-centered programs among others.

There is still a wide gap in achieving the third 90 of the UNAIDS 90:90:90 target. Viral load coverage and suppression rate for children were 56% and 53.8% respectively while viral load coverage for adolescents aged 15-19 years was 59.6% with 51.7% suppression rate (FMOH 2018). Poor logistics of sample transfer and result retrieval, inadequate human resources & capacity, infrastructural and supply chain challenges, drugs and commodities stock out, heavy reliance on donor funding and poor adherence to treatment are some major contributing factors militating against achievement of the third 90. The National Integrated Sample Referral Network (NISRN) was adopted in 2018 to overcome logistic challenges. While there has been progressive improvement in the quality and coverage of services, the implementation is still challenged by facility-level resistance, an insufficient number of staff/riders, infrastructural challenges such as erratic power supply as well as poor management of sample pick-ups and result delivery.

1.4.5 DISCLOSURE AND TRANSITION

Disclosure remains poor among children and adolescents. This has serious implications for adherence to treatment and retention in care. In a study that assessed the rate of disclosure to HIV positive children aged six years and above in a paediatric clinic in Nigeria, disclosure was 13.5% and was reported to have improved adherence to care in those receiving disclosure of status. Additionally, HIV disclosure can improve psychosocial support which improves retention & treatment adherence. Phased implementation of adolescent centered programmes

like the “Operation Triple Zero” (OTZ), Zvandiri, has the potential to improve disclosure, adherence, retention, and viral suppression among adolescents living with HIV.

The OTZ is an asset-based approach to build the knowledge and skills of adolescents on HIV and other health issues, clinic navigation, self-esteem, and assertiveness, in a safe and enabling environment. In addition, the adolescents use active participatory approach leading to competence, confidence and connection, and a positive life decision. The OTZ model also affords the adolescents the opportunities to build skills for self-dependence and self-determination to achieve health and life goals as they transition to adulthood.

During the life span of this document, the paediatric and adolescent programme will also leverage on other models with documented successes in other countries (REACH, BIPAI Teen Clubs, Ariel Adherence clubs, etc.

Currently, there are no national structures for transitioning within pediatric age bands and from adolescents to adult age groups. The lack of clear guidance on transfers and transition policies in health facilities may be responsible for ineffective transition of adolescents into adult care thereby leading to poor retention. Reports from a nationwide survey on the transition of adolescents to adult HIV clinics in Nigeria revealed that only 15.4% of facilities had separate pediatric/adolescent and adult HIV clinics had a written transfer or transition policy².

1.5 RATIONALE FOR THE NATIONAL PAEDIATRIC AND ADOLESCENT ART ACCELERATION PLAN

The first national acceleration plan for pediatric HIV treatment and care was developed in 2016 to address the poor progress with the expansion of paediatric HIV services in Nigeria. However, due to poor implementation, the plan was unable to make much impact. Current data (NASCP) still show a huge gap/unmet needs as only 51,127(36.5%) of estimated 140,000 children living with HIV in Nigeria accessed ART in 2018. Significant gaps still exist in achieving the UNAIDS 90:90:90 targets of case identification, linkage to treatment and viral suppression by the year 2020. If this status quo is maintained, it will be impossible to attain the UNAIDS 95:95:95 targets by 2030.

The wide gap observed in the ART coverage between Adults, children, and adolescents underscores the fact that the majority of children and adolescents living with HIV are still underserved in terms of case finding, linkage to optimal ART and viral load testing coverage.

The new acceleration plan will build on the achievements of the first plan and address existing challenges through:

- Expansion of TOR of the paediatric subcommittee of the NTTA to monitor implementation and review strategies where necessary.in line with the Gantt chart. As well as conduct of a mid-term evaluation
- Government ownership and improvement of funding opportunities to aid sustainability.
- Mobilization of resources and leverage on existing local funding opportunities.
- Harmonization of evidence-based strategies across different implementing partners and programmes.

1.6 DEVELOPMENT PROCESS OF THE NATIONAL ACCELERATION PLAN

The National Acceleration Plan for Paediatric and Adolescent HIV Care and Treatment was developed through an inclusive process led by the National AIDS and STIs Control Programme (NASCP) of the Federal Ministry of Health. The development of the plan received contributions from all stakeholders, including other agencies of government, academia, bilateral and multilateral partners, implementing partners and civil society organizations.

2

THE NIGERIA PAEDIATRIC AND ADOLESCENT SERVICE DELIVERY FRAMEWORK



2. THE NIGERIA PAEDIATRIC AND ADOLESCENT SERVICE DELIVERY FRAMEWORK

The National Paediatric and Adolescent HIV Service Delivery Framework (SDF) is an integral component of the National Acceleration Plan for Pediatrics and Adolescents HIV Treatment and Care (NAP), which is aimed at improving identification, linkage, treatment, retention, and viral suppression in children and adolescents infected with HIV in Nigeria. The National SDF comprises of a set of interventions intended to complement and fortify existing initiatives to ensure Nigeria meets the global targets for ending AIDS in children, adolescents, and women while strengthening service delivery and cross-cutting elements of HIV care cascade among these target groups. This framework also takes into cognizance the Nigeria's federal governance structure, socio-cultural and economic context, and the rights of all people in Nigeria to equitable access to HIV related services.

The National SDF was adapted from the UNICEF SDF, leveraging an extensive process of evidence reviews conducted by UNICEF in identifying high impact interventions used to locate, link, treat and retain paediatric and adolescent clients in quality care to suit different national and sub-national contexts.

2.1 NATIONAL SERVICE DELIVERY FRAMEWORK DEVELOPMENT

The National-SDF was developed through a multi-layered process, informed by the UNICEF SDF, and harnesses available data to inform patient-centered programming for paediatric and adolescent HIV care. The National-SDF provides differentiated models of care for different age groups on specific interventions for testing, linkage, treatment options, and retention, ensuring patient-specific approaches rather than a 'one size fits all' model. As part of the evaluation of the country's HIV program (as detailed in chapter one of this document), adapting the National-SDF involved an assessment of the national and state level typologies from a paediatric and adolescent HIV epidemiology perspective. NASCP of the FMOH engaged partners in this multi-layered process involving data analysis, typology assessment, development of the solution matrix, and monitoring indicators, in alignment with the National Acceleration Plan for Paediatrics and Adolescents HIV Treatment and Care.

The country-situation assessment commenced with a multi-layered use of data on prevalence, MTCT rate, and adolescent HIV incidence per state. These data, using the UNICEF situation assessment tool was used to determine state-specific typologies and inform the age-specific interventions in the solution matrix. The National-SDF has nine typologies (Class A -I), which aims to guide states with age-specific strategies according to their respective typologies. The typologies will help to establish where the need is greatest along the continuum of care cascade.

Table 1: Typology classification (Adopted from the UNICEF Paediatric and Adolescent SDF).

TYPOLOGY CLASSIFICATION	GENERALIZED						CONCENTRATED		
	High HIV prevalence (5% or more)			Lower prevalence (<5%)			G	H	I
A	B	C	D	E	F				
TYPOLOGY DESCRIPTION	GENERALIZED HIGH PREVALENCE mixed picture with high MTCT but fewer than 10,000 adolescent infections per year	GENERALIZED HIGH PREVALENCE mixed picture with low MTCT rate but more than 10,000 adolescent infections per year	GENERALIZED HIGH PREVALENCE high MTCT rate and more than 10,000 adolescent infections per year	GENERALIZED LOW PREVALENCE mixed picture with high MTCT but fewer than 10,000 adolescent infections per year	GENERALIZED LOW PREVALENCE mixed picture with low MTCT rate but more than 10,000 adolescent infections per year	GENERALIZED LOW PREVALENCE mixed picture with high MTCT rate and more than 10,000 adolescent infections per year	CONCENTRATED mixed picture with high MTCT rate but fewer than 10,000 adolescent infections per year	CONCENTRATED mixed picture with low MTCT rate but more than 10,000 adolescent infections per year	CONCENTRATED high MTCT rate and more than 10,000 adolescent infections per year

2.2 NATIONAL SERVICE DELIVERY FRAMEWORK IMPLEMENTATION PROCESS

Figure 3 below summarizes the process of country-adoption and adaptation of the UNICEF Service Delivery Framework.

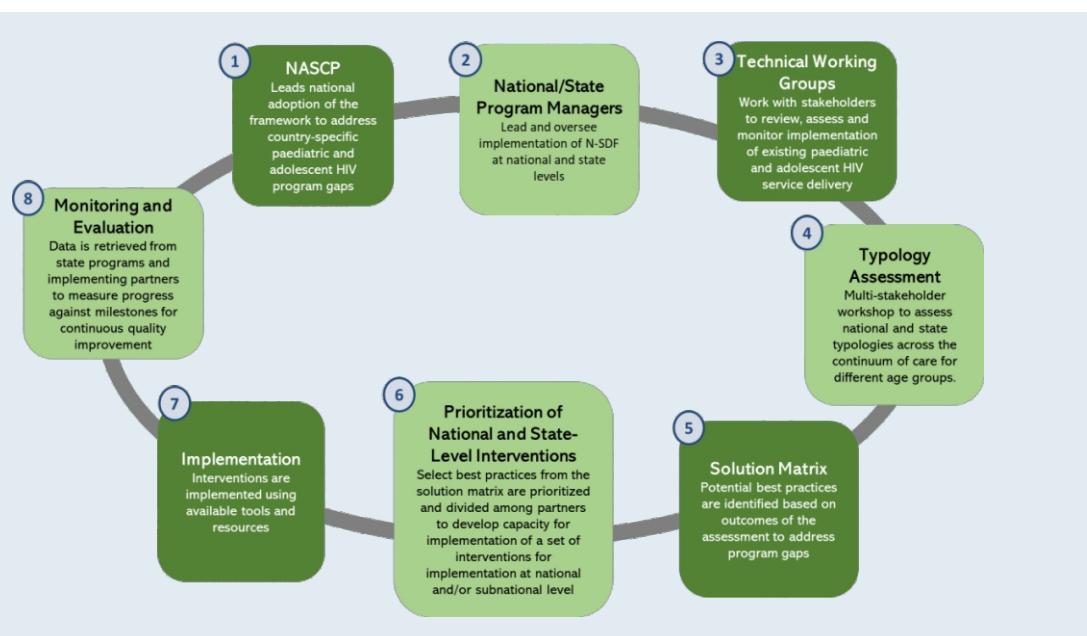


Figure 3: National-SDF development and implementation process.

2.2.1 THE SOLUTION MATRIX

The Solution Matrix is a compendium of age disaggregated “should do” and “could do” evidence-based interventions for improved HIV case identification, linkage, treatment, retention, and viral suppression strategies. This solution matrix was developed to identify service delivery strategies that would fit the typologies identified and address areas of greatest need. “Should do” interventions were developed based on robust evidence generated from the semi-quantitative assessment of studies, while “could do” interventions have less robust evidence but may be considered in state-specific contexts. See Table 2 below for a representation of the Solution Matrix.

CONTINUUM OF CARE					
AGE	STRENGTH OF EVIDENCE	LOCATE	LINK	TREAT	RETAIN
0-4 YEARS	SHOULD DO	<ul style="list-style-type: none"> Index family-based testing (including in adult ART service) Mentor mothers (and other peer support models for mothers) Mobile and electronic tracking platforms (linked to early infant diagnosis (EID) testing) Mother-infant paired service (including mother-infant pair tracking for missed appointments or lost-to-follow-up) Point-care-(POC) technologies for EID Task shifting for testing and linkage Testing sick children in tuberculosis, nutrition, out-and in-patient services 	<ul style="list-style-type: none"> Mentor mothers (and other peer support models for mothers) Mobile and electronic tracking platforms (linked to EID testing) Mother-infant paired services (including mother-infant pair tracking for missed appointments or lost-to-follow-up) Task shifting for testing and linkage 	<ul style="list-style-type: none"> Case management by mobile phone Decentralized treatment Mentor mothers (and other peer support models for mothers) Tasking shifting for treatment and retention 	<ul style="list-style-type: none"> Appointment systems (including appointment diaries and appointment tracking through community outreach) Differentiated service delivery (DSD) including family-based DSD for stable children Home-based adherence and psycho-social support Mentor mothers (and other peer support models for mothers) Mobile SMS reminders POC technologies for viral load Task shifting for treatment and retention
	COULD DO	<ul style="list-style-type: none"> Campaign-based testing Congregation-based testing Testing in immunization/growth monitoring services Very early EID abd treatment 	<ul style="list-style-type: none"> Economic incentives and social protection 	<ul style="list-style-type: none"> Telemedicine Very early EID and treatment 	<ul style="list-style-type: none"> Economic incentives and social protection
	SHOULD DO	<ul style="list-style-type: none"> Assisted disclosure Home-based and mobile testing Index family-based testing (including in adult ART services) Risking screening for provider-initiated testing and counselling Task shifting for testing and linking Testing sick children in tuberculosis, nutrition, out-and in patient services 	<ul style="list-style-type: none"> Assisted disclosure Task shifting for testing and linkage 	<ul style="list-style-type: none"> Assisted disclosure Case management by mobile phone Decentralized treatment Task shifting for treatment and retention 	<ul style="list-style-type: none"> Appointment systems (including appointment diaries and appointment tracking through community outreach) Assisted disclosure Differentiated service delivery (DSD) (including family based) for stable children Home-based adherence and psychosocial support mobile SMS reminders POC technologies for viral load Tasking shifting for treatment and retention
	COULD DO	<ul style="list-style-type: none"> Campaign-based testing Congregation-based testing School-based testing 	<ul style="list-style-type: none"> Economic incentives and social protection 	<ul style="list-style-type: none"> Telemedicine 	<ul style="list-style-type: none"> Economic incentives and social protection
	SHOULD DO	<ul style="list-style-type: none"> Adolescent-friendly health services (Including a) adolescent designated Testing point at the facility, B) integrated HIV testing services at the HIV clinic, family planning clinic, gender-based Violence centre, in – and –out- patient Department and C) integrating sexual And reproductive health services) Adolescent peer support (including teen Clubs) Assisted disclosure Differentiated service delivery (DSD) for Locating adolescents HIV self-testing Home-based and mobile testing Index family-based testing (including in adult ART services) Social network testing (for high-risk Subpopulations) Task shifting for testing and linkage 	<ul style="list-style-type: none"> Adolescent-Friendly Health services (Including a) adolescent linkage to care navigators and b) mental health and substance Use screening and Support) Adolescent peer Support (including Teen clubs) Assisted disclosure Task shifting for testing and linkage 	<ul style="list-style-type: none"> Adolescent-Friendly health Services (including a) adolescent-dedicated spaces and days and b) mental health and substance Use screening and Support) Adolescent peer Support (including Teen clubs) Assisted disclosure case management by mobile phone Community-based treatment Decentralized treatment Integrated mental health and substance abuse disorder care Task shifting for treatment and retention. 	<ul style="list-style-type: none"> Adolescent-friendly health services (including a)adolescent peer-managed appointments and lost-to-follow-up tracking and b) mental health and Substance use screening and support) Adolescent peer support (including teen clubs) Adolescent transition Appointment systems (including appointment diaries and appointment tracking through community outreach) Assisted disclosure Case management by mobile phone Differentiated service delivery (DSD) for stable adolescent (including for adolescent key populations) Home-based adherence and psychosocial support Integrating mental health and substance abuse disorder care Mobile SMS reminders POC technologies for vital load Risk assessment for poor adherence Task shifting for treatment and retention
	COULD DO	<ul style="list-style-type: none"> Compaign-based testing Congregation-based testing Online social network support Risk screening for community testing School-based testing 	<ul style="list-style-type: none"> Economic incentives and social protection Online social network support 	<ul style="list-style-type: none"> Online social network support Telemedicine 	<ul style="list-style-type: none"> Economic incentives and social protection Online social network support

Figure 4: The Solution Matrix

Note: Text in green indicates interventions implemented in communities or in communities and facilities.

