2009 - 2014

Enhancing Nigeria's Response to HIV&AIDS Programme

Final Report

2014

Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Clinic
ART	Antiretroviral therapy
BBC-MA	BBC Media Action
CHEW	Community Health Extension Workers
CSO	Civil Society Organisation
DFID	Department for International Development
DHIS	District Health Information System
ENR	Enhancing Nigeria's Response to HIV&AIDS Programme
ERPS	Epidemiology and Response Policy Synthesis
FLHE	Family Life Health Education
FOSY	Female Out of School Youth
FRA	Fiduciary Risk Assessment
FAD	Finance & Accounts Department
GF	Global Fund
GoN	Government of Nigeria
GRIPP	Getting Research into Policy and Practice
HAF	HIV&AIDS Fund
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPDP	HIV&AIDS Project Development Programme
IEC	Information Education and Communication
IPC	Interpersonal Communication conductor (Agent)
IPs	Implementing Partners
JFA	Joint Financing Arrangement
LACA	Local Action Committee for HIV and AIDS
IRB	Institutional Review Board
IBBSS	Integrated Bio-Behavioural Surveillance Survey
FIDA	International Federation of Female Lawyers
JAR	Joint Annual Review
JFA	Joint Financing Assessment
LOP	Life of Project
LGA	Local Government Area
LQAs	Lot Quality Assurance Sampling
MAP	Measuring Access and Performance
MARPS	Most At Risk Population
MPPI	Minimum Preventive Package Intervention
MDA	Ministry Departments and Agencies
MNCH	Maternal, Newborn and Child Health

MoE	Ministry of Education
MoEd	Ministry of Education
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoWA	Ministries of Women's Affairs
MOT	Mode of Transmission
M& E	Monitoring and Evaluation
MARPS	Most At Risk Population
MTR	Mid-Term Review
MTSS	Medium term Sector Strategy
MSH	Management Science for Health
MTSS	Medium term Sector Strategy
MSM	Men who have Sex with Men
NACA	National Agency for the Control of AIDS
NASACA	Nasarawa State Agency for the Control of AIDS
NHOCAT	National Harmonized Organisational Capacity Assessment Tool
NARHS	National HIV&AIDS and Reproductive Health Survey
NHRC	National HIV&AIDS Resource Centre
NJAR	National Joint Annual Review
NJAR	National Joint Annual Review
NNRIMS	National Nigeria Response Information System
NSP	National Strategic Plan
NEPWHAN	Network of Persons Living with HIV&AIDS in Nigeria
OCAT	Organisation Capacity Assessment Tool
OPR	Output to Purpose Review
OSY	Out of School Young People
PADEF	Partnership Assessment and Development Framework
PATHS 2	Partnerships for Transforming Health System 2
PEP	Peer Education Program
PEPFAR	President’s Emergency Plan for AIDS Relief
PLHIV	Person Living with HIV
PCRP	Presidential Comprehensive Response Plan
PMTCT	Prevention of Mother To Child Transmission
PHC	Primary Health Care
PLACE	Priority for Local AIDS Control Efforts
PSRHH	Promoting Sexual Reproductive Health and HIV
STI	Sexually Transmitted Disease
STTA	Short Term Technical Assistance
SFH	Society for Family Health
SPARC	State Partnership for Accountability, Responsiveness and Capability

SRH	Sexual and Reproductive Health
STAR	Society Tackling AIDS through Rights
SOP	Standard Operating Procedure
SACA	State Agency for The Control of AIDS
SASCP	State AIDS and STI Control Programme
SASA	State AIDS Spending Assessment
SHARHS	State HIV&AIDS and Reproductive Health Survey
SMOH	State ministry of Education
SMoA	State Ministry of Health
SSP	State Strategic Plan
SUOP	State Unified Operation Plan
TOC	Theory of Change
TA	Technical Assistance
TWG	Technical Working Group
TOR	Term of Reference
UOP	Unified Operational Programs
UNAIDS	United Nations Joint programme on HIV&AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UAFC	Universal Access to Female Condoms
VFM	Value for Money
WB	World Bank

Foreword

The United Kingdom Department for International Development (DFID) supported Enhancing Nigeria's Response to HIV&AIDS (ENR) programme is pleased to share this report that summarises the results, lesson learnt and outlines select innovation of the programme over the last six years. All programme objectives and outcome were exceeded. Comprehensive HIV knowledge increased from 35% for male and 23% for females as at 2007 to 45% for males and 38% for females by 2014. The Proportion of people who received HIV counselling and testing (HCT) and received results increased from 13% to 50% for female and from 15% to 44% for males between 2007 and 2014. At the end of the programme all 7 states with anti-stigma and discrimination laws in Nigeria were all ENR states. Quality of available data, particularly state level data and its use in decision making also increased significantly during the programme.

ENR distributed 1.2 billion male and 4.0 million female condoms in the six years, expanded access to condoms in the rural areas from 50% in 2007 to 90% as at end of 2014, in this way ensuring that Condom use increased with 69% of men and 56% of women having used a condom in last risk sex in ENR states in 2014 up from 56% for male and 40% for female in 2007. These condoms, with the associated health promotion and increased use prevented an estimated 109,364 new HIV infections, provided 8,400,000 couple years of contraceptive protection, averted 2,500,000 unintended pregnancies, preventing 10,000 maternal deaths and averted 10 million disability adjusted life years (DALYs).

This report focuses on detailing the results achieved in the six years and highlights only a few of the approaches, methods and processes used in delivering the three objectives of the programme. The reader is referred to a wide variety of supporting materials (technical briefs, factsheets, manuals, journal articles, flipcharts and "how to guide"). These are available for the National HIV&AIDS Resource Centre at the National Agency for the Control of AIDs office in Abuja or available online at www.nhrc.org

ENR was implemented by a consortium comprising the Society for Family Health (SFH) as Managing Agent; ActionAid Nigeria, BBC WST, Population Services International (PSI), Options Consultancy Services, Benguela Health Pty, Population Council and Crown Agents for procurement and implemented as both a National programme (Federal component and a National Social Marketing element) and as a state programme across the following eight states of Akwa Ibom, Benue, Cross River, Enugu, Kaduna, Lagos, Nasarawa and Ogun states.

This report is presented in five key areas:

1. Provides an overview to HIV&AIDs in Nigeria, the ENR programme and performance against the programme outcomes and Impact Indicators.
2. Strengthening federal and state government stewardship for sustainable and effective multi-sectoral and evidence -informed HIV prevention response.
3. Generating and using evidence for decision making.
4. Strengthening the Institutional and technical capacity of civil society to engage in HIV and AIDS prevention and care and support interventions.
5. Improving knowledge, changing attitudes and ensuring availability of commodities for effective HIV&AIDS prevention.

Sir Bright Ekweremadu
Team leader

Dr. Omokhudu Idogho
Programme Director

1. Overview

1.1 HIV&AIDS in Nigeria

In 2007 when the Enhancing Nigeria's Response to HIV&AIDS (ENR) programme was designed, HIV prevalence was 3.6% among the general population with an estimated 3.9 million people living with HIV. The North Central states of Benue, Nasarawa, FCT and South –South states of Cross River and Akwa Ibom were the epicenter of the epidemic.

