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UBRAF 2012-2015

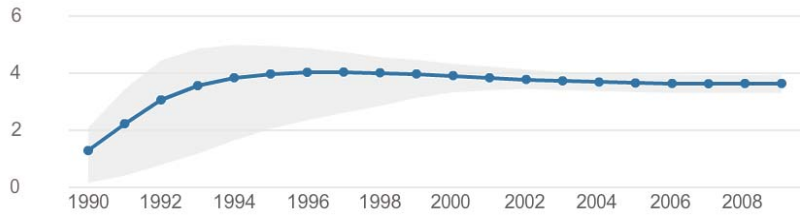
Country Case Study: Nigeria

Key HIV and AIDS information for Nigeria
(Source: ANC Sentinel Study 2010)

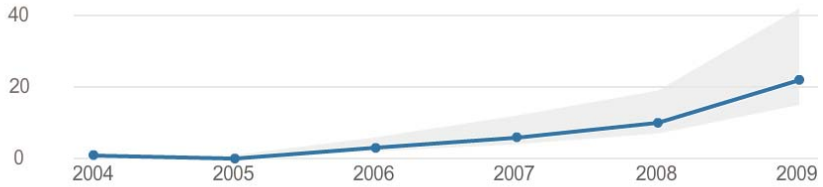
HIV and AIDS Estimates (2010)

- Number of people living with HIV: **3,140,000**
- Adults aged 15 to 49 prevalence rate: **3.42%** (Population Study) **4.1%**
- Adults aged 15 and up living with HIV: **2,810,000**
- Women aged 15 and up living with HIV: **1,660,000**
- Children aged 0 to 14 living with HIV: **321,580**
- Annual Deaths due to AIDS: **215,130**
- Orphans due to AIDS aged 0 to <15 years: **2,229,883**
- Prevalence rate among IDUs : 5.6% (IBBSS 2007)
- Prevalence rate among inmates: 7% and prisons staffs:3.4% – NARHS 2007

HIV prevalence 1990-2008



PMTCT coverage 2004-2009



Funding

- GFATM grants (current): $648,190,063 for HIV
- PEPFAR funds: $17 million annually for PMTCT. For 2010 and 2011 additional 'plus-up funds' of $20 million for each year
- World Bank $225 million (2011 – 2014), $140.3 million (2002 to 2010)
- DFID $160 million 2009 - 2013
- Domestic Funding: 7.6% in 2008 (NASA 2010)

UNAIDS Programme-wide staff capacity in-country 2010

- Full-time staff working on HIV**:** 38 (*UNAIDS Secretariat: 10, UNDP: 3, UNFPA: 1, UNICEF: 7, WHO: 16, World Bank: 1)*
- Part-time staff working on HIV: 9 (UNAIDS Secret.: 1, UNESCO: 1, UNICEF: 1, UNODC: 1, WHO: 2, World Bank: 3)

INTRODUCTION

1. This case study reports on how UNAIDS works together and how it finances its work and activities at country level through the Joint Programme of Support on AIDS (JPS). Its examines how the UNAIDS 2012-2015 Unified Budget, Results and Accountability Framework (UBRAF) will further enhance and refocus the JPS as a programming and coordinating tool to best address the key drivers of the epidemic in Nigeria, with a priority placed on eliminating vertical transmission of HIV.

BACKGROUND

2. Globally, Nigeria has the largest adult and paediatric HIV epidemic after South Africa (UNAIDS, 2008). The most recent population-based survey and antenatal sentinel surveillance report an HIV prevalence of 3.6% and 4.1% (2010) respectively. In 2010, there were about 3.1 million people living with HIV (PLHIV) in Nigeria and nearly 60% of PLHIV are female. The highest HIV prevalence of 5.7% is now found among the 30-34 years age group. The prevalence among the 15-24 years age group (who are considered an index of new infections) has steadily declined from 6% in 2001 to 4.1% in 2010. This may be a result of the impact of the scale up of prevention interventions among young people.