2.2.2 IMPLEMENTATION OF THE NATIONAL SERVICE DELIVERY FRAMEWORK

The National SDF is intended to guide national, and state HIV program managers to improve the quality of pediatric and adolescent HIV service delivery by identifying and implementing context-specific priority interventions.

The national HIV program is expected to provide strategic leadership with the adoption and implementation of the framework through robust multi-stakeholder engagement to define the country situation using the assessment tools provided. This includes:

- Coordination of technical working groups for programmatic planning and identification of optimal interventions leveraging the solutions matrix.
- Development of specific implementation plans in collaboration with stakeholders
- Resource mobilization and sustained supply security for a seamless implementation of optimal paediatric and adolescent HIV interventions
- Leading capacity building of relevant healthcare workers on the implementation of strategies and interventions in the developed using the solutions matrix
- Harmonizing national and state-level data from existing reporting systems and implementing partners into a paediatric dashboard for adequate progress monitoring and continuous quality improvement
- Convening quarterly national program review meetings for assessment of the N-SDF implementation, identification, and mitigation of challenges.

The state's HIV programs are responsible for the state-level implementation of the N-SDF, including:

- Coordinating state technical working groups for programmatic planning and identification of optimal interventions based on their unique state typologies.
- Leading state-level implementation of the N-SDF in collaboration with the implementing partners and facilities.
- Conducting supportive supervisions and mentoring to ensure effective implementation of the N-SDF
- Ensuring timely reporting of state-level pediatric and adolescent service delivery data.

2.3 SYSTEM STRENGTHENING ELEMENTS

There are cross-cutting, system strengthening elements that should be prioritized according to typology settings and contexts. Overall, these elements proffer sustainability to HIV programs among infants, children, and adolescents. It is important to note that these elements will hasten the progress towards achieving the Sustainable Development Goal 3 and unburden the healthcare system.

The following system strengthening interventions should be considered with high priority.

1. A favorable policy environment with guidelines and policies that support identification, linkage, treatment, and retention, as well as tools that support the provision of a standard of care across various facility levels.

2. Reduction of HIV-related stigma and discrimination in the health setting and the community.
3. Adequate human resources, task shifting, and task sharing can be explored to close this gap, and all allow for the expansion of HIV programs.
4. A functional supply chain system for drugs and other commodities to necessitates accurate forecasting and timely procurement of products.
5. Political will and buy-in from governments and stakeholders to commit to ambitious targets, including sub-national targets for HIV testing and treatment among infants, children, and adolescents.
6. Strengthen community engagement, collaboration, and foster engagement of caregivers and adolescents living with HIV in decisions that impact them.

The Paediatric and adolescent N-SDF is action-oriented and structured to address gaps and deliver quality results for Paediatrics and adolescents across different age groups and settings. This dialogue tool focuses attention on assessing the progress of Paediatric and adolescent service delivery in line with the UNAIDS 'super-fast-track' (95-95-95 goals). The N-SDF seeks to reinforce existing guidance and other recommendations on service delivery.

3

STRATEGIC INTERVENTIONS FOR THE ACCELERATION OF PAEDIATRIC AND ADOLESCENT HIV TREATMENT AND CARE



3. STRATEGIC INTERVENTIONS FOR THE ACCELERATION OF PAEDIATRIC AND ADOLESCENT HIV TREATMENT AND CARE

3.1 INTRODUCTION

The acceleration plan for paediatric and adolescent HIV treatment and care aims at fast-tracking the reduction of the burden of HIV among children and adolescents in Nigeria. It recommends strategies that are geared towards ensuring that every child living with HIV is diagnosed early and started on treatment in a timely manner to avert complications of untreated HIV and attendant mortality. The plan seeks to improve access to high-quality testing, treatment, and care services, increase uptake of HIV services, retain enrolled clients in care and attain viral suppression in line with the UNAIDS 95:95:95 goal by 2030. Achieving the strategic objectives as outlined in the plan will require concerted action by all tiers of government and stakeholders to implement the recommendations.

3.2.ACCELERATION SCENARIOS

Closing the current gap in HIV treatment and care for children and adolescents in Nigeria requires HIV testing and treatment targets which are consistent with the level of need in the country. Modeled below are three different scenarios using programme data and projected targets. The models are, status quo model, moderate and rapid acceleration models for paediatric and adolescent ART coverage (2020-2022).

If the status quo model is maintained in the delivery of paediatric HIV services, ART coverage for children will be at a meager 41% by 2020 and 46% by 2022. In the moderate acceleration model, the ART coverage for children will increase from 36% in 2018 to 47% by 2020 and 70% by 2022. The rapid acceleration model describes an increase in the paediatric ART coverage from 36% in 2018 to 55% by 2020 and 95% by 2022. To achieve this, there is a need for a two and three-fold increase in the number of children living with HIV to be identified in the year 2020 and 2021, respectively (figure 4a, 4b, table 3).

For the adolescent age group, the status quo model will increase the ART coverage from 34% in 2018 to 40% in 2020 and 45% by 2022. In the moderate acceleration model, the adolescent ART coverage will increase from 34% in 2018 to 50% in 2020 and 70% by 2022. While the rapid acceleration model describes an increase in the coverage from 34% in 2018 to 55% in 2020 and 95% by 2022 (figure 5a, 5b, table 4).

To achieve this, there is a need for about three and three-half fold increase in the number of adolescents living with HIV to be identified in the year 2020 and 2021, respectively.

The government of Nigeria in collaboration with relevant stakeholders, have agreed to adopt the rapid acceleration model for the treatment of children and adolescents living with HIV in line with current needs.

Projected Scenarios for Children

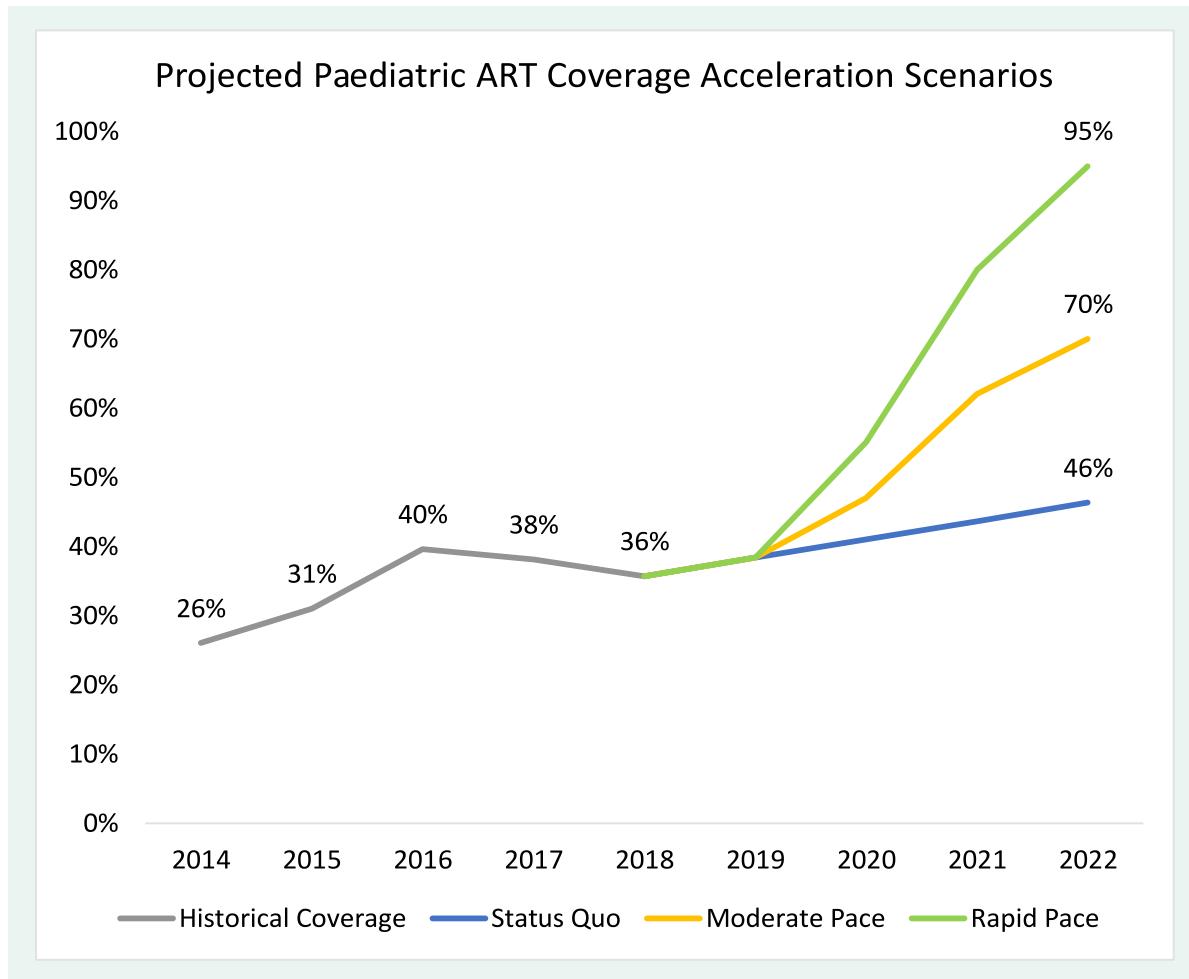


Figure 5a: Projected Paediatric ART coverage acceleration plan

Scenario 1: Status quo: ART coverage from 36% in 2018 to 41% by 2020 and 46% by 2022.

Scenario 2: Moderate Pace ART coverage from 36% in 2018 to 47% by 2020 and 70% by 2022.

Scenario 3: Accelerated Pace ART coverage from 36% in 2018 to 55% by 2020 and 95% by 2022.

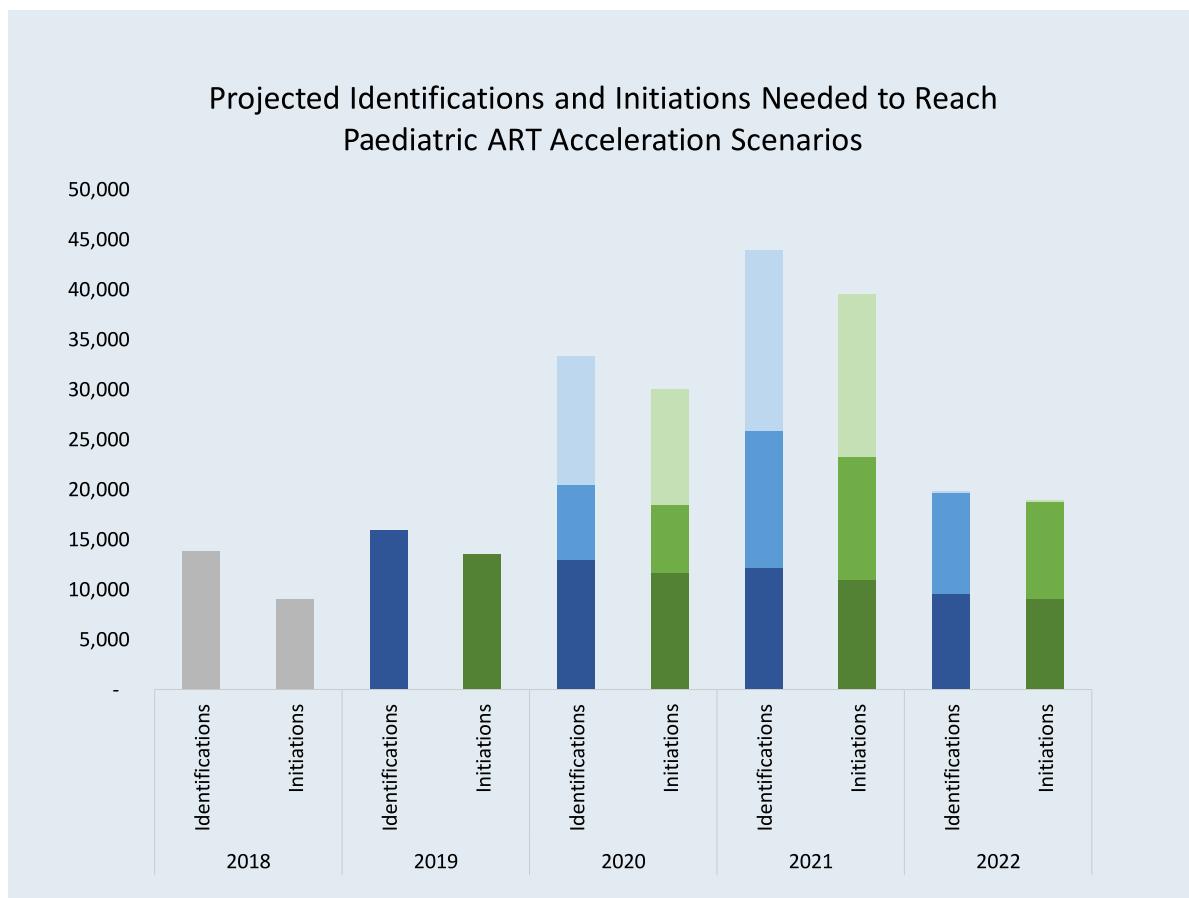


Figure 5b: Projected Acceleration scenarios for Paediatric ART coverage (2020 -2022)

█	Status Quo	█	Moderate	█	Rapid
█	Status Quo	█	Moderate	█	Rapid

Interpretation of Graph: In this graph, the dark blue segment of the bar graph shows the projected identification needed to reach the ART coverage target set in the “Status Quo”. The medium-blue segment of the graph shows the incremental increase in projected identifications needed to reach the moderate scenario. The light blue segment of the bar graph shows the additional incremental increase needed to reach the Rapid scenario. The entire bar is needed to reach the Rapid scenario. The same logic applies to the green bars for initiations.