Sexual transmission particularly heterosexual transmission comprise the major risk factor for most Nigerians, with increasing cases among men who have sex with men and injecting drug users. Mother-to-child transmission and transfusion of infected blood and use of infected sharp objects contributes to the balance of new infection. Access to services and treatment was very low with only 9% of men and women of reproductive age having taken a HIV test and received results and only 17% of PLHIV were on antiretroviral therapy. Condom use in last risk sex was 48% (56% for males and 40% for females). The Institutional arrangements for the HIV&AIDS response were at its infancy as they were all transiting from committees to statutory agencies, planning and coordination was very weak and the sector driven mainly by donor funding.

As the ENR programme winds down, 2013 HIV prevalence among general population has stabilised to 3.4% with an estimated 3.2 million people living with HIV. Twelve-plus-one (12 + 1) states (Kaduna, Akwa Ibom, Lagos, Kano, Oyo, Benue, Rivers, Sokoto, FCT, Taraba, Nasarawa, Imo and Cross River) now accounts for about 70% of Nigeria HIV burden with Rivers, Oyo, Imo and Sokoto states being the new addition to the original 6 high prevalence states of Akwa Ibom, Benue, Cross River, Kaduna, Lagos and Nasarawa**.** Access to services and treatment has improved compared to 2008 with about 17% of the population having taken a HIV test and collected result and 20% of eligible population on antiretroviral treatment as at 2012. These levels of service coverage suggest that there is still a lot of work to do in expanding access to services. Condom use among female sex workers with clients is in the 90% range but remain low at around 50% with boyfriends. The policy environment, including the quality of planning coupled with availability of data has improved with a National HIV&AIDS Policy, National Strategic Plan and states equivalent available and being used in the National HIV&AIDS Response. Coordination of partners and increasing financing by the government can also be seen in the last six years albeit still less than 30% of total funding required for the sector.

1.2 The Enhancing Nigeria's Response to HIV&AIDS Programme

The Enhancing Nigeria's Response to HIV&AIDS was an innovative six year, integrated HIV prevention and institutional strengthening programme, implemented nationally (working with the National Agency for the Control of AIDS and Federal Ministries of Health, Education and Women Affairs; and the National Commodity Social Marketing component), and across eight states. Designed in 2007, the programme which started in January 2009 builds on two previous United Kingdom's Department for International Development (DFID) programmes, the Promoting Sexual Reproductive Health and HIV Reduction (PSRHH); and the Strengthening Nigeria's Response to HIV&AIDS (SNR) programmes.

The goal of the programme which ended in December 2014 was to contribute to Nigeria's achievement of the Millennium Development Goal 6 by reducing the spread of HIV epidemic and mitigating the impact of AIDS. The expected Outcome of the programme was to improve access of those most vulnerable to infection to effective HIV & AIDS prevention, treatment, care and support information and services. To achieve this Outcome, the programme delivered the following three Objectives at the federal level and with the State Agencies for Control of AIDS (SACAs), in eight states. These are:

1. Strengthening stewardship for sustainable and effective multi-sectoral and evidence-informed HIV prevention response by federal and state government;
2. Improving the institutional and technical capacity of civil society to engage in HIV & AIDS prevention, care and support interventions;
3. Improving knowledge, changing attitudes and availability of commodities conducive to safer practices for effective HIV prevention.

The eight ENR states outlined in the table below is home to about a quarter of Nigerians as at the midpoint of the project in 2012, and account for about 50% of new HIV infection in the country. The programme was implemented by a consortium comprising the Society for Family Health (SFH) as Managing Agent; ActionAid Nigeria, BBC WST, Population Services International (PSI), Options Consultancy Services, Benguela Health Pty, Population Council and Crown Agents. The final total programme budget was £118 million made up of £68m programme cost and £50m procurement budget. Expenditure of £64.5m was expended on project cost and £46.2m for procurement making a total of £110.7 million spent at end of the project. Out of the total budget, £18m was generated from social marketing of commodities. Key cost drivers in the programme were directed towards technical assistance to strengthen government of Nigeria at federal and the eight states; ensuring commodities (condoms and lubricants) security and expanded use of evidence in decision making.

Table 1

	State	Population
1	Akwa Ibom	4,754,603
2	Benue	5,080,479
3	Calabar	3,438,043
4	Enugu	3,903,088
5	Lagos	10,994,357
6	Kaduna	7,301,781
7	Nasarawa	2,232,713
8	Ogun	4,547,975
	Total	**42,253,039**

ENR programme theory of change was based on a dual track HIV Prevention and Institutional Development Framework with the aim of averting new HIV infections. ENR works with government and civil society to develop the capacity of critical institutions to deliver their core mandates and to implement direct HIV prevention interventions and contribute to reducing HIV infection rates. The public sector strengthening strands is also to facilitate the generation of the evidence required to inform policy and practice. The second strand is focused on direct HIV prevention and service delivery intervention in communities as a direct response to the epidemic but also to generate, and to ensure rapid skills transfer on what works in prevention to both government and to CSOs. While the former, described as the indirect strand as it operates through government, had a medium to longer gestation period to deliver results, it however ensures wider coverage using public sector resources and guarantees long term sustainability. The latter had a more direct impact on the epidemic and in combining both the ToC allows for effective intervention that is at scale and sustainable on the longer term. Gender lens are used both in the institutional development as well as the direct HIV prevention intervention to design, implementation and in measuring results.

The ENR programme was designed to be a catalytic prevention programme which assumed that other implementing partners' interventions will complement ENR interventions, including the assumption that US$225 million from the World Bank's HIV & AIDS Project Development Programme (HPDP) 2 will be available by 2010 to the government of Nigeria (GoN) for HIV & AIDS control. Unfortunately this assumption did not hold true until the very last year (2014) of the programme. This led to increased emphasis being placed on the direct level interventions carried out in the states to ensure that behaviour change communications interventions were carried out to generate the desired improvements in knowledge, attitudes and behaviour.

1.3 Summary of Impact of the ENR Programme

The overall aim of the ENR programme was to increase access of the most vulnerable to effective HIV & AIDS prevention, treatment, care and support information and services. The programme implemented strategies across three objectives. The first objective was aimed at improved governance and strengthened Institutional capacity of government for planning, coordination, reporting, and resource mobilisation. Other areas covered include better use of evidence to track the epidemic and in programmatic and allocative decision making. The second objective was strengthened civil society organisations delivering more effective interventions at the frontline of the AIDS response and also as advocates for an enabling environment for effective HIV&AIDS response. The third objective implemented two major strategies for reducing HIV transmission, the first being actions to improve people knowledge of their HIV status, which would in turn lead to appropriate decision making depending on HIV status, including reducing partners, using a condom and taking up services, and secondly expanding access to services including HIV counselling and testing, PMTCT and condoms. Summary of achievements at the end of programme is itemised below.

1.3.1 Uptake of HIV counselling & testing services in ENR states.

The programme exceeded its completion target as the percentage of males and females aged 15 – 49 years who received HIV counselling and testing and got results increased from the baseline of 13% female and 15% males to 50% (females) and 44% (males).