3. The main mode of transmission in Nigeria is heterosexual intercourse, which is estimated to account for over 80% of all infections. The remaining 20% are mainly made up by mother-to-child transmission (MTCT), key populations at higher risk and unsafe blood transfusions. In 2010, the number of pregnant women was estimated to be 6 million in Nigeria. It was also estimated that about 229,480 pregnant women require prevention of mother-to-child transmission of HIV (PMTCT) services to prevent HIV transmission to their children. This number represents 15% of the total number of mothers who need PMTCT in low and middle income countries. Nigeria alone contributes 30% of the global MTCT burden.

4. Other modes of transmission, such as MSM (Men who have Sex with Men) and IDUs (Injecting Drug Users) are also growing in importance. Key drivers of the epidemic in Nigeria include multiple concurrent (hetero-)sexual partnerships; transactional and inter-generational sex; and low levels of knowledge about the risk of unprotected sex. Entrenched gender inequalities and widespread poverty, as well as poor quality of healthcare services, are also key factors in the persistence of HIV in Nigeria. HIV-related stigma and discrimination constitute a major obstacle to testing and counselling and the provision of AIDS treatment and care. The key populations at higher risk include female sex workers, young people, as well as MSM and IDUs. However, the Modes of transmission modelling (2008) found that the majority of new infections are occurring among the general population.

5. Nigeria has developed the second National HIV/AIDS Strategic Framework and Plan (NSF/P) 2010-2015. The overarching priority of the National Strategic Plan (NSP) is to reposition prevention of new infections as the centrepiece of the national HIV and AIDS response. The comprehensive multisectoral plan is made up of a number of intervention programs broadly clustered around complementary thematic areas (behaviour-change and prevention of new infections, treatment, care and support, human rights, policy and advocacy). Apart from the NSP, 34 state-level strategic plans, 5 network-plans and 19 government / ministries / departments / agencies' plans have been developed. State operational plans have also been developed.

6. The National PMTCT Scale up Plan 2010-2015 has also been developed with clear incremental targets and strategies based on decentralization and service integration at Primary Health Care levels for the elimination of mother to Child Transmission of HIV in the country. It is important to note that Nigeria is committed to the Elimination of MTCT agenda which is reflected in the targets of the Scale up Plan.

JOINT TEAM AND JOINT PROGRAMME OF SUPPORT ON AIDS

7. The establishment of the Joint UN Team on AIDS (JUNTA) in 2006 and the implementation of a JPS since 2007 have provided an effective framework and mechanism for coordination of the contributions from UN agencies to the national AIDS response[1]. This coordination arrangement emerged as part of the wider UN reform agenda to get UN agencies at the country level to "Deliver as One". It also constitutes a framework for mobilizing, packaging and delivering overall UN system support collectively. The JUNTA is comprised of approximately 47 focal points that meet monthly under the leadership of the UNAIDS Country Coordinator (UCC).

8. The JPS in Nigeria is developed through a highly consultative and participatory process with Federal and State government partners, civil society, the business community and all cosponsor agencies. Individual agencies and States incorporate the JPS into their workplans. The present JPS is aligned with the 2010-2015 National Strategic Framework (NSF). For the development of all the Annual Work-Plans (AWPs) of the JPS including the 2011 and 2011/2012 biennial plans, national partners from the 10+1 priority states, including civil society, identified priorities and needs based on their respective states' strategic frameworks for support from the UN system. This 'bottom-up' approach ensures ownership of the process by state actors and the UN System's commitment to decentralization and alignment of support with national needs at all levels. The JUNTA also organizes retreats with all partners to review progress on the implementation of the JPS, identify key challenges and further redefine the implementation strategies. This review process builds synergy, trust, relevance and national ownership.

9. The achievements of the JUNTA in supporting and adding value to the national response on AIDS in Nigeria are appreciable, and reflect the commitment of a strong and accountable UNCT leadership on AIDS spearheaded by the UN Resident Coordinator and the UNAIDS Country Coordinator, supported by the various heads of UN agencies and colleagues designated to serve on the JUNTA. The JPS is now in its third biennial sequence (2007-2008, 2009-2010, and 2011-2012) and has been effective at ensuring coherence of the different agencies' inputs and relevance to the national response in terms of alignment with country objectives and priorities on AIDS as expressed in the 2010-2015 National Strategic Framework on AIDS (NSF) and the UN Development Assistance Framework (UNDAF). The JPS is based on the inputs from the different UN agencies in the country, in accordance with the country-level adaptation of the UNAIDS Division of Labour, which reflects a combination of global mandates and local capacities. It should also be noted, that the Cosponsors' regional offices play an important role in supporting the implementation of the JPS. The UN is – by comparison - not a major source of funding and hence its strategic importance and added-value is in the area of in policy setting and technical support, bringing together the comparative advantages of each agency as reflected in the new UNAIDS Division of Labour.