Table 2: Rapid Acceleration for Paediatric ART (0-14years)

Scenario 3 - Rapid Acceleration for Paediatrics ART (0 – 14 years)								
	Historical Trend			Baseline	Acceleration Phase		Consolidating Phase	Aggregate Data
	2016	2017	2018	2019	2020	2021	2022	2019-22
Estimated Number of Children Living with HIV. (UNAIDS 2018)	141,923	142,023	143,296	136,669	130,818	125,900	120,603	
Paediatric ART Coverage	40%	38%	36%	38%	55%	80%	95%	
Total Number of Children Currently and Projected on ART yearly.	56,202	54,111	51,157	52,413	71,950	100,720	114,573	
Number of Children newly started on ART yearly (Current and Projected).	13,097	8,274	9,060	13,533	30,020	39,563	18,889	102,005
Gap for Children on ART (Current and Projected).	85,721	87,912	92,139	84,256	58,868	25,180	6,030	
% Gap for Children on ART (Current and Projected).	60%	62%	64%	62%	45%	20%	5%	
Retention in Care at 12 months.			76%	76%	80%	85%	95%	
Attrition (1 - Retention)			24%	24%	20%	15%	5%	
Number of Children Living with HIV newly Tested Positive (Current and Projected)	8,849	15,978	13,883	15,922	33,355	43,958	19,883	113,119

Projected Scenarios for Adolescents

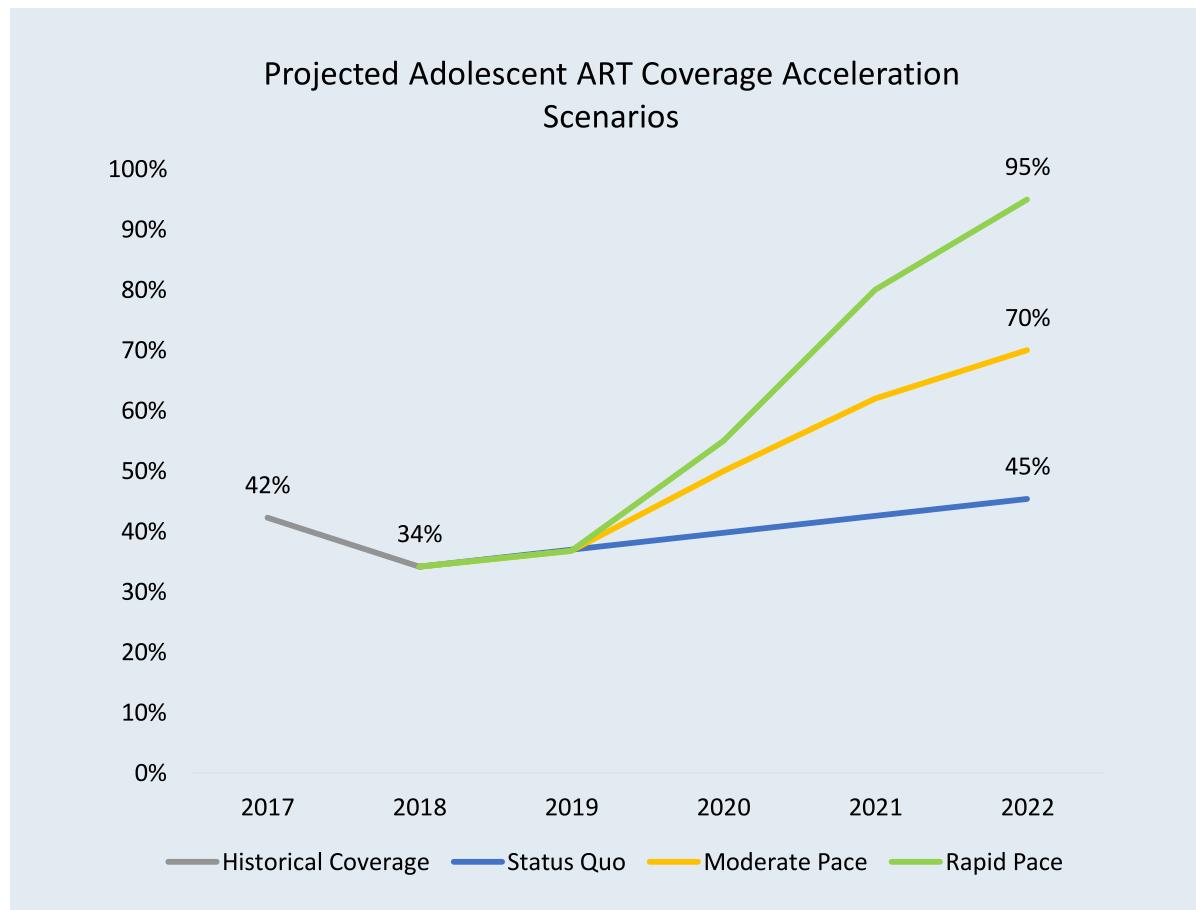


Figure 6a: Projected Adolescent ART coverage acceleration plan

Scenario 1: Statusquo: ART coverage from 34% in 2018 to 40% by 2020 and 45% by 2022.

Scenario 2: Moderate Pace ART coverage from 34% in 2018 to 50% by 2020 and 70% by 2022.

Scenario 3: Accelerated Pace ART coverage from 34% in 2018 to 55% by 2020 and 95% by 2022.

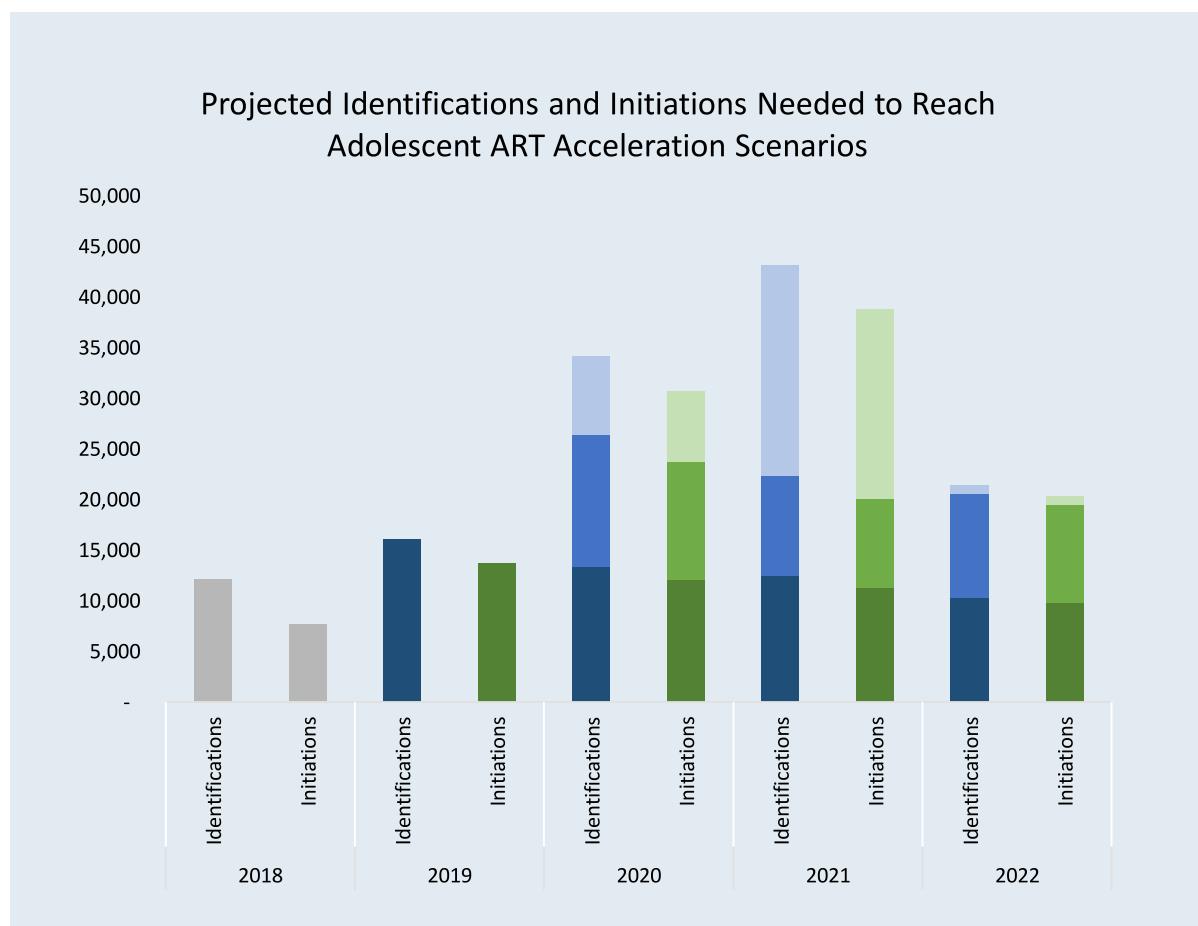


Figure 6b: Projected acceleration coverage for Adolescent ART

■	Status Quo	■	Moderate	■	Rapid
■	Status Quo	■	Moderate	■	Rapid

Interpretation of Graph: In this graph, the dark blue segment of the bar graph shows the projected identification needed to reach the ART coverage target set in the “Status Quo”. The medium-blue segment of the graph shows the incremental increase in projected identifications needed to reach the moderate scenario. The light blue segment of the bar graph shows the additional incremental increase needed to reach the Rapid scenario. The entire bar is needed to reach the Rapid scenario. The same logic applies to the green bars for initiations.

Table 3: Rapid Acceleration for Adolescent ART Programme

	Scenario 3 - Rapid Acceleration for Adolescent ART Programme						Aggregate Data
	Historical Trend	Baseline	Acceleration Phase		Consolidating Phase	2019-22	
	2017	2018	2019	2020	2021	2022	
Estimated Number of Adolescents Living with HIV. (UNAIDS 2018)	120,431	121,656	122,706	121,608	119,615	117,092	
Adolescent ART Coverage	42%	34%	37%	55%	80%	95%	
Total Number of Adolescent Currently and Projected on ART yearly.	50,581	41,363	45,156	66,884	95,692	111,237	
Number of Adolescent newly started on ART yearly (Current and Projected).	8,835	7,724	13,720	30,760	38,840	20,330	103,650
Gap for Adolescent on ART (Current and Projected).	69,850	80,293	77,550	54,724	23,923	5,855	
% Gap for Adolescent on ART (Current and Projected).	58%	66%	63%	45%	20%	5%	
Retention in Care at 12 months.		76%	76%	80%	85%	95%	
Attrition (1 - Retention)		24%	24%	20%	15%	5%	
Number of Adolescents Living with HIV newly Tested Positive (Current and Projected)	15,713	12,134	16,141	34,178	43,156	21,400	114,874

3.3 THEORY OF CHANGE (TOC)

The goal of the national plan for the acceleration of paediatric and adolescent HIV treatment and care is to contribute to improved health, survival, and development of all children and adolescents living with HIV by intensifying paediatric and adolescent HIV case-finding and increasing access to ART, retention in care, viral suppression, and support. The theory of change (TOC) underpinning this acceleration plan is summarized in Figure 5.

The theory of change addresses the current paediatric and adolescent HIV treatment gap (estimated 36% and 37% coverage respectively in 2018) by outlining a logical process towards reaching 95% of children and adolescents living with HIV in Nigeria with optimal antiretroviral treatment by 2022. Achieving this outcome will contribute to improved health, survival, and development of all children and adolescents living with HIV in Nigeria. Four programmatic outputs are outlined to contribute to the aforementioned outcome. First, strengthening the critical role of the federal, state, and local governments in leading, planning, coordinating, financing and monitoring the paediatric and adolescent HIV programmes. Secondly, strengthening the capacity at all levels of the healthcare delivery system to deliver high impact interventions for HIV case-finding, effective linkages to treatment and care is very important in achieving the desired outcome. Thirdly, promoting the participation of empowered parents/caregivers, families, and communities both as beneficiaries and actors, will stimulate the demand for quality services and also support its delivery. Lastly, ensuring an uninterrupted supply of medicines and other commodities for testing and treatment.

3.4 STRATEGIC INTERVENTIONS

The strategic interventions outlined below were selected by stakeholders based on their likelihood to contribute to the achievement of defined outputs. This supposes that other critical assumptions are met, and potential risks identified and mitigated.

Goal Option 1: To reduce morbidity and mortality among children and adolescents living with HIV by 95% in 2022.

Outcome: Children and adolescents living with HIV are retained on ART and are virally suppressed.