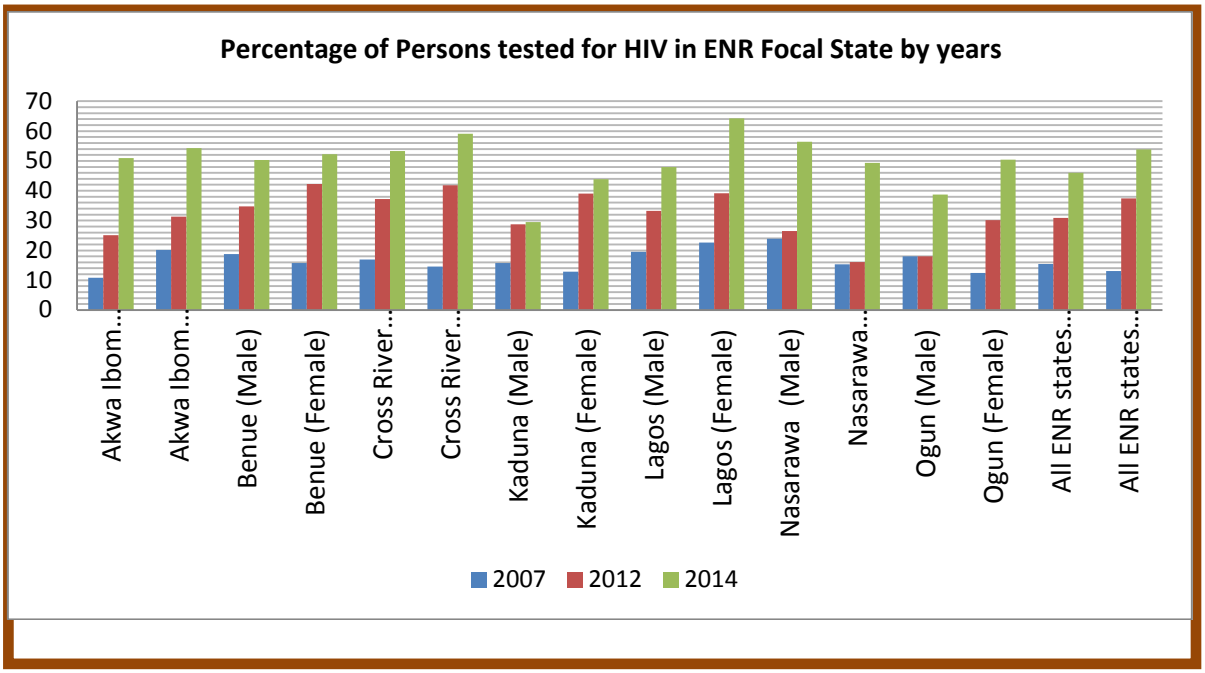
Table *2*: Percentage of males and females aged 15-49 years who received HIV counselling & testing and got results in ENR states.

	Baseline (2007)	2012 NARHS	Target (2014)	2014 SHARHS
Females	13%	37.4%	18%	49.5%
Males	15%	30.9%	20%	43.7%

A breakdown of the HCT utilisation by state in table below shows that there were significant increases in all ENR focal states between 2007 and 2014. In most states the 2014 figures was higher for females than males.

The reasons for the considerable increase in the figures can be explained by the increased mobilisation of resources from partners, the improved coordination of activities by government authorities and increased demand creation activities. All these were supported by ENR. The development of the Strategic plans at State and National level mobilised services to communities and funding from partners, the support for the various technical working groups led to improved coordination, and the demand creation was largely orchestrated by the Programme in the states working with both government authorities, civil society and other partners.

Figure 1: Percentage of persons tested for HIV in ENR state by years



These percentages are further collaborated in reviewing actual numbers of persons tested using figures obtained from routine data. While 960,000 were tested for HIV in the ENR focal states in the whole of 2013, 920,000 persons have already been tested in the first half of 2014. (See table below). Although the changes are remarkable, these would have been better but for occurrences of stock-outs that occurred in 2014.This led to missed opportunities to provide HCT services. It is therefore important that as demand creation efforts expand, government works to ensure availability of promoted services. In addition to demand creation activities, provision of HCT kits, supporting joint working of state stakeholders in the testing effort, ENR also trained a number of HCT counsellors and testers to improve linkages between the health promotion work and access to HCT services.

Table 3: Comparison of number of persons tested for HIV and received their results (2013 and first half of 2014) by State

Indicators	Total no of individuals HIV counselled & test received result Q1-Q 4 (2013)			Total no of individuals HIV counselled & test received result Q1-Q 2 (2014)		
	All	Female	Male	All	Female	Male
Benue	172,974	78,219.00	94,755.00	208,042	111,537	96,505
Nasarawa	84,702	46,293.00	38,409.00	135,053	69,806	65,247
Cross River	128,627	72,930.00	55,697.00	69,335	34,475	34,860
Akwa Ibom	64,777	44,602.00	20,175.00	89,523	56,021	33,502
Enugu	108,007	66,977.00	41,030.00	111,576	67,672	43,904
Lagos	156,345	75,725.00	80,620.00	186,608	95,006.00	91,602
Ogun	95,625	59,711.00	35,914.00	70,925	27,223	43,702
Kaduna	156,034	72,135.34	83,898.66	50,686	25,053	25,633
Total	967,091	516,592	450,499	921,748	486,793	434,955

Data Source: National Validated data NACA and LSACA

1.3.2 Access of the population to condoms across Nigeria

This indicator measures access to condoms by determining the percentage of communities in the ENR focal states where condoms may be obtained if desired. The Measuring Access to Performance (MAP) survey used the Lot Quality Assurance Sampling (LQAS) to track this indicator. Three MAP surveys conducted during the Life of Project (LOP) revealed improvements and by 2013, the programme target had been achieved.

Table *4*: Percentage of the population with access to condoms.

	Baseline (2007)	MAP Survey (2011)	Target (2014)	MAP Survey (2013)
Urban:	**95%**	95%	95%	95%
Rural:	50%	70%	65%	90%

A state by state analysis is presented below in table 5. The increase in rural areas was achieved by opening and expanding the number of new outlets in rural areas. The new outlets included traditional outlets such as pharmacies, chemists, supermarkets and clinics; as well as non-traditional outlets such as hotels, brothels, hawkers, street vendors and local garages. The establishment of further outlets was linked to the Community based HIV&AIDS Interpersonal Communication (C-HIPC) work being conducted by the C-HIPC agents. NARHS 2012 and SHARHS 2014 further confirm this numbers as it revealed that in rural areas of the country, 75.4% of persons considered condoms to be accessible while 67% of persons considered them to be affordable as at 2014.

	2009		2011		2013	
State	Urban	Rural	Urban	Rural	Urban	Rural
Akwa-Ibom	95%	90%	95%	95%	95%	95%
Benue	95%	70%	95%	60%	95%	85%
Cross River	95%	70%	95%	95%	95%	90%
Kaduna	95%	70%	95%	80%	95%	85%
Lagos	95%	95%	95%	95%	95%	95%
Nasarawa	95%	95%	95%	95%	95%	95%
Ogun	95%	95%	95%	95%	95%	95%
ENR			95%	84%	95%	91%

Table 5: Comparison between Scores for MAP Surveys conducted in 2009, 2011 and 2013
Source: MAP Survey report 2011[1]& Preliminary Analysis of MAP 2013

[1] Measuring Access and Performance Report 2011, Society for Family Health

1.3.3 Condom use at last high risk sex

The whole aim of condom programming, as part of the National HIV Prevention Minimum Package is to ensure that all high-risk sex is protected. In Nigeria, the definition of high risk is any sex act that occurs between non-marital, non-cohabiting partners. The programme significantly exceeded the completion target of 65% (males) and 50% (females). The Indicator increased from 56% (males) and 40% (females) in 2007 to 69% (males) and 56% (females).