[1] The members of the JUNTA include the UNAIDS Secretariat and 10 Cosponsors (ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, WFP, WHO and the World Bank) – as well as IOM and UN Women.

FUNDING MECHANISMS

10. Although funding for the national response in Nigeria has increased steadily since 1999 as a result of increased political commitment from the government, the 2007/2008 NASA showed that public funding of the response dropped from 14.6% in 2007 to 7.6% in 2008. External financing sources accounted for 85.4% of all HIV expenditure in 2007 and increased to 92.35% in 2008. These external financing sources include PEPFAR, the Global Fund, the World Bank, bilateral donors and the UN system. The World Bank is currently about to start disbursing a new US$ 225 million credit to the government for a second HIV/AIDS programme development project over a 5-year period (2011-2014). Since the beginning of PEPFAR in 2004, the US has committed more than US$ 1.5 billion to Nigeria's national AIDS response for prevention, treatment and care interventions as well as support for health system strengthening. PEPFAR supports the country with US$ 17 million annually for PMTCT and additional "plus up funds" of US$ 20 million each in 2010 and 2011. The UK Department for International Development provided $35 million between 2003 and 2010, and is now implementing a $160 million follow on project. Global Fund grants to Nigeria between 2003 and 2008 totalled US$ 84.6 million to assist persons with ART, pregnant mothers with PMTCT treatment, and people with HIV counselling and testing.

11. Excluding the World Bank, the UN system as a group (mainly UNICEF, WHO, UNDP, UNAIDS Secretariat and UNFPA) has spent nearly US$ 20 million since 2001 on HIV and AIDS, and is expected to spend over US$ 11 million between 2009 and 2012 within the framework of the UN Joint Programme of Support on AIDS (JPS). During the same period the World Bank provided a credit of $140.3 million to the country for the first HIV/AIDS Programme Development Project.

12. The total UBW budget for Nigeria in 2010 was US$ 2,373,015. Examples of UBW-funded inter-agency activities during 2010 include:

- UNICEF assisted Nigeria in addressing procurement and supply management issues, collaborating with PEPFAR, CHAI and other partners to identify and address implementation bottlenecks. Technical support was provided for adoption and adaptation of revised international guidelines for paediatric HIV treatment.

- UNDP provided support to the national network of people living with HIV and other non-governmental organisations to strengthen their leadership, advocacy and coordination role. Support was provided to national authorities for the development of the second National HIV/AIDS Strategic Framework and other national and state strategic plans and policies, including policies that address gender-based violence, promote gender equality, and increase the engagement of men and boys. Assistance to Nigeria focused on integration of HIV into the Poverty Reduction Strategy Paper and project management and coordination of the AIDS response at national and state level.

- UNFPA sponsored a consultation (attended by Nigerian representatives) on the implementation of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages.

- UNODC provided technical assistance to Nigeria to develop costed national strategies and action plans to address the needs of people who inject drugs, people in prison, and people vulnerable to human trafficking. Specific support was provided for resource mobilization

and the development of programmatic tools, guidelines and best practices for people vulnerable to human trafficking.

- ILO trained Labour Ministry staff in HIV-related workplace policies and programming. Training support was also provided to HIV focal points among employers' and workers' organisations, as well as to factory inspectors. Specific support was provided to national authorities with respect to the access to justice of people living with HIV.

- WHO provided normative guidance, strategic information, and capacity-building tools. Service coverage and utilization data from Nigeria were reported to WHO and incorporated in the 2010 Towards Universal Access report.