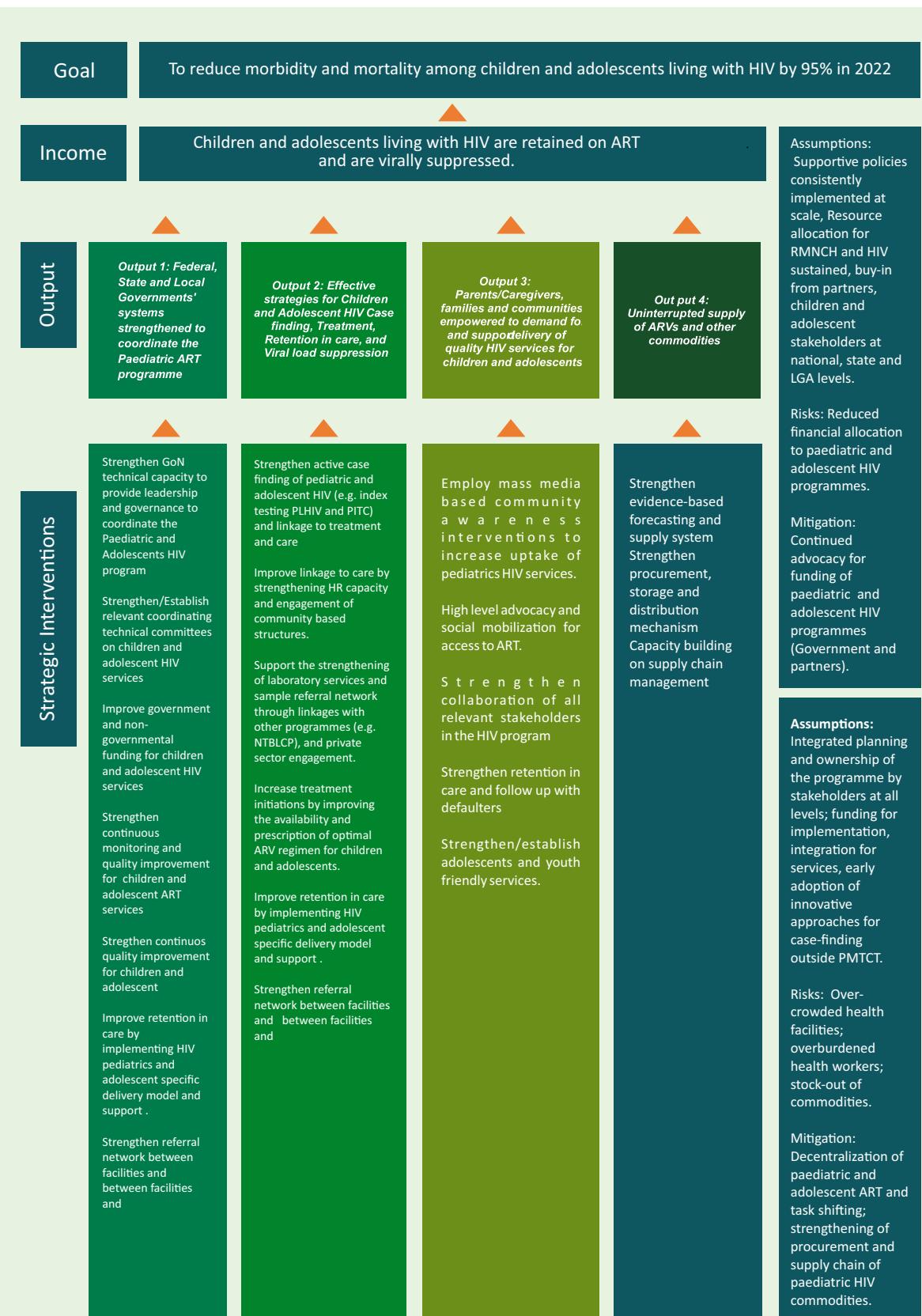


Figure 7: Theory of Change for the acceleration of Paediatric and Adolescent HIV treatment and Care in Nigeria

GENERAL ASSUMPTIONS, RISK AND MITIGATION

Assumptions: Supportive policies consistently implemented at scale, Resource allocation for RMNCH and HIV sustained, buy-in from partners, children, and adolescent stakeholders at national, state and LGA levels.

Risks: Reduced financial allocation to paediatric and adolescent HIV programmes.

Mitigation: Continued advocacy for funding of paediatric and adolescent HIV programmes (Government and partners).

Assumptions: Integrated planning and ownership of the programme by stakeholders at all levels; funding for implementation, integration for services, early adoption of innovative approaches for case-finding outside PMTCT.

Risks: Over-crowded health facilities; overburdened health workers; stock-out of commodities.

Mitigation: Decentralization of paediatric and adolescent ART and task shifting; strengthening of procurement and supply chain of paediatric HIV commodities.

3.4.1 Output 1: Federal, state and local government systems strengthened to coordinate children and adolescent ART services.

Strategic Interventions:

- a. Strengthen leadership and governance at National, States and LGAs children and Adolescent ARV services.
- b. Establish & strengthen relevant coordinating technical committees on children and adolescent ART.
- c. Improve government and non-governmental funding for children and adolescent HIV services.
- d. Strengthen M&E systems to improve data management to capture age disaggregated data
- e. Strengthen continuous monitoring and quality improvement for children and adolescent ART services.

3.4.2 Output 2: Effective strategies for Children and Adolescent HIV Case-finding, Treatment, Retention in care, and Viral load suppression

Strategic Interventions:

- a. Strengthen active case finding of pediatric and adolescent HIV (e.g. index testing PLHIV and PITC) and linkage to treatment and care.
- b. Improve linkage to care by strengthening HR capacity and engagement of community-based structures
- c. Support the strengthening laboratory services and sample referral network through linkages with other programmes (e.g. NTLCP), and private sector engagement

- d). Increase treatment initiation by improving the availability and prescription of optimal ARV regimens for children and adolescents
- e). Improve retention in care by implementing HIV paediatrics and adolescent specific delivery models and support
- f). Strengthen facility-facility and community-facility referral network
- g). Improving data quality and reporting.

3.4.3 Output 3: Parents/caregivers, families, and communities empowered to demand for and support delivery of quality HIV services for children and adolescents.

Strategic Interventions:

- a. Improve community awareness for the uptake of pediatric and adolescent HIV services
- b. High-level advocacy and social mobilization for access to pediatric and adolescent HIV services
- c. Engage PLHIV in active case finding and retention in care
- d. Strengthen contact tracing and follow up of defaulting clients
- e. Institute feedback mechanisms from parents/caregivers and the communities
- f. Identify, train, and deploy CBOs to test and identify children and adolescents living with HIV.
- g. Actively follow up pregnant women and children including catch – up during EPI and nutrition services
- h. Introduction of Point of Care (POC) testing strategies to increase access to EID and expand case finding.

3.4.4 Output 4: Uninterrupted supply of ARVs and other commodities.

Strategic Interventions:

- a. Strengthen evidence based forecasting and supply system
- b. Strengthen procurement, storage and distribution mechanism
- c. Leverage existing structure for capacity building on supply chain management system

Output 1: Federal, State, and Local Government systems strengthened to coordinate the Paediatric ART programme

Coordinated leadership is important for the HIV treatment programme in Nigeria. The successful expansion of paediatric and adolescent HIV services will depend largely on the capacity and commitment of government and stakeholders to fund, coordinate and manage key elements of paediatric and adolescent HIV programme implementation.

- I. Strengthen Leadership and Governance at National, States and LGAs for Children and Adolescent ARV services.

The Government of Nigeria provides leadership and governance for the national HIV/AIDS programme response. Thus, there is a need to strengthen the technical capacity of the GoN to execute this role and provide effective governance to coordinate the paediatric and adolescent's HIV programme in Nigeria. Relevant HIV programme staff should be trained in paediatric and adolescent HIV programme management including policy formulation, strategy development, implementation, and coordination. There should be designated paediatric HIV focal persons at

all levels. These designated persons will ensure leadership and coordination of the paediatric and adolescent HIV programme. Periodic monitoring and supervisory visits to health care facilities should be institutionalized and fully funded by ministries of health/health departments and relevant agencies particularly at the state and LGA levels. A key role to be strengthened is the coordination of partners' activities with a view to promoting equity and adoption of strategies for improved service delivery.

II. Establish/Strengthen relevant coordinating technical committees on Children and Adolescent ART

At all levels of government, there is a need to strengthen existing technical committees on paediatric HIV services or establish the committees if they do not exist. These committees should have clearly articulated terms of reference and function in an advisory capacity to the government. They should serve as platforms for regular periodic review of programme implementation strategies, M & E, experience sharing, identification of challenges & proffer solutions. At lower levels where it may not be feasible for such a committee to stand alone, the expected roles should be clearly defined in the terms of reference to any other committee that is responsible for children's and adolescents HIV services.

It is recommended that the paediatric subcommittee of the National Task Team on ART is strengthened and her TOR expanded to enhance her capacity to perform additional roles for monitoring the implementation of this acceleration plan. These functions will include periodic review, domestication at regional and sub-regional levels, midterm evaluation, and implementation of the acceleration plan at all levels.

III. Improving Government and Non-Governmental Funding for Children and Adolescent HIV Services

Increasing domestic funding is critical to sustaining the country's HIV response and increased investments in paediatric and adolescent HIV services at all levels of government. Nigeria's National AIDS Spending Assessments indicate that external donor funding accounts for more than 70% of HIV expenditure. This emphasizes the need to utilize annual budgetary processes to increase domestic funding for paediatric and adolescent HIV services. Thus, the capacity of programme manager should be strengthened in the areas of advocacy for increased budget allocation, releases, and efficient utilization. To achieve this, funding for HIV services including paediatric and adolescent HIV services should be institutionalized in the annual budgets of relevant government organizations.

IV. Strengthen M&E systems to improve data utilization in addressing age-specific interventions.

The Monitoring and Evaluation systems at all levels should be strengthened to properly document and use age and sex disaggregated data/indicators especially for children less than 12 months and various strata of adolescents. This can be achieved by building the capacity of M& E officers through regular trainings and retrainings as well as monitoring and supervision at all levels. The facilities should be equipped with electronic data capturing systems for real time data entry with fast and prompt feedbacks.

V. Strengthen continuous monitoring and quality improvement for children and adolescent ART services.

The quality of ART and ART related services provided at facility level is crucial in determining the treatment outcome and overall wellbeing of children and adolescents living with HIV, thus the need to monitor this is essential. Paediatric and Adolescent specific program review using data should be incorporated into existing facility quality improvement activities to highlight successes, gaps and opportunities for remedial interventions. Technical support and guidance in form of supportive supervisory visit and monitoring should be provided at both local government and state levels. Relevant service providers especially Paediatric and Adolescents HCWs should be trained on Continuous Quality Improvement Management and ART services. Paediatric and Adolescent specific quality improvement projects should be supported by established quality management systems across all facilities and effective change ideas instituted and scaled up.

I. HIV CASE-FINDING:

In Nigeria, only 35.6% (51,127 children) of the estimated number of children living with HIV know their status⁵. The prevalence of paediatric HIV is 0.2%, thus highlighting the challenges of case finding. Consequently, many HIV infected children and adolescents are yet to be identified despite the availability of life-saving treatment.

To address this gap, new strategies to improve identification and case findings of HIV positive children and adolescents are required. Nigeria plans to expand its testing coverage by strengthening the already existing strategies such as index testing, PITC and the introduction of HIVST services for mature minors and older adolescents and caregivers assisted HIVST for children and adolescents who are yet to attain the age of consent and strengthening EID.

a) Index Testing

Active HIV case finding among children and adolescents through a family-centered approach is a high yield intervention. This strategy entails testing children and adolescents of index HIV-positive parents or siblings. Systematic implementation of this approach will require active tracking of children or siblings of index clients aided by the use of a family tracking tool in relevant clinical and community settings. For the sexually active adolescents, sexual network testing strategy should also be considered.

Engagement of associations/networks of people living with HIV/AIDS (PLHIV) for peer mobilization, pediatric and adolescent HIV testing and linkage may further optimize the feasibility of this strategy. It is expected that if implemented systematically, consistently, and at scale, this strategy should lead to the identification of many HIV positive children and adolescents.

b) Provider-Initiated Testing and Counseling (PITC)

Provider-Initiated Testing and Counseling (PITC) is HIV testing and counseling, which is initiated and offered to persons attending health care facilities by health care providers. PITC should be presented to all children and adolescents visiting the health facilities and those with conditions that might suggest underlying HIV disease. To scale up PITC within facilities in-

country, stakeholders will need to ensure supply of testing commodities, conduct capacity building and integrate testing services where applicable.

c) Use of HIV Risk Assessment Checklist

The low prevalence of HIV among children 0 -14 years according to the NAIIS report underscores the need for a more targeted testing whereby testing services are prioritized to those children and adolescents that are more likely to be at higher risk of HIV infection as part of the strategy for improving HIV case identification among children and adolescents. HIV risk assessment entails deciding as to whether an HIV test is indicated or not, following an assessment using a set of predetermined criteria. Targeted HIV testing among children and adolescents can be achieved using the HIV Risk assessment checklist (**Annex 2**) to prioritize children at risk of HIV for testing as part of effort to improve HIV case identification yield and program efficiency especially in Nigeria with low prevalence of HIV among children and adolescents. HIV Risk stratification checklist can also be used to increase the precision of the Provider Initiated Testing and Counselling (PITC) strategy across various facilities, and at the community level when lay healthcare providers are in doubt of what to do. To achieve this, all healthcare providers should be trained on the use of the HIV Risk Assessment checklist.

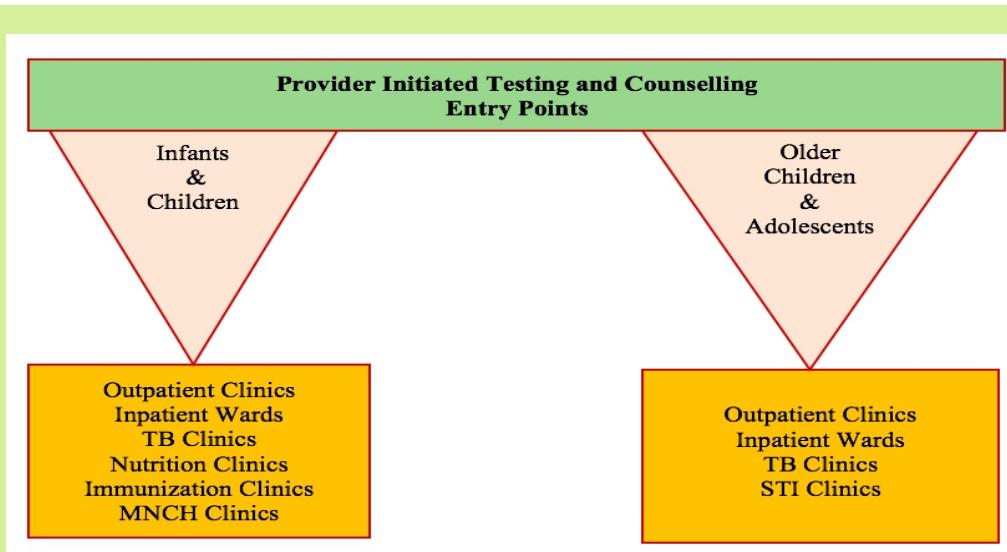


Figure 8: Various entry points for Testing and Counseling

d) Strengthening EID

Early identification and initiation of ART for HIV infected infants can reduce mortality by up to 76% and slow disease progression among these children. Early Infant Diagnosis (EID) is the standard of care for the diagnosis of HIV infection in children less than 18 months. Nigerian EID coverage as of 2018 is 23%. Currently, the EID programme is faced with various challenges including delays in the pre-analytic phase (sample collection and weak DBS sample transport logistics e.g. packaging, storage and transportation to PCR testing labs), analytic (delays in testing at PCR laboratories and PCR machine downtime) and post-analytic (long turn-around times, delay in return of results, loss to follow-up of -infant-mother pairs, and poor linkage to life-saving pediatric treatment) along the facility-laboratory interface.