Table *6*: Percentage of males and females aged 15-49 years involved in high risk sex who used condoms in last risk sex in ENR states

	Baseline (2007)	SHARHS 2011	NARHS 2012	Target (2014)	2014 Achievement (SHARHS 2014)
Males	56%	68.8%	65.7%	65.0%	69.0%
Females	40%	55.4%	49.1%	50.0%	56.1%

1.3.4 Impact on Prevalence

The goal of the ENR programme was to contribute to the reduction in HIV prevalence in the country. While prevalence is often not a good measure of HIV prevention work particularly in the context of improvement in treatment programmes, the lack of Incidence studies in Nigeria necessitated that prevalence be used as measure of the impact of the programme. Data from the antenatal HIV seroprevalence survey showed a drop from 4.6% in 2008 to 4.1% in 2010 in HIV prevalence among pregnant women attending antenatal clinics. General population prevalence as measured by National HIV&AIDS and Reproductive Health Survey shows a small but significant drop of General Population prevalence from 3.6% in 2007 to 3.4% in 2013.

1.4 Value for Money Analysis

Value for Money (VFM) was an integral part of the ENR strategic framework, with the programme developing a full VFM framework in 2011 with eight indicators and eight sets of evidences for tracking VFM performance. Assessment against this framework and other international benchmark indicates strong evidence to show ENR is good value for money.

At the level of cost effectiveness the use of the 1.2billion male and 4.0 million female condoms and the associated health promotion between 2009 and 2014 provided 8,400,000 couple years of contraceptive protection, averted 2,500,000 unintended pregnancies, prevented 109,364 new HIV infections, prevented 10,000 maternal deaths and averted 10 million disability adjusted life years (DALYs). At the cost of $16 per DALY averted compared to International bench mark of US$19 to US$205 per DALY averted), ENR was not only cost effective but very efficient in resource use.

The funding arrangement for ENR was based on a grant from DFID and income generated by the programme. As a result, for every £1 invested by DFID, £1.18 is available to the programme. This would infer that more value for money is being realised based on the design alone. Of this, £1.18, only £0.10 (8%) is spent on overheads. This is low compared to other DFID funded projects. The

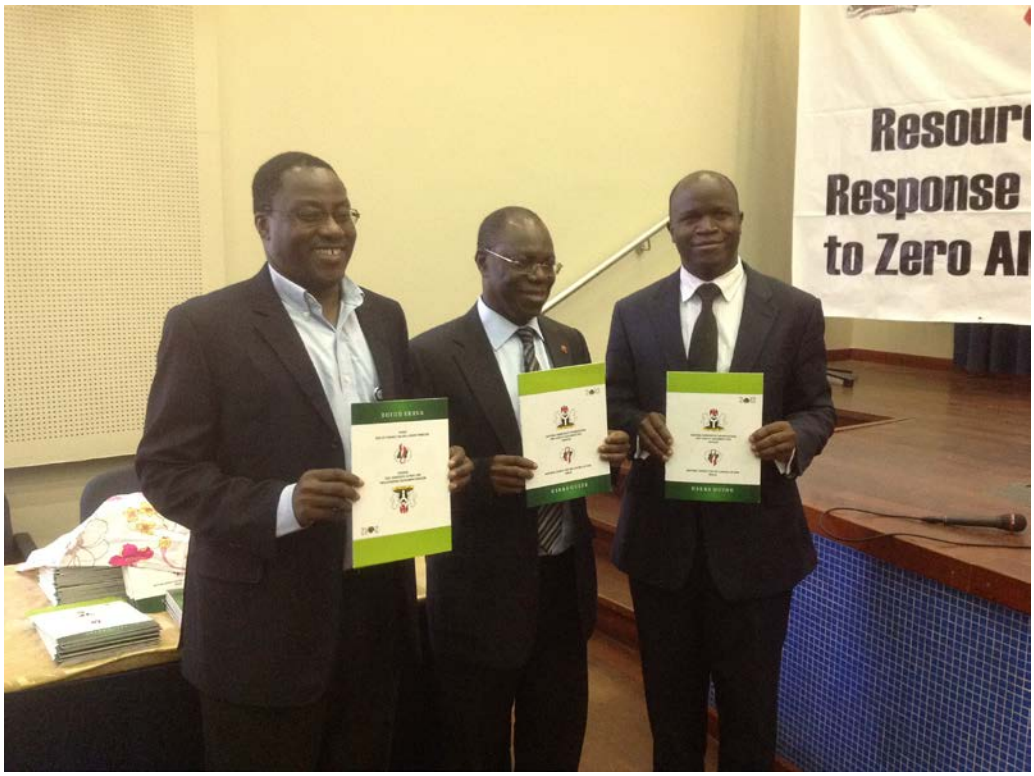
budget actually projected 15% compared to actual expenditure of only 8% spent on overheads. The embedment of staff in SACAs remains both a method of keeping overhead costs down and increasing the efficiency of skills transfer from ENR to SACA staff at state level.

The unique design and implementation of the mass media component saw the programme realise ₦184,847,124 (£710,950) from free air slots of media messages on television and radio through ENR media partners just in the first 9 months of the 2014. The average cost of reaching one individual using Community HIV&AIDS Interpersonal Communication intervention was N18 (6.5p) over the life of programme (LOP), with a total of 12 million such interpersonal contacts over the programme life.

1.5 Conclusion

In conclusion the ENR programme in six years exceeded its LOP mandate and made significant contribution to Nigeria AIDS response. It developed many processes, methodologies and tools that would continue to help in delivering high quality HIV&AIDS programme Interventions to Nigeria. The Programme strengthened the skills of public sector Ministries, Department and Agencies to perform better at their stewardship responsibilities and stronger civil society organisation while holding government to account CSOs were also capable of delivering high quality HIV and AIDS intervention at the frontline. As a programme, it is ENR's hope that this contribution will continue to be sustained. The next three section of this report will present performance in the three major strands of work implemented by the programme and results achieved.

This report should be read with the technical briefs, tools and other approach documents also developed by the programme to provide guidance to policy makers, programme managers and implementers who may want to take any aspects of the intervention described in this report forward.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2 Strengthened Federal and State Government stewardship for sustainable and effective multi-sectoral and evidence -informed HIV prevention response

2.1 Summary of Achievements

All targets were achieved or exceeded expectations

ENR interventions under Output 1 were rated medium risk in the logframe and it was not always clear if interventions would achieve the desired results. However as the programme ended ENR had achieved all life of programme targets. All eight focal states and partners at the federal level have shown improved capacity that adds value to Nigeria's AIDS response including evidence of improved performance in core stewardship areas of planning, coordination, reporting and resource mobilisation.

Additionally tools, approaches and methodology developed under this output are becoming critical legacies of the programme. The new Organisational Capacity Assessment (OCA) tool, NHOCAT, is not only popular and widely used in Nigeria, but it has also been adopted internationally. The NHOCAT has played its role in promoting harmonized capacity building. The State Unified Operation Plans (SUOP) and associated evidence-based planning and decision-making framework is also being widely used across all states.

2.2 Enhanced Capacity of National and State MDAs to provide gender-responsive policy, planning and coordination of the HIV prevention response

MDAs at Federal level and all States have achieved an OCA threshold score of 60% in 2014

Between 2009 and 2011, ENR used an Organisational Capacity Assessment (OCA) tool that was developed by the Strengthening Nigeria Response to HIV&AIDs (SNR) Programme in 2006 and modified by ENR in 2009. Baseline OCA was conducted in 2010 for seven focal states and the federal level and repeated in 2011 which showed significant improvement of the OCA scores. However further improvements were made to the tool in close cooperation with NACA and development partners. This led to the development of the National Harmonized Organisational Capacity Assessment Tool (NHOCAT). The NHOCAT which is more cost effective, easier to complete, less time intensive and provides a simple overview (a 'dashboard') through a simple traffic light system has been adopted by all NACA/SACA partners when measuring organisational capacity, allowing for comparison and coherent approach to capacity strengthening.