- Under the leadership of the government, and in partnership with DFID, Global Fund, USG and the UN Joint team, the World Bank is delivering a technical support package to improve the efficiency and effectiveness of HIV prevention in Nigeria. The package of support is sub-divided into six areas: (**1**) Collecting and categorizing existing HIV-related research and data in Nigeria, (**2**) Developing policy briefs for HIV prevention prioritisation, (**3**) Developing a Strategy, Study Designs and Cost Estimates for Most-At-Risk-Population Surveillance, (**4**) Modelling impact of HIV interventions and cost effectiveness (including Public Expenditure Tracking Surveys for HIV/AIDS as part of existing Public Expenditure Reviews). (**5**) Impact evaluation framework and implementation of an HIV prevention program science approach in some States, and (**6**) Impact evaluation of the community response to HIV and AIDS: Financed jointly with DFID, the World Bank supported the evaluation of the community response to examine the impact high level of CBO engagement on HIV/AIDS-related outcomes, including knowledge, awareness, behavior, and social transformation. The findings of this evaluation will inform the new World Bank project.

- UNESCO documented and published the Nigerian experience as part of a set of case studies on sexuality education entitled 'Levers of Success', and subsequently supported a costing study on the Family Life and HIV Education (FLHE) Programme in Lagos State as part of a six-country international study on the cost and cost-effectiveness of comprehensive sexuality education programmes. The economic data and research instruments designed for the costing study, as well as the documentation of good practice in this area, can be used as important tools for governments and other stakeholders to plan, budget and mobilize resources for the scale-up of school-based HIV prevention and sexuality education programmes in the country.

- The UNAIDS Secretariat provided ongoing technical support to national authorities, including oversight of the UN Joint Programme of Support. UNAIDS also coordinated the UN's support to the development of the national AIDS Policy and the National Strategic Framework/Plan. Assistance was provided for the development of the country progress report in 2010 and in making epidemiological estimates.

13. In general, funding for implementing the JPS is ad-hoc and mainly through parallel financing, with individual agencies responsible for initiating and implementing activities in their Annual Work Plans (these are comprised of prioritized activities from the 10+1 JUNTA States and individual agency mandates) and managing resources from their budgets. Cosponsors' funding sent to and managed by the UCO is *"pooled"* for 'UN Cares' activities and 2 inter-agency cost-shared positions *(UN joint programme consultant and UN care facilitator)* serving

all agencies and based in the UCO. Often, funding is channelled to NACA, FMOH etc. for the implementation of centralized activities.

14. The Development Partners Group on HIV in Nigeria made some attempts to finalize a joint financing arrangement (JFA) to pool donor funding for more harmonized support to NACA; if concluded money from this arrangement will not directly fund the JPS but will contribute to scaling up universal access to prevention, treatment, care and support.

PMTCT – KEY ACHIEVEMENTS AND CHALLENGES

15. Key achievements of the JPS in support of the national scale-up of PMTCT services are:

- Several high level advocacy visits to the leadership of the Federal Government of Nigeria were conducted by the UN and US Government /OGAC leadership in support of scaling-up HIV programmes and PMTCT in particular. Nigeria is one of the countries benefitting from additional 'Plus up' funding for PMTCT over and beyond existing PEPFAR financing. The UN and the US Government have instituted joint coordinating meetings to ensure synergy and prevent duplication of activities.
- The National PMTCT Scale up Plan 2010-2015 and the two-year operational plan (2010-2011) have been developed and the JPS provided both technical and financial support.
- National reviews and the adaptation of the WHO 2010 guidelines were completed for PMTCT, HIV and infant & young child feeding, as well as for Paediatric treatment.
- States are also being supported to build up M&E capacity. State Government teams and M&E TWG were trained on data quality assurance (DQA) and DHIS/NNRIMS, facilitated by NACA.
- The UN supported the reprogramming of Global Fund Round 9 resources to scale up PMTCT services. These funds have been approved and the grant has been signed.

16. Key challenges facing the Scale up of PMTCT services to eliminate paediatric HIV include:

- Inequitable geographical distribution of services and slow expansion of services due to poor coordination and inadequate number of trained health workers to provide services;
- Inadequate participation of the private sector where many pregnant women are seen;
- Weak procurement and supply management systems;
- Poor coordination of all partners working on PMTCT; and
- Weak monitoring and evaluation systems and mentoring to improve quality of services.