To improve EID coverage and reduce TAT, the country has adopted and scaled up National Integrated Specimen Referral Network (NISRN), with partners also piloting innovative strategies for electronic results return including use of Electronic Medical Records (EMR), using USSD technology and also revitalizing the use of SMS printers. Strengthening efficient Infant-Mother pair (IMP) tracking systems also has the potential to strengthen EID coverage.

Strengthening the existing EID service delivery models are necessary components in improving pediatric case finding.

Current strategies are as highlighted in 1.3.1

Recommended strategies to improve EID coverage as proposed in the January 2020 National Guideline review include:

- Incorporating NAT at birth
- Introduction of POC EID
- Scale-up the use of mentor mothers for Community Based EID
- Monitoring mother –infant care cascade

The introduction of point of care testing for EID has the potential to increase the identification of HIV positive infants across all entry points in facilities. It has the potential to reduce TAT and LTFU by eliminating the need for sample transportation to centralized laboratories, therefore increasing linkage to care and early initiation of treatment.

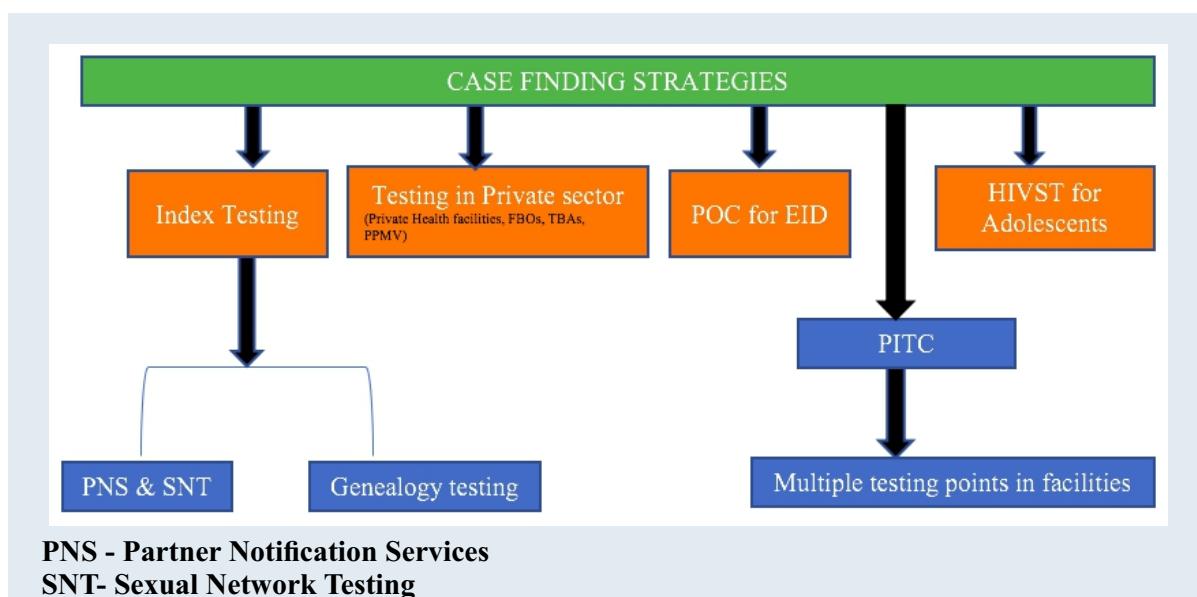


Figure 9: Strategies for Case Finding

II. LINKAGE TO CARE

Diagnosis of HIV without appropriate linkage to HIV care and treatment services provides little to no benefit to the child. Programmes must take responsibility for linking HIV positive children and adolescents to HIV care and treatment services; the intended outcome is to place all children and adolescents diagnosed with HIV on life-saving antiretroviral treatment, retain them in care and ensure they achieve and maintain viral suppression.

Effective strategies to improve linkage to care among children and adolescents include:

Community-based:

- Assigning a unique infant-mother pair (IMP) identifying number for tracking HIV Exposed Infant and mothers together (from pregnancy through cessation of breastfeeding).
- Engagement of community health workers and expert clients to support IMP tracking as well as older children identified but not initiated
- Strengthen the link between the community and facility-based HIV programs.
- Leveraging on OVC services
- Introducing community-level support groups for parents of HIV positive children and adolescents to educate them on the need to seek care.

Facility -based:

- Strengthening the “Test and Start” strategy.
- Building the capacity of HCWs to effectively document patient information in the respective registers.
- Paediatric focal point designates to review facility data and patient information to ensure follow up for children and adolescents not initiated.

III. TREATMENT INITIATION

Analysis of pediatric antiretroviral therapy (ART) coverage shows an increase from 30.4% in 2014 to 35.6% in 2018. In contrast, the adult ART coverage was 55% of all adults estimated to be living with HIV in 2018. This clearly indicates that children and adolescents are lagging behind accessing HIV services in Nigeria.

Early initiation of ART is associated with improved survival for patients and a reduction of the incidence of advanced HIV disease (AHD). The National Guidelines for HIV Prevention, Treatment and Care (2016) recommend initiation of ART as soon as possible, preferably within two weeks of diagnosis of HIV infection.

Challenges to initiation of ART in children and adolescents:

- Supply chain issues that affect the availability of Optimal ARVs
- Inadequate healthcare provider capacity
- A limited number of health care providers are trained on paediatric and adolescent ART services

Strategies to optimize the treatment of children and adolescent with HIV include:

- Support introduction, monitoring and uptake of paediatric optimal ARV regimen and formulations.
- Train and retrain all cadres of healthcare providers on HIV service delivery and implement task-shifting policies as required.
- Advocate for the manufacturing of appropriate fixed-dose combinations ARVs to reduce pill burden and improve adherence
- Support and strengthen supply chain management, forecasting and quantification to avoid stock out at facilities

RETENTION IN CARE

Retention in care is critical at ensuring optimal outcomes for children and adolescents enrolled in HIV care and treatment. Service delivery models that promote patient retention should be strengthened and scaled up to all health facilities. Tracking and follow-up of children on treatment will help in identifying defaulters, those who are not receiving adequate treatment support at home, infants, and children/adolescents who experience treatment failure.

Barriers to retention:

- A limited number of health facilities providing adolescent-friendly services
- Stigma, discrimination, and lack of disclosure/acceptance of HIV status
- Poor monitoring and tracking of patients on treatment resulting in LTFU
- Inadequate availability of skilled health personnel, job aids, limited capacity to manage pediatric HIV/AIDS especially at lower levels of care
- Inconsistent drug pick-up by parents for children
- Non-flexible clinic appointments
- Poor adherence due to pill burden and treatment fatigue
- Financial factors associated with accessing care
- Challenges with pediatric ART formulations and administration.
- Poor/ Low Viral Load coverage and sample log for prompt result

Strategies to improve retention:

- Establish a policy to standardize and promote an adolescent package of care
- Establish guidelines for the implementation of age-appropriate and structured disclosure for children and adolescents
- Establish guidelines for the implementation of age-appropriate and structured psychosocial support for children and adolescents
- Improve the capacity of HCW through regular trainings and provision of job aids aimed at improving viral load coverage and use of results for decision making.
- Build the capacity of health care providers on psychosocial support for children and adolescents
- Strengthen the provision of treatment literacy for patients/caregivers and patient tracking systems.
- Develop and distribute innovative job aids for health care providers and caregivers (e.g. video clips)

- Provide appropriate Paediatric ARV formulations without stock out.
- Differentiated care models for children and adolescents with multi-month prescription as appropriate
- Stratified & dedicated clinic hours for adolescents
- Expand Viral load coverage with POC devices

V. STRENGTHEN REFERRAL NETWORK

The Paediatric HIV program requires an effective referral network to address the full range of needs of HIV positive children and adolescents. However, this is one of the weakest components of the health system and is often profound in the care of children and adolescents. HIV infected children need other services including ancillary medical services, nutritional, psychosocial, educational, legal and household economic strengthening. The availability of these services cut across the public, private-for-profit and non-profit facilities.

Weak inter and intra facility referral of children and adolescents affect effective service delivery, contribute to poor adherence and loss to follow up. Therefore, there is a need to strengthen the referral network.

Strategies for improving referrals:

- Establish an appropriate model to ensure coordinated referral between the different levels of care including feedback mechanism (private facilities, FBO, TBAs)
- Develop a National/State referral directory
- Scale-up and strengthen National Integrated Specimen Referral Network (NISRN) and prioritize samples from children and adolescents.
- Strengthen referral networks or Integrated service delivery between various service delivery points within a facility.
- Use of PLHIVs/support group members for a referral from the community to facilities and vice versa.

VI. IMPROVING DATA QUALITY AND REPORTING

- Quality data and accurate reporting go a long way in guiding program activities to ensure appropriate and targeted strategies to improve outcomes. There is a need to build on the quality of data and reporting from programs to ensure continued progress in the fight against HIV/AIDS in Nigeria.

3.4. 3 Output 3: Parents/Caregivers, families and, communities empowered to demand and support delivery of quality HIV services for children and Adolescents

Within families and communities, lack of information, knowledge, poverty, myths, beliefs, and stigma are significant obstacles to the uptake of children and adolescent HIV testing and treatment¹⁰. Weak health system and poor attitude of HCWs are also barriers to uptake of children and adolescent HIV testing and treatment¹¹. Improving awareness of the benefits of early initiation of ART for children and adolescents living with HIV, bringing messages of hope for children and adolescents living with HIV, and appropriate messages that target these groups and their parents alike can lead to significant acceptance and uptake of paediatric and adolescent ART services.

I. Employ mass media-based community awareness interventions for increased uptake of paediatric and Adolescent HIV services.

Improving public awareness on paediatric and adolescent HIV will serve to mitigate barriers to uptake of HIV testing and treatment. This will be done through the development and dissemination of educational messages and materials on paediatric and adolescent HIV testing and treatment through different modes of communication including the mass media (e.g., IECs materials) and social media.

II. High level advocacy and social mobilization for access to paediatric and adolescent HIV services:

Relevant Civil Society Organizations (CSOs), local philanthropists, community gatekeepers, village women committee, and other community support structures will all intensify advocacy to relevant authorities at all levels for increased funding of HIV/AIDS response. These organizations will also mobilize communities to improve the uptake of paediatric and adolescent HIV services.

III. Strengthen collaboration of all relevant stakeholders in HIV Treatment and Care Programme:

Functional partnerships between implementing organizations, health facilities, and associations/networks of PLHIV will facilitate the acceleration of paediatric and adolescent HIV testing, care, treatment and support services

The involvement of PLHIV in the HIV/AIDS response is a useful strategy in enhancing the quality and effectiveness of the response. This will be done through:

- Formal engagement with Associations/Networks of PLHIV and other stakeholders to identify best approaches for accelerating paediatric and adolescent treatment and care services.
- Interactive sessions with associations of adolescents living with HIV/AIDS and parents/caregivers to identify best approaches to increase uptake of HIV/AIDS services in their community.
- Sensitization of PLHIV on active case finding for HIV-infected children and retention in care.

IV. Strengthen retention in care and follow-up of defaulters

Retention in care is critical to ensure optimal outcomes for children and adolescents enrolled in HIV care and treatment. In this regard, the provision of funds for implementing facility and community-based tracking and follow-up is important. This will serve to identify defaulters as well as those who are not receiving adequate treatment support at home. PLHIV support groups should be enabled to carry out this role in the community.

V. Strengthen/Establish Adolescent and Youth-Friendly Services

It is widely recognized that adolescents are a unique group due to the various life changes encountered in this phase of life. It is also a phase fraught with experimental behavioral practices, some of which lead to negative health consequences. Adolescents are estimated to comprise 8% of people living with HIV in Nigeria. Therefore, there is a need to institute strategies that will help such adolescents navigate through their many challenges and also enable them to benefit from effective and optimal care.

These strategies include:

- Provision of adolescent-friendly services in an enabling environment to improve retention in care.
- Establish and strengthen a functional support group system to facilitate linkages and information sharing using social media platforms.
- Organize mentorship activities among ALHIV, peer educators, and peer mentors to help them navigate through other service delivery points in the facility. Create flexible clinic days/hours to accommodate school schedule for ALHIV to meet, interact and play games with their peers
- Address issues of disclosure, psychosocial barriers and organized transition to adult care using the national PMM tools
- Strengthen differentiated care models for children and adolescents

VI. Institute Feedback Mechanisms

Establishing strong feedback mechanisms with parents/caregivers and families will improve the ability and competencies of HCWs. This will further identify and analyze complex cases and situations, formulate appropriate solutions that will improve the quality of services provided for children and adolescents. This can be achieved through appropriate communication and written reports, with the potential to strengthen adherence, referrals, tracking and linkages within and across programmes.

3.4.4 Output 4: Uninterrupted supply of ARVs and other commodities.

Strategic Interventions:

- a. Strengthen evidence based forecasting and supply system
- b. Strengthen procurement, storage and distribution mechanism
- c. Leverage existing structure for capacity building on supply chain management system

4

IMPLEMENTATION ARRANGEMENTS



4. IMPLEMENTATION ARRANGEMENTS

4.1 The implementation of the acceleration plan will require the involvement of stakeholders at all levels. Hence, to achieve the goal and objectives of the plan, it is pertinent to map out these stakeholders and the respective roles they will play in the implementation of the proposed strategic interventions and activities. The acceleration plan acknowledges that the Government of Nigeria through the Federal Ministry of Health (FMOH), State Ministries of Health (SMOH) and Local Government Area (LGA) health department will lead the implementation of the plan and this is in keeping with the National HIV/AIDS strategic plan. It is expected that the multilateral and bilateral development partners, private sectors, faith-based organizations (FBOs) as well as the civil society organizations (CSOs) will play an important role in the achievement of the set goal and objectives.