> *"NHOCAT dashboard is extraordinary and the most useful aspect of the tool. It helps to quickly identify gaps . . ."*
>
> **Hajia Maimuna Mohammed**
> **Director of Partnership & Coordination-NACA**

Table 7: Progress against Indicator 1.1 (based on 2014 OCA)

OCA Score	Federal	Akwa Ibom	Benue	Cross River	Enugu	Kaduna	Lagos	Nasarawa	Ogun
Aggregate	**70**	**74**	**80**	**77**	**73**	**75**	**80**	**78**	**73**
SACA (NACA)	75	74	87	80	74	76	80	79	77
MoH	62	74	74	73	72	74	82	84	69
MoE	60	76	64	70	67	66	75	60	68

A summary of the achievements against this indicator as of end of October 2014 is presented in the table 7 above. The 2012 and 2014 Organisational Capacity Assessment (OCA) thresholds for Federal and ENR focal States were measured using the 2012 and reviewed in 2014 with support from ENR under the leadership of NACA. Analysis of the findings from the OCA conducted in 2014 revealed Federal and eight ENR focal States have aggregate scores above 60% threshold. All the states made significant improvements over the 2012 score while the federal level maintained its status

USE OF NHOCAT NATIONALLY AND INTERNATIONALLY

The NHOCAT is not only used by agencies that are supported by ENR, but also by other agencies (most especially line ministries and CSOs that SACAs supervise under the World Bank HPDP 2 credit). The NHOCAT has implemented beyond the States that are supported by ENR. The USAID-funded ***SHIPs-for-MARPs*** project assessed several MDAs in 11 states of Nigeria. In 2013 ***NACA*** deployed the NHOCAT in other states of Nigeria not covered by ENR or the SHIPs for MARPs project. In 2014 a new DFID-funded programme, ***MNCH 2***, adopted lessons learnt from NHOCAT to develop an OCA tool to guide capacity building at the Local Government level. MSH has made the NHOCAT available to projects being executed in other countries. The NHOCAT was replicated in a new ***"Progress" tool*** which MSH projects use to assess capacity of CSOs and public sector bodies. This tool is in active use in Kenya and other developing countries.

In working to improve the construct behind the NHOCAT measure, ENR worked to strengthen and improve the five essential 'building blocks' required for delivering stewardship capacity. These are:

1. *Leadership and Governance*
2. *Policies & Plans*
3. *Monitoring and Administration Systems*
4. *HR and infrastructure*
5. *Coordination*

In addition to these building blocks, ENR also built capacity among MDAs to mainstream gender issues into HIV&AIDS programmes and activities both at the National and State levels[2]. ENR supported the appointment of Gender Focal persons in all SACAs, line ministries, and CSOs and supported the development, deployment and tracking of a gender management system in these MDAs.

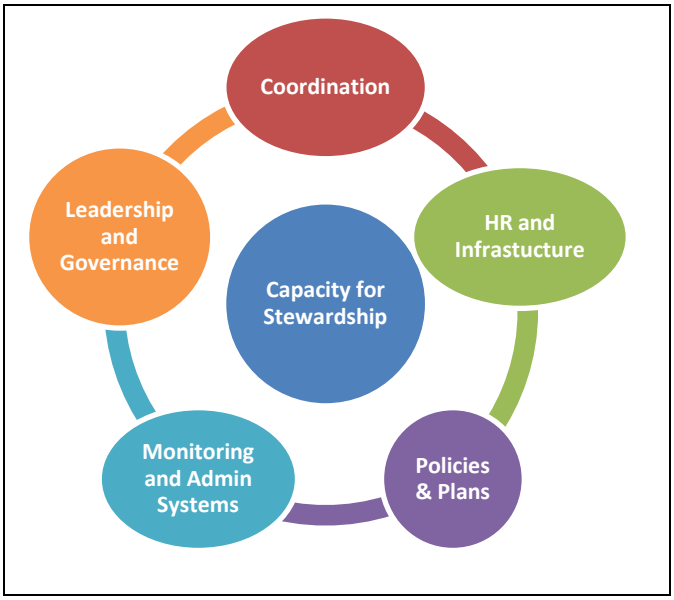


Figure 2: Output 1 Building Blocks

Expanded support to the Ministries of Health

ENR supported the health sector response as part of our integral support to a multi-sectoral HIV response in the states. However in light of the changing landscape of the AIDS epidemic, the programme increased its focus on the Ministries of Health (MOH) more broadly beyond an initial narrow focus on only the State HIV/AIDS & STI Control Programmes (SASCPs). ENR worked to strengthen the SASCP, Health Planning, PHC and other units of the parent ministry to coordinate an

[2] More details in: *Institutionalizing Gender Management Systems: Experiences and Learning from Enhancing Nigeria's Response to HIV and AIDS Programme (ENR)* 2012.

effective broad-based health sector response as part of the overall State response. In Lagos, Enugu and Kaduna ENR worked with the DFID project, PATHS 2, and also aligned our work with the Lead IP principles of the USG implementing partners to better coordinate this support to the ministry in other ENR focal states. Elements of this support included planning, human resources development, deepening the evidence available for programmatic and allocative decisions including data on HCT and PMTCT uptake and gap analysis and in helping to coordinate this work within the M&E TWG. Other aspect of the support included contributing to demand creation for services including the use of C-HIPCs agents and mass media and in making commodities such as HCT rapid kits available, training of frontline service providers and expanding access through mobile HCT testing linked to the demand creation/health facility interface.

2.3 National, States and selected MDAs harmonising and coordinating the HIV & AIDS response

Whereas 2.2 helps measure the overall capacity of selected National and State level MDAs, this indicator focuses on three key performance areas of 'planning, reporting and coordination' that demonstrate stewardship in practice. A summary of the achievements against this indicator as of October 2014 is presented in table 8 below. The results indicate that targets in all four domains were exceeded.

Table *8*: 2014 Progress against indicator 1.2

Indicator 1.2 Domain	Baseline	2012 Results	2014 Target	Trends as at October 2014
ENR State SACA with a Unified State Operational Plan	No ENR SACAs with a Unified State Operational Plan	**6 States**: Akwa Ibom, Benue, Cross River, Kaduna, Nasarawa, Ogun	7 States	**8 States**: Akwa Ibom, Benue, Cross River, Enugu, Kaduna, Lagos, Nasarawa, Ogun
NACA and ENR States producing programme reports	Neither NACA nor ENR States producing programme reports	**6 States**: Akwa Ibom, Benue, Cross River, Kaduna Nasarawa, Ogun **Federal**: 1	7 States and 1 Federal	**7 States**: Akwa Ibom, Benue, Cross River, Enugu, Kaduna, Nasarawa, Ogun **Federal**: 1
NACA and ENR state producing Financial reports	No ENR state producing Financial reports	**6 States**: Akwa Ibom, Benue, Cross River, Kaduna Nasarawa, Ogun **Federal**: 1	5 States and 1 Federal	**7 States**: Akwa Ibom, Benue, Cross River, Enugu, Kaduna, Nasarawa, Ogun **Federal**: 1
The Federal and ENR states have functional[3] Prevention, M&E and Policy & Gender TWGs	No ENR states with functional Prevention, M&E and Policy & Gender TWGs	**3 States**: Cross River, Kaduna, Ogun **Federal**: 0	6 States and 1 Federal	**8 States**: Akwa Ibom, Benue, Cross River, Enugu, Kaduna, Lagos, Nasarawa, Ogun **Federal**: 1

[3] ENR (and NACA, following ENR's example) defines 'functional' TWG as one meeting all of the following four criteria:

- Having a clear terms of reference (TOR), with scope of work able to shape the state's HIV response;
- Holding meetings at least as often as specified in the TOR;
- Producing and keeping reports/minutes of such meetings;
- Action points arising from meetings are recorded in the minutes and followed up in subsequent meetings.