17. To address these challenges, first and foremost, Nigeria has committed itself to the agenda for eliminating new born HIV infections. Following GF-UN Regional Consultation in May 2010, the country delegation made a decision to scale up PMTCT coverage targets from 80% by 2015 to 90%. This is reflected in the National PMTCT scale up plan 2010-2015. In addition, Nigeria participated in the November 2010 Global technical consultation on the elimination of MTCT where the Nigeria modelling was clarified.

18. A strong team from Nigeria participated in the Regional Consultation meeting in Dakar on the Elimination of MTCT in April 2011. A country Action Plan for elimination was developed and a

national consultation is planned for May 2011 which is expected to increase political commitment, leadership and leverage resources for the elimination agenda. There are also a number of policy changes that have been made to achieve the elimination of MTCT in the country. These include – the new National PMTCT guidelines which incorporate the new WHO guidelines on PMTCT, the National RH/HIV integration guidelines and the National Integrated Maternal Newborn and Health Strategy (IMNCH). There is also the infant feeding policy for HIV exposed babies which recommends breastfeeding for 12 months with ARV cover for infant or mother.

19. The country has also adapted a strategy for the decentralization and integration of services at the Primary Health Care levels to ensure increased access to PMTCT services. The National Health Sector Development Plan has clearly spelt out targets towards the elimination of MTCT which is in line with targets of the Scale up plan. There are also targets to reduce the unmet need for family planning, increase coverage of Antenatal Care and increase the number of skilled attendance at health facilities. This is being implemented through the Midwife Service Scheme (MSS) funded by the MDG office.

20. The key lessons learnt from the experiences of the country so far in implementing PMTCT services are:

- The country will only achieve the elimination of MTCT if it strengthens the health system which is the vehicle for carrying health care services including PMTCT.
- The high number of women who attend at least one ANC visit is an opportunity to provide PMTCT services to at least 58% of women in Nigeria. This target can be achieved almost immediately by ensuring that all centres providing ANC integrate PMTCT into their existing services.
- PMTCT services will only be successfully delivered and elimination achieved if services are integrated into existing health care programs at PHC levels.
- Community involvement in creating demand and the sustainability of services is key to the success of the elimination agenda.

21. All the above mentioned measures to address the poor access to PMTCT services are captured in the JPS and will be addressed through the UBRAF.

JOINT PROGRAMME OF SUPPORT AND UBRAF

22. The Joint Programme of Support has been a strong tool in coordinating cosponsor activities around collective key results for HIV, which in Nigeria includes a big emphasis on PMTCT related interventions. Indeed, the government and partners (UN and others) realise that the attainment of the global strategic goal of virtually eliminating vertical transmission requires significant efforts to scale up PMTCT in Nigeria. The JPS has also been a powerful tool in the mobilization and strategic allocation of resources for this joint work. This process will be further enhanced from 2012 onwards with the country-level application of the UNAIDS Unified Budget Results and Accountability Framework (UBRAF), which will strengthen the prioritization and resource allocation process in line with UNAIDS strategic directions and goals and will also help the Joint Team to build an even more robust monitoring and evaluation framework to measure outcomes and identify bottlenecks and opportunities.

23. Furthermore, the UBRAF will help to address some of the key constraints encountered in the past. In particular, it will contribute to developing and strengthening a unified framework to

capture and report under the JPS, all UN support to the national response on AIDS, increase resources through more funding for the JPS and UCO for implementing key strategic activities including coordination at national and sub-national levels.

24. It is crucial to keep in mind that “Delivering As One” on HIV and AIDS in Nigeria by an Abuja-based ‘centralized’ JUNTA remains a formidable challenge, in view of the vastness and the decentralized administrative structure of the country as well as the need for further strengthening coordination at national and state levels overall. Funds from the UBRAF will be catalytic resources, and sustained advocacy efforts with the government will be maintained for increased national funding for HIV. Mapping of, and collaborating with, donor and partners, including training institutions with an established capacity structure, will be important to meet the identified capacity gaps.

25. Finally, the UBRAF will constitute a solid instrument for financing joint UN work on AIDS at country level. The UBRAF is perceived as a powerful planning tool which, with a JPS based on a robust results framework and the new Division of Labour, will enhance accountability among cosponsors and contribute to an effective UN contribution to the country-level AIDS response.

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