4.2 ROLES AND RESPONSIBILITIES

4.2.1 NATIONAL AND STATES HIV/AIDS AND STIs CONTROL PROGRAMMES

NASCP and SASCP have the overall responsibility for coordinating the implementation of the plan at national and state levels, respectively. The state HIV/AIDS and STIs control programmes will be responsible for adopting and coordinating state-level implementation of the strategies articulated in the plan. Following recommendations from NASCP, the Federal Ministry of Health will expand the Terms of Reference (TOR) of the Paediatric ART subcommittee to oversee the implementation of the National Acceleration plan. The membership will be made up of members of the paediatric subcommittee of the NTTA. The will perform the following duties:

- Provide technical guidance on development of job aids/SOPs and implementation protocols.
- Conduct high-level advocacy on behalf of NASCP on issues about the implementation of the acceleration plan;
- Collaborate with reputable media and social mobilization consultants, as well as organizations focused on social and behavioral change modifications to develop suitable media messages and IEC materials for broadcast and dissemination;
- Serve as technical experts providing mentorship and supportive supervision for all tiers of health care facilities.
- Provide clinical updates and training using onsite as well as online (virtual) training platforms.

NASCP will be responsible for the following:

1a. Support for implementation of national-level interventions

Activity 1: Production and dissemination of job aids and protocols/guidelines for facility-level interventions. These job aids and protocols/guidelines will provide guidance for the implementation of case finding strategies via pediatric and adolescent-focused HIV testing services such as index PLHIV testing and PITC. These documents will be developed by the steering committee which will be at liberty to co-opt additional resource persons as it deems necessary to achieve its objectives.

Activity 2: Consultative meetings with implementing partners to develop and disseminate the job aids and SOPS.

Activity 3: Advocacy to support the implementation of pediatric HIV services through funding, technical, and logistic support.

Activity 4: Provide guidance to state ministries of health and SASCP in the implementation of pediatric HIV services.

1b. Support for implementation of State level interventions.

Activity 1: Dissemination of job aids and protocols/guidelines for facility level interventions. These documents will provide guidance for implementation of case finding strategies via pediatric-focused HIV testing services such as and PITC.

Activity 2: Consultative meetings with implementing partners to develop and disseminate the job aids and SOPS.

Activity 3: Advocacy to support the implementation of pediatric and adolescent HIV services through funding, technical and logistic support.

Activity 4: Provide guidance on the implementation of pediatric and adolescent HIV services at Local government level and private health facilities.

II. Support improvement of quality of paediatric and adolescent HIV care in ART centres

Activity 1: NASCP will convene a series of meetings of the acceleration plan steering committee to develop, monitor, and supervise the quality of paediatric and adolescent HIV services using an approved national checklist.

Activity 2: NASCP will ensure that paediatric ART meetings hold every quarter with the participation of relevant implementing partners so as to reinforce harmonization of practices and ensure coordination of activities in the field.

Activity 3: Conduct on-site mentoring and supportive supervision of ART sites providing paediatric and adolescent HIV services.

III. Support increased public awareness for uptake of ART services

Activity 1: NASCP will convene a series of meetings of the expanded steering committee on acceleration plan implementation for the purpose of developing appropriate messages using IEC materials as well as radio and television jingles. Messages developed will target a wide range of audiences which will include caregivers (parents, guardians, siblings etc.), community and religious leaders, private health care practitioners including community pharmacists, patent medicine vendors and other members of the informal health sector. The thrust of these messages will be that all parents living with HIV should have all their children tested for HIV and that children with recurring illnesses should immediately be taken to a health facility for HIV testing. In addition, all pregnant women should be referred to health care facilities for testing and subsequently linked to PMTCT services

Activity 2: Production and airing of radio and television jingles, newspaper advertorials, as well as discussions in radio/television talk show whenever possible. Production and dissemination of messages using IEC materials in the local dialect, social media (WhatsApp, Facebook, Instagram, Twitter) and any other community appropriate medium.

Activity 3: NASCP will convene a consultative meeting with NEPWHAN and its affiliates such as APYIN and ASWHAN including community-based NGOs to determine roles they can play in increasing uptake of paediatric and adolescent HIV services including HIV testing. The focus will be on providing non-financial incentives such as the provision of HIV test kits and consumables to organizations that are already self-sustaining. Relevant NGOs/CBOs and PLWHA networks will be provided with updated service directory of facilities they can refer HIV positive children to for further care.

Activity 4: NASCP will sustain the consultative meeting with MNCH programme partners and other stakeholders including NPHCDA to agree on modalities for linking HIV testing for children to MNCH services. NASCP will be responsible for providing rapid test kits and additional human resources when needed for HIV testing in MNCH settings.

IV. Engagement with Private Sector Service Providers

Activity 1: NASCP will sustain meetings with the Association of Private and General Medical Practitioners of Nigeria (APGMPN), as well as other stakeholders involved in HIV testing services. The objective will be to ensure routine screening and linkage to treatment.

Activity 2: NASCP, in close collaboration with partners, will convene seminars/meetings on paediatric and adolescent HIV prevention, care and treatment for the private sector providers. These seminars will receive wide media coverage and will contribute to the public awareness creation agenda and support the implementation plan to achieve set targets.

Activity 3: Allocation and distribution of printed IEC materials, job aids, wall charts, SOPs to private service providers will be carried out by NASCP in collaboration with partners.

V. Engagement with Professional bodies.

Activity 1: NASCP will engage professional associations to create awareness on paediatric and adolescent HIV services.

Activity 2: NASCP will engage professional associations like Paediatric Association of Nigeria (PAN), National Association of Nigerian Nurses and Midwives (NANNM), Association of Medical Laboratory Scientist of Nigeria (AMLSN), Pharmaceutical Society of Nigeria (PSN) and all other relevant stakeholders to support HIV services through training, monitoring and supervision of their members in the area of testing and linkage of HIV positive children and adolescent to treatment.

Activity 3: NASCP will engage professional bodies to ensure inclusion of the management and

care of children and adolescents infected with HIV as part of their regular Continuous Medical Education (CMEs) programmes.

VI. Strengthen Logistics Systems for Paediatric and Adolescent HIV Diagnosis

Activity 1: NASCP will work with all relevant stakeholders to carry out quantification, forecasting, procurement and distribution of test kits, paediatric ARVs, and other commodities required to meet the expected increase in HIV testing and treatment of children and adolescents.

Activity 2: NASCP will work with its partners to ensure availability of laboratory reagents and commodities for Early Infant Diagnosis (EID) services.

Activity 3: NASCP will collaborate with stakeholders to ensure timely availability of results “reduced turnaround time” for DBS and patient care.

4.2.2 The Multilateral and Bilateral Partners

The multilateral (UNICEF, WHO, UNAIDS, World Bank) and bilateral partners notably PEPFAR, and the Global Fund will provide technical and financial support to the Government of Nigeria for the implementation of the acceleration plan. Specifically, these organizations will play the following supportive roles.

NASCP will support the;

- Provision of additional funding for paediatric and adolescent HIV services
- Government of Nigeria to improve the coordination of paediatric and adolescent HIV services.
- Government of Nigeria to provide paediatric and adolescent HIV commodities
- Provision of technical support when necessary to accomplish specific activities of the acceleration plan.
- Training and re-training of health care providers at all levels for the delivery of quality paediatric and adolescent HIV activities.
- Activities related to improving quality of services including clinical mentoring of staff and supervision activities
- Activities related to community mobilization for increased uptake of services
- Operational research, documentation, and dissemination of best practices to inform policy change

4.2.3 The Civil Society Organizations and other Community Stakeholders

The Civil Society Organizations (CSOs), notably the associations/networks of people living with HIV/AIDS will collaborate with the FMOH/SMOH/LGAs and implementing partners to create community awareness around children and adolescent ART services. Specifically, these organizations will:

- Advocate for increased funding for children and adolescent ART
- Create community awareness on children and adolescent ART services
- Be involved in peer mobilization for children and adolescent HIV testing and treatment
- Participate in peer support and community-based activities to accelerate children and adolescent HIV case-finding, treatment, and retention in care.

4.2.4 The Health Facilities

There are many significant and important roles that the health facilities can play to improve the quality of care offered children living with HIV/AIDS and thereby contribute to improved retention in care.

- Health facilities providing ART services will be encouraged to adopt children and adolescent-friendly policies for those living with HIV.
- Management of health facilities will be encouraged to set up a patient triaging system that ensures that HIV positive children and adolescents receive prompt attention.
- Management of health facilities should ensure that paediatric clinics are provided with adequate facilities for infection control.
- Management of health facilities will be encouraged and supported to set up children playpen to pre-occupy them while they wait to be served.
- Health care workers should be trained on attitudinal change and should be aware of anti-stigma law to prevent stigmatization, patient rights to ensure quality service provision and child safeguarding policy to prevent abuse of the children and adolescents in their care.
- Management of health facilities will be encouraged to implement a policy of routinely offering HTS to children and adolescents attending their facilities as well as abolishing user fees for HIV services.

5

MONITORING AND EVALUATION



5. MONITORING AND EVALUATION

5.1 INTRODUCTION

The Nigeria National Response Information Management System Operational Plan (NOP II) 2011-2016 serves as the monitoring and evaluation guide used by all stakeholders for tracking, monitoring and evaluating the national AIDS response. The NOP II provides a monitoring platform for the National HIV/AIDS Strategic Framework 2010-2015.

Monitoring is a crucial component of the N-SDF following the assessment and application of evidence-based solutions proposed in the solutions matrix. The selected interventions should be monitored routinely. The essence of ensuring a robust monitoring effort is to get a good understanding of whether the applied solutions are yielding the desired results. There are five key areas for monitoring the implementation of the service delivery framework to ensure a continuous quality improvement cycle and achievement of set targets.

1. Increasing use of age- and sex-disaggregated data
2. Increasing the use of data on the uptake of services along the locate-link-treat-retain continuum
3. Analyzing data to identify location focus
4. Maintaining a continuous quality improvement cycle
5. Milestone tracking of implementation and scaleup of service delivery interventions

The WHO Consolidated Strategic Information Guidelines for HIV in the Health Sector 2015 was developed to consolidate and update existing M& E guides. It provides guidance for the selection, collection and systematic analysis of strategic information to guide the health sector response to HIV. The aim of consolidation is to ensure that all indicators are in one place, are prioritized and linked in a result chain, and can be used to support quality care along the health sector cascade of HIV services. The guidelines align with the 2020 global 90-90-90 target. Nigeria currently determines treatment targets based on Test and Treat strategy defined in the 2016 National Guidelines for HIV Prevention, Treatment, and Care. However, the country has adopted the 2015 WHO Strategic Information Guidelines.

5.2 DATA COLLECTION AND FLOW

The monitoring and evaluation framework for the National Acceleration Plan for Paediatric HIV Treatment and Care is aligned with the NOP II, and indicators drawn from the draft revised health sector monitoring and evaluation framework. This framework will focus on relevant paediatric and adolescent HIV indicators that will monitor progress with the acceleration of paediatric and adolescent HIV services and thus the effectiveness of the proposed strategic interventions. As with all national health sector data, data collection sources will include facility and outreach reporting system for routine service data, vital registration and population-based surveys. There will be detailed data disaggregation in line with the 2015 WHO Strategic Information Guidelines.

As stipulated in the NOP II, health facilities collect data daily with specially designed forms and registers. The Local Government Area (LGA) M&E HIV/AIDS focal persons collect data

monthly from the facilities. The LGA focal persons collate the information from all LGA health facilities and send summary tables to the SMOH (SASCP), monthly. The SMOH (SASCP) collates the information from all the LGAs and on a quarterly basis, sends the summary data to NASCP and gives a copy to State Agency for the Control of AIDS (SACA) who forwards a copy to the National Agency for the Control of AIDS (NACA). NASCP then collates the health sector data from all States and shares the information with NACA and Department of Health Planning and Research (DPRS) of the FMOH, on a quarterly basis. Reporting to national leaders and donors occurs at this level as well as feedback to states and LGAs. The indicators needed to monitor the progress of the National Acceleration Plan will be captured by the data entry personnel at each level of data flow. The progress of specific indicator vis -a vis targets will be reviewed and reported by the M and E officers. The progress, challenges and quality improvement will be addressed at the monthly or Quarterly LGA, State or National review meetings.

In addition to the above, most comprehensive health facilities have Electronic Medical Recording (EMR) system through which patient information is boarded into the National Data Repository (NDR). The District Health Information System (DHIS) has been developed to facilitate direct real time data entry by facility M&E officer thus reducing transcription errors thereby improving data quality.