At the start of the ENR programme, state-wide plans were characterised by the presence of multiple drafts of plans each aimed at different audiences. There were no states that had a singular state-wide reference plan. The National Joint Annual Review conducted in 2011 had identified lack of unified HIV response plan at the National and State level as one of the causes of difficulty in managing and evaluating the response. By 2014, as a result of ENR's support, and under NACA's strong leadership, all eight ENR focal states and 22 other Nigeria states produced a State Unified Operational Plan (SUOP) of good qualities with all state-level partners incorporated.

Programme and Financial reports

In improving reporting in Nigeria's HIV&AIDS sector, ENR has improved accountability, performance monitoring and knowledge management. At the end of the programme in 2014 seven focal states have produced annual response reports incorporating improved financial information. These reports have been disseminated for use by stakeholders. The production of the three waves of National AIDS Spending Assessment Report (NASA) report covering the period of 2008 to 2013 has been very useful to NACA to generate summary National financial report. In addition, this information is being used by all stakeholders in tracking government commitment and in allocative decision making.

Functional Technical Working Groups (TWGs)

TWGs are essential coordinating platforms and are present at the Federal level and in all ENR focal states. Each state has several TWGs, serving diverse functions, while at the Federal level there are about a dozen of them domiciled in NACA alone. Following ENR's working definition of functionality and our focus on three strategic TWGs, the National level and all eight focal states achieved the end of programme target. The strategic contribution of these TWGs can be seen in the following areas:

- the Policy, Advocacy & Gender TWGs in ensuring legislation that converted their respective SACAs into statutory bodies in Akwa Ibom and Ogun States; the passage of state anti-stigma laws in Benue, Cross River, Kaduna and Nasarawa States and state-wide adoption of the State HIV work place policy and guidelines in Akwa Ibom, Enugu, Kaduna, Lagos and Ogun States; continued release of monthly funds to the Local Government AIDS agencies in Benue and Cross River States;
- the review of the SUOP by the M&E TWGs in all our focal states;
- Development of Prevention Plan at the National level by the National Prevention TWG and similar state plans by counterpart TWGs in Akwa Ibom, Benue, Kaduna, and Nasarawa;
- review and update of HIV Communication Plan at National, as well as in Akwa Ibom, Cross River, Kaduna and Ogun States by the Prevention TWG.

3 Generating and using evidence for Decision Making

3.1 Summary of Achievements

The generation and use of appropriate information in programmatic and allocative decisions making is essential for better HIV prevention policy making, planning and programming at all levels. When ENR commenced work in 2009, there was a lack of reliable data. Routine statistics generated from implementation of HIV interventions were grossly incomplete and unreliable. There was also a lack of state specific survey data to assess the impact of state level interventions. At the end of 2014 all LOP targets have been achieved across the 8 states and at the National level. In addition, ENR deepened the understanding of policy makers and programme implementers in using a gender lens to analyse, interpret and use data in planning and resource allocation.

3.2 Strengthening Surveys, other Data Generation and Use

The first strand of ENR contribution to this area was the generation of useable data, particularly data that can be disaggregated up to state level to aid that level of planning. Most available data was either national or at best can be broken down to geopolitical zones. The programme worked closely with both the Federal Ministry of Health, States Ministries of Health, National Agency for the Control of AIDS and State Agencies for the Control of AIDS in the eight ENR states to produce a number of Surveys and Studies which were robust enough to be disaggregated and useable at state level. In doing this the capacity building of personnel of the relevant Ministries, Departments and Agencies (MDAs), CSOs and other stakeholders that were involved were priotised and developed. Surveys that ENR supported to ensure the states had state level data included the:

- Integrated Bio-Behavioural Surveillance Survey for high risk groups (IBBSS) 2010,
- State Specific HIV and AIDS and Reproductive Health Survey (SHARHS) 2011 and 2014,
- National HIV and AIDS and Reproductive Health Survey (NARHS) in 2012,
- National AIDS Spending Assessment (NASA) 2008/2009 produced in 2010; 2010/2011 produced in 2012; 2012/2013 produced in 2014
- State AIDS Spending Assessment for six ENR states produced in 2013 and 2014

The programme is optimistic that staff in State Ministries of Health just like their counterpart at the Federal can design and conduct surveys and other research studies such as NARHS and SHARHS now. In addition to generating new data like the NARHS 2012, NARHS 2007 was secondarily analysed to generate data for the states.

Other critical studies produced by the programme that provided important information for programme development, implementation and review include:

Stigma Index Study conducted in 2014 in partnership with the Network of Persons Living with HIV and AIDS in Nigeria (NEPWHAN). This is a newly adopted measure for determining the level of Stigma in the country. It measures stigma by determining the number of PLHIV that experienced acts of discrimination in the previous 12 months.

HIV Prevalence and Sexual Risk Behaviour among Out-of-School Youth (OSAY): This was conducted to provide information on HIV prevalence among Out of School Adolescents and Young people (OSAY) which is very limited in the country. This study provides information on HIV prevalence, sexual risk behaviours and factors associated with HIV among OSAY which is critical in designing effective programmes for this population group.

Sexual Risk Behaviours among Persons with Disabilities: Persons with Disabilities (PWD) remain a neglected sub-population in Nigeria and studies on HIV prevalence among them are lacking in Nigeria. This study in partnership with the Joint National Association of People with Disability and the Federal Ministry of Women Affairs and Social Development was conducted to bridge this gap. The study findings provide useful information to support policy work and programming amongst this group.

3.3 Strengthening the Routine System for Evidence and Informed Decision Making

The second strand of ENR intervention in this area was to strengthen the routine system from facilities to the Federal level for data collection, analysis and use. The capacity assessment of the routine Monitoring/Evaluation (M&E) and information management systems in the states carried out at programme inception in 2009 remains one of the most comprehensive done till date in the country. The findings were used to develop an intervention plan which was implemented over the last five years of the programme. Results in this area include:

- Enhanced skills of LGA and states personnel to manage and coordinate the routine data collection system including the use of the database DHIS 1.4 and the follow on DHIS2.0;
- Enhanced skills of CSOs and facilities on the use of the various registers and forms of the National Nigeria Response Information System;
- Expanded roles of the M&E TWG to quality assure emerging data and use same to produce fact sheets, policy briefs and other useable formats for policy influencing and programme implementation in the states.
- Strengthening the use of the data collected through the introduction of monthly M&E action planning meetings in the LGAs.

These processes at the state level have improved the level of completeness and quality of data in the states. As a result of the technical assistance provided to the states by ENR and other partners, the level of reporting for HIV services has improved in Lagos from as low as 17% in 2012 to over 70% in 2013. In Enugu and Cross River similar experiences have been seen.