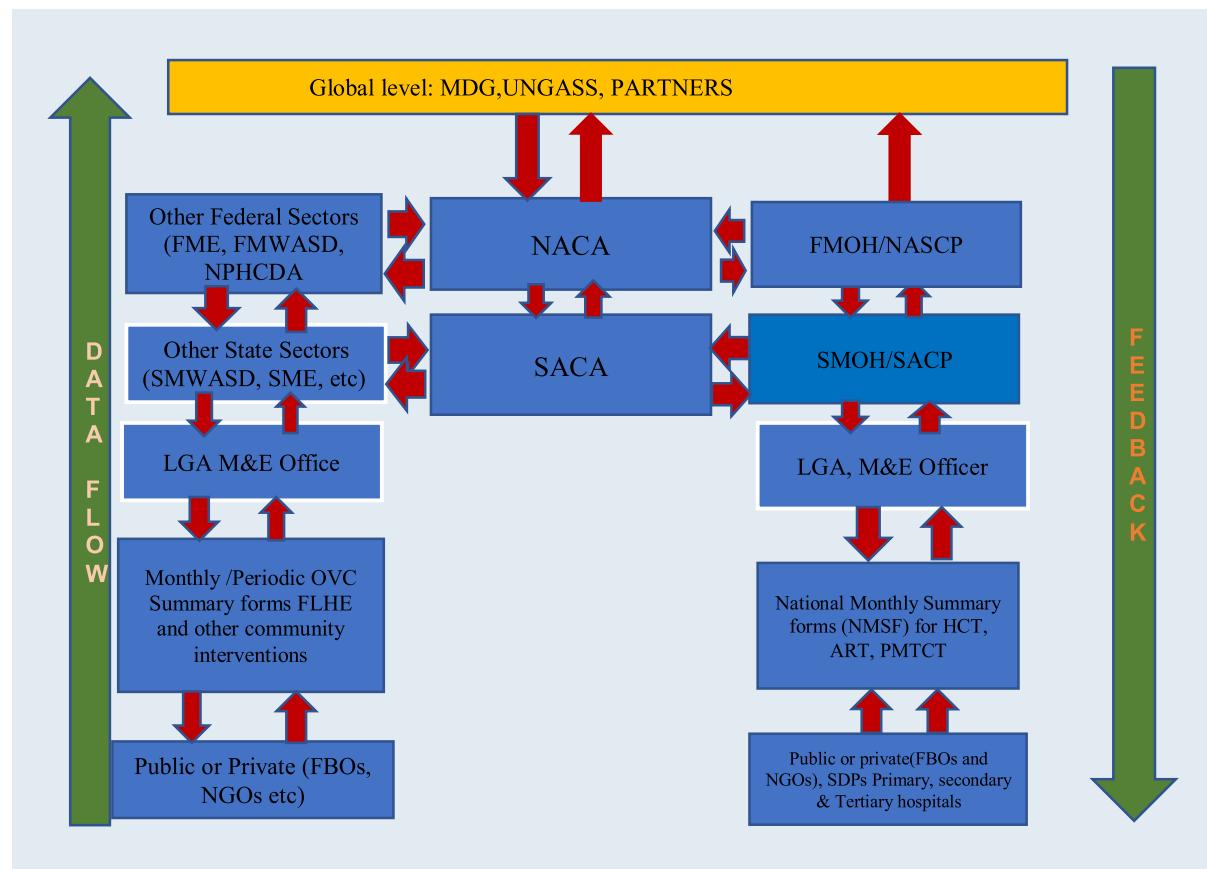


Figure 10: Revised National Flow Chart for Health and Non- Health Sector

ANNEX 1: MONITORING AND EVALUATION FRAMEWORK

INDICATORS	DEFINITION How is it calculated?	BASELINE What is the current value? (2019)	TARGET What is the target value? 2020 2021 2022	DATA SOURCE How will it be measured?	FREQUENCY How often will it be measured?	RESPONSIBLE Who will measure it?
IMPACT INDICATORS						
% of annual AIDS death among CLHIV (0 – 14) years during the reporting period.	N: Number of annual AIDS deaths among CLHIV. D: Estimated number of CLHIV.			Programme Data. Spectrum.	Annually	STATE/FMOH
% of annual AIDS death among Adolescents Living with HIV ALHIV) (10 -19)years during the reporting period.	N: Number of annual AIDS deaths among adolescents living with HIV. D: Estimated number of ALHIV.			Programme Data. Spectrum.	Annually	STATE/FMOH
OUTCOME INDICATORS						
% of CLHIV and ALHIV on ART who are virally suppressed at 6 months during the reporting period.	N: Number of CLHIV and ALHIV who are virally suppressed at 6 months of initiation of ART. D: Number of CLHIV and ALHIV on ART that received a VL test result at 6 months of initiation on ART.			Programme Data. Programme Data.	Bi-annually	STATE/FMOH

% of CLHIV and ALHIV on ART who are virally suppressed at 12 months during the reporting period.	N: Number of CLHIV and ALHIV who are virally suppressed at 12 months of initiation of ART. D: Number of CLHIV and ALHIV on ART that received a VL test result at 12 months of		Programme Data. Programme Data.	Annually	STATE/FMOH
	initiation on ART.				
% of CLHIV and ALHIV on ART who are retained on ART at 6 months after initiation during the reporting period.	N: Number of CLHIV and ALHIV alive and on ART at 6 months of ART initiation. D: Number of CLHIV and ALHIV initiating ART up to 6 months before the beginning of the reporting year. (This includes those who have died since starting therapy, those who have stopped therapy and those lost to follow - up as of month 6.)		Programme Data. Programme Data.	Bi-annually Cohort Analysis	SMOH/ FMOH

OUTPUT INDICATORS	N: Number of CLHIV and ALHIV who are retained on ART at 12 months of initiation during the reporting period.			D: Number of CLHIV and ALHIV initiating ART up to 12 months before the beginning of the reporting year. (This includes those who have died since starting therapy, those who have stopped therapy and those lost to follow-up as of month 12)			SMOH/ FMOH
	Programme Data.	Bi-annually	Programme Data.	Bi-annually	Programme Data.	Bi-annually	
% of CLHIV and ALHIV on ART who are retained on ART at 12 months of initiation during the reporting period.	N: Number of CLHIV and ALHIV alive and on ART at 12 months of ART initiation.						
% of CLHIV and ALHIV who tested for HIV and received results during the reporting period.	D: Total number of CLHIV tested for HIV						

	N: Number of exposed HIV- infants who received EID/DNA - PCR test for HIV within two months of birth during the reporting period.	D: Population-based denominator: Estimated number of HIV-positive pregnant women during the reporting period.	Bi-annually SMOH/ FMOH
% of infants born to HIV-positive women receiving a DNA-PCR test for HIV within 2 months of birth during the reporting period.		Programme Data. Spectrum	
	% of HIV Exposed babies who tested for HIV within 18 months of birth by Rapid Test during the reporting period.	N: No. of HIV Exposed babies who tested for HIV within 18 months of birth by Rapid Test. D: Estimated number of HIV-positive pregnant women during the reporting period.	Bi-annually SMOH/ FMOH

% of CLHIV and ALHIV who test HIV-positive during the reporting period.	N: Number of CLHIV and ALHIV who test HIV-positive. D: Estimated number of CLHIV and ALHIV.	Programme Data (numerator) Spectrum	Annually	SMOH/ FMOH
Proportion of newly diagnosed HIV-positive children and adolescents newly enrolled in clinical care during the reporting period	N: Number of newly diagnosed HIV-positive children and adolescents newly enrolled in clinical care during the reporting period. D: Number of newly diagnosed HIV-positive children N/A	Programme Data.	Bi-annually	SMOH/ FMOH
% of positive children and adolescents who received clinical assessment (WHO staging) OR CD4 count OR viral load OR current on treatment during the reporting period.	N: Number of positive children and adolescents who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load OR current on treatment. D: Estimated number of CLHIV and ALHIV.	Programme Data.	Bi-annually	SMOH/ FMOH

			Programme Data.	Bi-annually	SMOH/ FMOH
Number of CLHIV and ALHIV newly started on ART during the reporting period.	N & D: N/A				
ART coverage among CLHIV and ALHIV during the reporting period.	N: Number of CLHIV and ALHIV currently receiving ART. D: Estimated number of CLHIV and ALHIV.		Programme Data.	Bi-annually	SMOH/ FMOH
% of CLHIV and ALHIV in care (including PMTCT) who were clinically screened for TB in HIV care and treatment settings during the reporting period.	N: Number of CLHIV and ALHIV enrolled in HIV care whose TB status was assessed and recorded at their visit during last the reporting period.		Programme Data.	Bi-annually	SMOH/ FMOH
	D: Total number of CLHIV and ALHIV currently receiving HIV care during the reporting period.				

% of CLHIV and ALHIV Enrolled in HIV Care who have Active TB Disease.	N: Total number of CLHIV and ALHIV enrolled in care who have active TB disease during the reporting period. D: Total number of CLHIV and ALHIV currently in HIV care who were screened for TB during the reporting period	Programme Data.	Bi-annually	SMOH/ FMOH
ART coverage among HIV-Positive New and Relapsed TB children and adolescents during TB Treatment.	N: Total number of HIV-positive new and relapsed TB children and adolescents started on TB treatment during the reporting period who are already on ART or started on ART during TB treatment. D: Total number of HIV-positive new and relapsed TB children and adolescents registered during the reporting period	Programme Data.	Bi-annually	SMOH/ FMOH

ANNEX 2: CLASSIFICATION OF THE 36 STATE TYPOLOGIES IN NIGERIA

States	Abia	Adamawa	Akwa-Ibom	Anambra	Bauchi	Bayelsa	Benue	Borno	Cross River	Delta
Typology	D	D	D	D	D	D	D	D	D	D
States	Ebonyi	Edo	Ekiti	Enugu	FCT	Gombe	Imo	Jigawa	Kaduna	Kano
Typology	D	D	D	D	D	D	D	D	D	D
States	Katsina	Kebbi	Kogi	Kwara	Lagos	Nasarawa	Niger	Ogun	Ondo	Osun
Typology	D	D	D	D	D	D	D	D	D	D
States	Oyo	Plateau	Rivers	Sokoto	Taraba	Yobe	Zamfara			
Typology	D	D	D	D	D	D	D			

ANNEX 3: RISK STRATIFICATION FORM FOR FACILITY & COMMUNITY



NATIONAL AIDS AND STIs CONTROL PROGRAMME FEDERAL MINISTRY OF HEALTH

COMMUNITY BASED PAEDIATRIC/ADOLESCENT (0-19 YEARS) HIV TESTING SCREENING CHECKLIST

State: _____	LGA: _____	Community: _____	Household No: _____
Child's Name: _____	Unique ID: _____ / _____ / _____ / _____ / _____ <small>(State code/LGA code / Org. code/serial No/Index serial No)</small>		
Sex: _____ Age: _____ Years: _____ Months_____ <small>(Enter month if child is below 2 years)</small>	Date of Assessment (dd/mm/yy): _____		
Relationship of Respondent to the child: _____ Phone number: _____ Delivery (Home/Facility): _____			

I am going to ask you some questions about your child's overall well being. Whatever we discuss will remain confidential. Are you comfortable to continue? YES [] /NO []. (If NO, do not continue with the screening, explore barriers and provide support)

Do you know the HIV status of your child/ward? YES [] /NO: [] (If NO or HIV negative, proceed to risk assessment). If YES, what is the status? Positive []/Negative []

(Do not use this checklist for a known HIV-positive child/adolescent, rather ensure the known HIV-positive child/adolescent is on ART)

INSTRUCTIONS:

1. Please use one checklist per child and ask all the questions as applicable
2. After the assessment, if caregiver/child reports YES to at least one risk factor below (**Child at risk**), offer/refer for HIV testing and tick 'YES' at the bottom of the form. If not, tick 'NO' at the bottom of the form and work with the caregiver during posttest counseling to develop a risk reduction plan.
3. Support the mother of infants **aged 0-18 months** at risk aged **0-18months** should be referred for EID services.
4. All children **0-14 years** will respond to questions in **Section A** through their parents/caregiver
5. All adolescents **15-19 years** will respond to questions in **Section B** (Request audio privacy where parent or caregiver is present).

Section A

	YES	NO	DO NOT KNOW
All Children (0-19 years of age)			
1. Is the infant/child/adolescent's caregiver/biological parent (s):			
a. HIV-positive? Mother [] Father []			
b. Having a long-standing sickness (frequent hospital visits/admissions, frequent use of medicines)?			
c. Deceased due to an illness/sickness? Mother [] Father []			
2. Does the infant/child/adolescent have a sibling that is:			
a. HIV-positive?			
b. Having a long-standing sickness (frequent hospital visits/admissions, frequent use of medicines)?			
3. In the last three months, has this infant/child/adolescent:			
a. Been sick (e.g. frequent hospital visits/admissions, frequent use of medicines)?			
b. Has had ≥ 2 of following: Frequent Cough, longstanding Fever, longstanding Diarrhea, Loss of weight//poor weight gain, longstanding/frequent skin rash, unexplained swelling on the neck, behind the ears or under the armpits?			

4.	a. Has the infant/child/adolescent/parent/caregiver ever had or currently have Tuberculosis (TB)?		
5.	Has the infant/child: a. Ever received blood transfusion?		
	b. Had any of the following in the last 3 months: circumcision, ear piercing, scarification, injection/drip outside the hospital, uvulectomy?		
6.	Has the infant/child with an HIV positive mother missed an Early Infant Diagnosis Testing milestone? <ul style="list-style-type: none">• At <2 months• At 9 months• At 18 months or 3 months after cessation of Breastfeeding		
7.	Has the child/adolescent ever been: a. Forced to have sex (any form)?		
	b. Pregnant (female children)?		

Section B [To be completed for 15-19 years only in addition to section A]

8.	Have you ever had sex in the past? (anal, vaginal or oral)		
9.	Have you experienced painful urination, lower abdominal pain, vaginal or penile discharge or sores/rash on the genitals in the past?		
10.	Have you ever injected drugs, shared needles or other sharp objects in the past?		

Child/Adolescent at risk: YES []/NO []

Service provider Name: _____ Designation: _____ Phone no: _____ Sign /Date: _____

Please Tick as appropriate

- | | |
|--|---|
| <input type="checkbox"/> Refused risk assessment | <input type="checkbox"/> Referred for HTS/EID based on risk assessment result |
| <input type="checkbox"/> Test not required based on risk assessment result | <input type="checkbox"/> Risk assessed and referred for testing but refused testing |



**NATIONAL AIDS AND STIs CONTROL PROGRAMME
 FEDERAL MINISTRY OF HEALTH**

FACILITY BASED PAEDIATRIC & ADOLESCENT (0-19 YEARS) RISK STRATIFICATION CHECKLIST

State: _____	LGA: _____	Facility Name: _____	Entry Point: _____
Child's Name: _____	Child Hospital No.: [] [] [] [] [] []		
Sex: _____	Age: _____	Years: _____	Months _____
(Enter month if child is below 2 years)		Date of Assessment (dd/mm/yy): [] [].[] [].[] []	
Relationship of Respondent to the child: _____		Phone number: [] [] [] [] [] [] [] [] []	

I am going to ask you some questions about your child's overall well being. Whatever we discuss will remain confidential. Are you comfortable to continue? YES [] /NO []. (If NO, do not continue with the screening, explore barriers and provide support as needed). Do you know the HIV status of your child/ward? YES []/NO: [] (If NO or HIV negative, proceed with risk assessment). If YES, what is the status? Positive []/Negative [].

INSTRUCTIONS: Do not proceed if the infant/child/adolescent has been tested for HIV in the **last three (3) months**. Do not use this checklist for a **known HIV-positive** infant/child/adolescent, rather ensure infant/child/adolescent is on ART.