3.4 NHRC established as a National Resource Base for Information Storage, Retrieval and Management

One of the key challenges in the Nigeria's two-and-a-half decade's response to HIV and AIDS is the lack of a systematic approach to information dissemination and utilisation. A lot of the materials and data generated in 3.3 above are often held in individuals or organisation information system and not widely available. In similar vein when programmes end, most of the generated materials and or lesson learnt are lost to the wider National response. This often led to duplication of effort

and repetition of what does not work. In responding to this gap ENR worked with NACA to establish a Resource Centre to serve as a repository to hold, manage and disseminate HIV and AIDS information and Survey data in Nigeria both physically and virtually.

The National HIV and AIDS Resource Centre (NHRC) which is situated in the NACA office in Central Area, Abuja presently contributes to the dissemination of HIV information by sending out e-news to registered members. In addition, since NACA has been hosting the Resource Center on its servers, the Center has experienced very little down time. In 2014 an average of 90 – 120 persons made use of the available infrastructure both physical and virtual daily.

3.5 Use of Evidence for Planning, Coordination, Resource Allocation and Technical Intervention Design

Two specific examples of data use in major programmatic and allocative decision making are provided below

ENR states use Incidence modelling and epidemiological synthesis studies and other studies for designing prevention strategies: All 8 ENR states have carried out incidence modelling through the use of the Mode of Transmission (MOT) Model which was developed by UNAIDS. These revealed that the major source of new HIV infection was amongst the general population and led to states reviewing their HIV strategies to focus efforts not just on risk groups but the general population. The MOT studies were used to inform the development of the State Prevention plans that included the target that over 80% of the population should be tested for HIV and to ensure that the general population was well covered in the behaviour change communication interventions in the states.

Support for Conducting National AIDS Spending Assessment NASA and its use to inform Programming and Policy formation: ENR provided technical assistance to NACA to carry out the first Nigerian National AIDS Spending Assessment (NASA) in partnership with UNAIDS (using National Health Accounts methodology). Since then it has supported two further studies generating six years of financial data on Nigeria AIDS response. The use of the information generated from previous assessments led to the declaration of commitment by the current President at the UN for increased national spending to the tune of 50% of funds spent on HIV in the country. This led to the development of the Presidential Comprehensive Response Plan (PCRP) which is likely to significantly increase the percentage of government spending on HIV&AIDS programming. It is also used to monitor the allocation and spending of the GON compared to the development partners.

The fourth and most critical strand of ENR intervention in supporting the generation and use of evidence in the National response was working with the states to actually use the available data and information in their planning, coordination and resource mobilisation mandates, and for CSOs in actual intervention designand implementation. Availability of state level data and with the focused capacity strengthening intervention by the programme, some examples of useable analytic documents produced by the states are listed below:

- Epidemiological and Response Policy Synthesis (ERPS) 2009;
- Mapping of Most at Risk Populations (MARPS).
- Fact Sheets for each quarter
- Knowledge, Attitude, Behaviour and Practice studies for each state – 2011, 2013

ENR also supported the actual

use of the data generated through supporting the state authorities to disseminate information generated from the surveys using various formats including dissemination meetings, fact sheets and posters, and support for ensuring this information was used for planning. Presently all meetings in the state for the development of plans, policies and strategies include a segment in which the prevailing HIV situation (epidemiology and response) is studied through an analysis of data generated from both surveys and the routine data.

3.6 Improving the Body of Knowledge on HIV Prevention through Scientific Publication

A major aim of ENR is to generate and share scientific knowledge and experiences alongside its other activities, as a way of building capacity and ensuring sustainability of its efforts beyond ENR. One area the programme that has excelled remarkably is the publication of articles in peer review journals; abstract presentations at national and international conferences; in the conduct of operational research; and development of success stories and best practices for dissemination. A synopsis of manuscripts submitted to or accepted by peer reviewed journals is annexed as section 7 in this document and a comprehensive book of abstract is also available.

4 Strengthening the Institutional and Technical Capacity of Civil Society to engage in HIV and AIDS Prevention and Care and Support Interventions

4.1 Summary of Achievements

The intent of this strand of work by the programme was to strengthen Civil Society Organisations (CSOs) capacity for effective HIV&AIDS Interventions at the front line, as well as their advocacy skills to influence pro community and pro enabling environment policies and legislations for effective HIV&AIDS Interventions. Using a combination of technical assistance and hands on mentoring by the end of December 2014, all 8 ENR focal states now have a minimum of 10 highly skilled and well equipped CSOs who can implement quality HIV prevention interventions using nationally accredited methodologies at the front line. In addition 7 of the 8 ENR states now have anti-discrimination laws and these are being used to protect PLHIV from stigma and discrimination and thus created an enabling environment for uptake of services. Lastly the CSOs

strengthened by ENR have begun to replicate this work by strengthening community based organisations creating a cascade effect.

4.2 Civil Society organisation empowered for effective HIV&AIDS Prevention

ENR provided technical support to the eight ENR focal state SACAs in strengthening the capacity of Civil Society Organisations (CSOs) to increase HIV prevention and organisational sustainability. This was aimed at ensuring that the states would have a large effective resource pool for the implementation of the World Bank HIV&AIDS Fund grant (HAF) as well as other programmes that would increase access to HIV services for the most vulnerable populations in the state.

In all eight states 245 CSOs were skilled in the use of various prevention methodologies including Peer Education Plus (PEP), Priority Local HIV&AIDS Control Efforts (PLACE), Society Tackling AIDS through Rights (STAR) and Community HIV&AIDS Interpersonal Communications (C-HIPC) with minimal support. In addition 135 of these numbers were equipped (see Table below) and hands on field mentoring implemented. The capacity building is seen to have been useful as a large percentage of the CSOs that were skilled received the World Bank HAF and other grant and in using the acquired skills and knowledge expanding the coverage of effective HIV&AIDS services.

Table 9: Number of CSOs trained and equipped to conduct Appropriate HIV Prevention Interventions

States	Number of SACA verified CSOs trained on use of appropriate HIV prevention interventions in 2012	Number of SACA verified CSOs equipped with required tools for appropriate HIV prevention interventions in 2012	Number of SACA verified CSOs trained and equipped on use of appropriate HIV prevention interventions in 2013
Akwa Ibom	***0***	***0***	***26***
Benue State	***0***	***0***	***35***
Cross River	25	25	4
Nasarawa	22	22	6
Kaduna	20	20	40
Ogun	20	20	0
Lagos	160	20	0
Enugu	0	0	30
Total	245	107	135

In the area of organisational development, some of the identified gaps include lack of strategic documents to guide the way CSOs worked and the lack of organisational sustainability. At the end of the programme, 25 of the core supported CSOs of these number now display evidence of the production and implementation of organisational strategic plans, annual operational plans, review and implementation of organisational policies. These had translated to increase funding of these CSOs as Table 9 below shows these 25 CSO partners have been able to obtain funding from other developmental partners to continue their work. Some have been able to source funding locally from private individuals including philanthropists and politicians.