1. If "Yes" to any of the questions below, **offer HIV testing**
2. If there is a response of "DON'T KNOW" without any "No" in any of the questions below, offer HIV testing
3. If all responses are "No" do not offer HIV testing
4. All children **0-14 years** will respond to questions in **Section A** through their parents/caregiver
5. Support the mother of infants **aged 0-18 months** with unknown HIV status to HTS, to determine eligibility for EID
6. All adolescents **15-19 years** will respond to questions in **Section A and B**. (Request audio privacy if parent/caregiver is present).

Section A

ITEM	YES	NO	DO NOT KNOW
1. Is the infant/child/adolescent's caregiver/ biological parent (s) HIV-positive? Mother []Y []N []Don't Know Father []Y []N []Don't Know			
2. Is the infant/child/adolescent's biological parent(s)/siblings deceased due to a long-standing illness/sickness?			
3. Was the child/infant delivered outside of a facility?			
4. Has the infant, child/adolescent had persistent/recurrent skin rash?			
5. In the last six months, has this infant/child/adolescent been sick (e.g. recurrent hospital visits/admissions, frequent use of medicines)?			
6. Has the infant/child/adolescent ever been transfused blood?			

7. a. Does the infant/child/adolescent have ≥ 2 of the following:			
<ul style="list-style-type: none"> • Persistent/Current Cough • Persistent Fever • Persistent Diarrhea • Loss of weight//poor weight gain • Unexplained swelling on the neck, behind the ears or under the armpits 			
7. b. Has the infant/child/adolescent/parent/caregiver ever had or currently have Tuberculosis (TB)?			
8. Has the infant/child with an HIV positive mother missed an Early Infant Diagnosis Testing milestone?			
<ul style="list-style-type: none"> • At <2 months • At 9 months • At 18months or 3 months after cessation of Breastfeeding 			
9. Has the child/adolescent ever been sexually assaulted (any form)?			

Section B

10. Have you ever had sex in the past? (Anal, vaginal or oral).		
11. Have you ever experienced painful urination, lower abdominal pain, vaginal or penile discharge or sores/rash on the genitals in the past?		
12. Have you ever injected drugs, shared needles or other sharp objects in the past?		

Infant/Child/Adolescent at risk: YES [] / NO []

Service provider Name: -----

Designation: -----

Phone no: [][][][][][][][][][]

Sign: -----

Date: [][].[][].[][][][]

Please Tick as appropriate

Refused risk assessment

Referred for HTS/EID based on risk assessment result

Test not required based on risk assessment result

Risk assessed and referred for testing but refused testing

ANNEX 4: GANTT CHART ON IMPLEMENTATION SCHEDULE

Output	Strategy	Activities	2020												2021												2022											
			JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
Output 1 : Federal, State and Local Governments' systems strengthened to coordinate the Paediatric and Adolescent ART programme	Strategy 1.1: Strengthen technical capacity to provide leadership and governance to coordinate the Paediatric and Adolescents' HIV program	Develop a Gantt chart to monitor implementation of the National Acceleration Plan at national and state levels Designated state specific pediatric and adolescent focal persons to coordinate state program activities in reference to the Gantt chart. State pediatric ART focal persons to coordinate program activities in reference to the gantt chart																																				
	Strategy 1.2: Strengthen/E establish relevant coordinating technical committees on children and adolescent HIV services	Participate in the national quarterly 2-day PMTC/EID task team meetings Participate in the 2-day biannual EID cascade/POC meeting Bi-annual 2-day national Coordination meeting of the Pediatric and Adolescent sub-committee of the NTA.																																				
	Strategy 1.3: Improve government and non-governmental funding for children and adolescent HIV services	Establish/strengthen state pediatric and adolescent sub-committees or Technical working groups																																				
	1.4 Strengthen M&E systems to improve data management to capture age-disaggregated indicators	Technical assistance at the national level to improve budgeting and financing for pediatric and adolescent HIV Advocacy and capacity building for states to improve budgeting and financing for Paediatric and adolescent HIV																																				
	1.5 Strengthen continuous monitoring and quality improvement for children and adolescent ART services	Quality improvement workshop with mentor-mothers/case managers to accessing milestone services for mother infant pairs																																				
	Output 2: Effective strategies for Children and Adolescent HIV case-finding, treatment, retention in care, and viral load suppression	Strategy 2.1: Strengthen active case finding of pediatric and adolescent HIV (e.g. index testing PLHIV and PTC) and linkage to treatment and care	Printing of HTS tools for pediatric and adolescent case finding (genealogy forms, index testing referral slips, contact trading tools, genoecopy register, SNT register, SNT form) towards ensuring routine implementation of index testing and HVST																																			
		Strategy 2.2: Strengthen active case finding of pediatric and adolescent case finding	Build capacity of health care workers (public and private) on strategies to improve pediatric and adolescent case finding Print, validated pediatric and adolescent HTS forms, index testing referral slips, contact trading checklist, Development of SOP, data recording tools, training manual and slides on HVST																																			
		Strategy 2.3: Strengthen active case finding of pediatric and adolescent case finding	Training of trainers on HVST Capacity building of relevant cadre (healthcare workers, AYP community champions) on HVST Adapt and adopt IEC materials on HVST Printing of HVST IEC materials Awareness creation among the populace on HVST using mass media and social media platforms Symposium for AYRs on HVST																																			
		Strategy 2.4: Strengthen active case finding of pediatric and adolescent case finding	Update directory of private sector facilities (formal and informal). Desk review at NASCP Sanitize private sector (formal and informal) operators on HTS and hold consultative meetings with national leadership of private medical practitioners on pediatric and adolescent HTS Strengthen and open use reporting of HTS activities in private sectors to the reports platform Capacity building for healthcare workers on POC for EID and VL Build capacity of mentor-mothers to increase access to EID for HEIs using MP tracking tool																																			

	Strategy 2.7: Improving data quality and reporting.	Quarterly online meetings to mentor SACPs & State M&Es on use of Data for Paediatrics and Adolescent programming using ECHO platform
		Retention analysis for Paediatrics and Adolescents
		National Biannual Q&A exercise
		State level quarterly Q&A exercise
		Printing of 1000 referral form booklet per state
		Distribution of the printed referral form booklets (5% of productive value)
		Printing and dissemination of the State Referral directives
		Engage ACSM committee at national and state levels to develop pediatric and adolescent ACSM strategy
		Develop IEC materials to create awareness for increased uptake of pediatric and adolescent HIV services
		Print and disseminate developed IEC materials
		Use social media to increase public awareness of Pediatric HIV and advocate for the elimination of stigma and discrimination among CLHIV/ALHIV in Nigeria
		Conduct 2 meetings with Journalist alliance for PMTCT in Nigeria (JAPAN) for improved awareness on pediatric and adolescent HTS uptake
		Conduct advocacy for Pediatric HIV among CSOs, traditional and religious leaders and local philanthropies
		Conduct advocacy to the First Lady of the Federation for sustainable financing of Pediatric HIV services (care, support and treatment) to increase access to ART
		Participate in zonal meetings of the Wives of Governors of the 36 states to facilitate integration of Pediatric HIV services for increased uptake
		Engage with Associations/Networks of PLHIV and other stakeholders to identify best approaches for accelerating paediatric treatment and care services (including increased uptake of HIV/AIDS services in their community, sensitization on active case finding for HIV-infected children and retention in Care)
		Conduct sessions with associations of adolescents living with HIV/AIDS and parents/caregivers to identify best approaches to increase uptake of HIV/AIDS services in their community
		Engage with Associations/Networks of PLHIV and other stakeholders to identify best approaches to increase uptake of HIV/AIDS services in their community, sensitization on active case finding for HIV-infected children and retention in care
		Develop a national protocol for Pediatrics and Adolescents defaulting and training of linkage Facilitators & CHWs
		Facilitate treatment literacy for caregivers for improved adherence support
		the CLHIV
		A 5 day National stakeholders meeting to develop IEC materials on Mentor
		Development of technology-based solution on retention targeting
		imittes and caregivers
		Printing and dissemination of National IEC materials to improve
		mention
		cale up community based DSD models to improve retention of paediatric above 5 years) and adolescents
		Sensitize and engage community pharmacists (CPs) on paediatric and adolescent ART regimen
		Train CPs on the community ART models
		Disseminate job aids on community ART models
		Devolve caregivers and children above 5 years to community ART model as appropriate
Output 3: Parents/Caregivers, families and communities empowered to demand for and support delivery of quality HIV services for children and adolescents	Strategy 3.1: Employ mass media based community awareness interventions for increased uptake of paediatric HIV services	Strategy 3.2: High level advocacy and social mobilization for access to ART
	Strategy 3.3: Strengthen collaboration of all relevant stakeholders in HIV Treatment and Care Programme	Strategy 3.4: Strengthen retention in care and follow-up of defaulters

Exchange Rate @ N380= \$1

ANNEX 5: BUDGET

BUDGET FOR THE NATIONAL ACCELERATION PLAN FOR PEDIATRIC AND ADOLESCENT HIV TREATMENT AND CARE						
OUTPUT	STRATEGY/ACTIVITIES	Year 1 Total Cost (Naira)	Year 2 Total Cost (Naira)	Year 3 Total Cost (Naira)	Year 1-3 Total Cost (Naira)	Year 1-3 Total Cost (\$ USD)
Output 1: Federal, State and Local Governments' systems strengthened to coordinate the Paediatric ART programme	Strategy 1.1: Strengthen GoN technical capacity to provide leadership and governance to coordinate the Paediatric and Adolescents HIV program	₦ 19,248,000.00	₦ 15,157,274.00	₦ 15,611,992.22	₦ 50,017,266.22	\$ 131,624.38
	Strategy 1.2: Strengthen/Establish relevant coordinating technical committees on children and adolescent HIV services	₦ 6,425,400.00	₦ 6,618,162.00	₦ 6,816,706.86	₦ 19,860,268.86	\$ 52,263.87
	Strategy 1.3: Improve government and non-governmental funding for children and adolescent HIV services	₦ 2,535,000.00	₦ 2,611,050.00	₦ 2,689,381.50	₦ 7,835,431.50	\$ 20,619.56
	1.4 Strengthen continuous monitoring and quality improvement for children and adolescent ART services	₦ 9,990,564.00	₦ 10,290,280.92	₦ 10,598,989.35	₦ 30,879,834.27	\$ 81,262.72
Output 2: Effective strategies for Children and Adolescent HIV Case-finding, Treatment, Retention in care, and Viral load suppression	Strategy 2.1: Strengthen active case finding of pediatric and adolescent HIV (e.g. index testing PLHIV and PITC) and linkage to treatment and care	₦ 96,000,600.00	₦ 23,298,600.00	₦ 23,997,558.00	₦ 143,296,758.00	\$ 377,096.73
	Strategy 2.2: Improve linkage to care by strengthening HR capacity and engagement of community based structures	₦ 125,545,000.00	₦ 129,311,350.00	₦ 133,190,690.50	₦ 388,047,040.50	\$ 1,021,176.42
	Strategy 2.3: Support the strengthening laboratory services and sample referral network through linkages with other programmes (e.g. NTBLCP), and private sector engagement	₦ 16,956,800.00	₦ -	₦ -	₦ 16,956,800.00	\$ 44,623.16
	Strategy 2.4: Increase treatment initiation by improving the availability and prescription of optimal ARV regimens for children and adolescents	₦ 57,050,000.00	₦ 82,078,700.00	₦ 84,541,061.00	₦ 223,669,761.00	\$ 588,604.63
	Strategy 2.5: Improve retention in care by implementing HIV paediatrics and adolescent specific delivery models and support	₦ 162,132,400.00	₦ 150,783,728.00	₦ 155,307,239.84	₦ 468,223,367.84	\$ 1,232,166.76
	Strategy 2.6: Strengthen facility-facility and community-community referral network	₦ 63,378,000.00	₦ 62,854,720.00	₦ 55,204,992.40	₦ 181,437,712.40	\$ 477,467.66
	Strategy 2.7: Improving data quality and reporting.	₦ 28,127,600.00	₦ 28,971,428.00	₦ 29,840,570.84	₦ 86,939,598.84	\$ 228,788.42
Output 3: Parents/Caregivers, families and communities empowered to demand for and support delivery of quality HIV services for children and adolescents	Strategy 3.1: Employ mass media based community awareness interventions for increased uptake of paediatric and adolescent HIV services and elimination of stigma and discrimination	₦ 30,750,100.00	₦ 772,500.00	₦ 795,675.00	₦ 32,318,275.00	\$ 85,048.09
	Strategy 3.2: High level advocacy and social mobilization for access to pediatric and adolescent ART	₦ 21,990,000.00	₦ 22,649,700.00	₦ 23,329,191.00	₦ 67,968,891.00	\$ 178,865.50
	Strategy 3.3: Strengthen collaboration of all relevant stakeholders in HIV Treatment and Care Programme	₦ 9,815,000.00	₦ 10,109,450.00	₦ 10,412,733.50	₦ 30,337,183.50	\$ 79,834.69
	Strategy 3.4: Strengthen retention in care and follow-up of defaulters	₦ 78,928,000.00	₦ 73,323,640.00	₦ 71,916,289.20	₦ 224,167,929.20	\$ 589,915.60
	Strategy 3.5: Strengthen / Establish Adolescent and Youth-Friendly Services	₦ 44,854,000.00	₦ 46,199,620.00	₦ -	₦ 91,053,620.00	\$ 239,614.79
	Strategy 3.6: Strengthen feedback mechanisms between facilities, state and national	₦ -	₦ -	₦ -	₦ -	\$ -
Out put 4: Uninterrupted supply of ARVs and other commodities	4.1 Strengthen evidence based forecasting and supply system	₦ 60,125,000.00	₦ 1,416,250.00	₦ 1,984,037.50	₦ 63,525,287.50	\$ 167,171.81
	4.2 Strengthen procurement, storage and distribution mechanism	₦ -	₦ -	₦ -	₦ -	\$ -
	4.3 Leverage existing structure for capacity building on supply chain management system	₦ 24,525,000.00	₦ 25,260,750.00	₦ 26,018,572.50	₦ 75,804,322.50	\$ 199,485.06
	TOTAL BUDGET	₦ 858,376,464.00	₦ 691,707,202.92	₦ 652,255,681.21	₦ 2,202,339,348.13	\$ 5,795,629.86