Table *10:* ENR supported CSOs and the Sources of Funding for Projects being implemented by Year or Securing funding

State	CSO	Major funding from partner/funder 2011-2013
Akwa Ibom	Broklin Foundation	ENR, SIDHAS, AONN, SFH (SHiPs for MARPS), GF RDT
	Community Partners Development	ENR, JHPIEGO, UNDEF, MSH, CSDP, HC3, ACOMIN
	Glocare Initiative	Community Charity, SFH (SHiPs for MARPS),
Cross Rivers	IPGH	FHI/GHAIN, World Bank, FHI SIDHAS, Canadian Fund for local initiative, PEPFAR Small Grant Programme, United State Dept. of State Young African women Development grant, ENR FHI360 SIDHAS & MAP, WB/HAF2
	PDF	German Leprosy, Global Fund, MAPS, FHI360, CEDPA, NEPWHAN, ENR ,FHI360 SIDHAS & MAP, WB/HAF2
	GGI	DFID, Comic Relief, European Union, Concern Universal, ENR WB/HAF2
	ARCOD	C-Change, ICAP/CHIPS, C-Change, ICAP/CHIP, DFID- ENR, USAID/SMILE project, WB/HAF2,
Lagos	CHIEF	Global Fund, DFID- ENR
	DFHI	Global Fund, SFH, ENR, SFH SHIPs for MARPS
	HUFFPED	FHI360, Global Fund, APIN, ENR, Zip-Up Plus –UDASI/SFH, SIDHAS-FHI 360,
	JAKIN	Global Fund/Health Alive, APIN, CDC/FHI, ENR, USAID/FHI 360, SFH Global Fund Malaria, SFH Global Fund HIV
	NYAP	Population Council, Global fund, UNODC, CDC, ENR, APIN, POP Council, HAF 2, CRSACA (HAF 2)
Ogun	POF	Hope Worldwide (USAID), IHVN, ENR, Global Fund-Community TB Care project (GF-CTBC) through Health Alive Foundation (SR), Society for Family Health, Center for Community Leadership and Health Access & Advancement
	YFSI	GF ATM HSS/CSS, Accord Project, SFH, ENR, OGSACA HAF 2, Global Fund OVC, Global Fund-Multi-Drug Resistant TB project (GF-MDRTB) and Global Fund-Community TB Care project (GF-CTBC) through Health Alive Foundation (SR),Global Fund-Community Systems Strengthening (GF-CSS),Society for Family Health (GF-Malaria)
	CCL	GF OVC; USAID/ACCORD-Hope Worldwide 2012-2013, USAID/SUCCOR 2008-2010, Monthly subvention from Chancery; Donations from parishes on World AIDS day ,ENR, OGSACA HAF2, Global Fund –Community Systems Strengthening (GF-CSS), DFID-SUNMAP, Catholic funding Agencies, Global Fund-Community TB Care project (GF-CTBC) through Health Alive Foundation (SR),Global Fund Malaria through SFH, Subventions from Chancery Donations from parishes
Kaduna	GIWAC	Bill & Melinda Gates Foundation, CIHPAC, SHiPs, ENR Nigerian Urban Reproductive Health Initiative (NURHI), Centre for Integrated Health Programs (CIHP), Strengthened Health Initiative (SHI),SFH
	SHED	DIFID and USAID, AHI 2013, ENR , CIHP, SUBEB, ESSPIN
	STD	Population Council, SFH, ENR
	YOTACID	DIFD (EPIN), World Bank (SUBEB), Global Fund Round 9, Japanese Embassy, DFID Mobilisation for Development and ENR, Global Fund, SFH, Legal Aid Council, SUBEB, ESSPIN

Nasarawa	NAWYCA	TY Danjuma foundation Youth, IHVN, ENR, NASACA HAF2, SFH/ Global Fund, SHIP for MARPs, USAID/CRS SMILE OVC project
	AHP	Accord STP Project, Hope worldwide, Pop Council, SFH, MSH, NASACA HAF2 (5 states) NACA, Pop. Council MARPS/IDUs, MSH-MTCT/MSM
	CEYTOCDEV	CiSHAN National (CSS), Foundation, ENR, NASACA HAF2, VSO, SFH/Malaria
Benue	OCAG	Mbasie, ENCAP, MAPS, ChristianAid for HIV and community health, USAID SHOPS FHI360 for Malaria and ENR, BENSACA (HAF 2), Global Fund, MAPS, FHI 360, USAID (ENCAP)
	OSAF	ENCAP (Renewed existing project with additional funds), Global Fund for Malaria Project through ACOMIN, CIPHAC and ENR, BENSACA (HAF 2), Global Fund
	MWT	Global Fund HIV-MARPS, ENR, SFH, CIHP, BENSACA

4.3 Facilitating an Enabling Environment for HIV&AIDS Service Delivery -ENR States with Effective Anti-Stigma and Discrimination Legislation

An enabling environment is critical for HIV&AIDS intervention and for uptake of services. HIV Stigma and discrimination is one major issue in the environment that not only limits individual health seeking behavior but impacts the community ability to protect its weak and those in need of such support. As at the end of the programme, 7 of the 8 ENR states (Lagos, Enugu, Kaduna, Nasarawa, Cross River, Benue and Ogun) now have HIV&AIDS anti-stigma and discrimination laws in place. The laws in Enugu and Lagos had been passed under the Strengthening Nigeria's Response to HIV&AIDs Programme. For the others the year of passage were Kaduna: 2009; Cross River: 2010; and Nasarawa: 2012. The anti-stigma bill for Benue was passed in December 2013, while in July 2014, the anti-stigma bill was passed in Ogun State. The only ENR state without the anti-stigma legislation is Akwa-Ibom state. The major reason being the fact that the initial engagement with Akwa Ibom focused on getting the SACA Agency Bill that transformed the committee into a full Agency passed so that the SACA could manage the implementation of the anti-stigma and discrimination law. The anti stigma bill has currently passed the second reading in the Akwa Ibom House of Assembly. The

Products of Stigma Law

The Nasarawa State Human Rights Commission HRC) dealt with an incident of the violation of a woman's rights who had tested positive in Nasarawa. Her husband and relatives sent the woman out of her home because of her HIV status. Her child and property were seized. This was reported to her support group and documented on the stigma diary. The HRC took on the case and ensured her child and properties were fully returned back to her.

agency is now in the forefront of initiatives being made to ensure that the anti-discrimination bill is passed.

ENR also supported the states to develop mechanisms to ensure the actual implementation of the laws. Immediately after a law was assented to by the executive in the states, ENR supported SACA to ensure that the laws are widely known. Two main methods used were dissemination meetings, targeting key stakeholders and the simplification of the law in local languages which were also disseminated widely to the populace through printed booklets/flyers. The programme also supported the setting up of systems to tackle complaints that were raised. To ensure that this was carried out an effective monitoring system was set up which included a "stigma diary" that documents individual acts of discrimination. These are maintained by various institutions including the State Chapters of Network of People Living with HIV and AIDS in Nigeria (NEPWHAN) and the state SACA as advocates; the use of the state chapters of the National Human Rights Commission as arbiters; and creating access to affordable legal representation through public legal aid and private non-profitable organisations such as FIDA, and human rights groups. Aside this ENR also supported the conduct of the Stigma Index survey at national level which is the newly promoted method of measuring Stigma and also link these two systems.

4.4 Support for other Laws Impacting on HIV and AIDS

In recognition of the fact that there were many practices that put people at risk of getting infected with HIV or reduce their access to HIV services, ENR also supported the various states and also worked with CSOs to scan their environment with the objective of identifying triggers of vulnerability to HIV infection and also bottleneck to effective programme implementation and which of these needs legislation to ameliorate. As a result various legislation, some of which have been passed and others still ongoing where developed as a result of this support. Example includes legislation on Widowhood rites and entitlements in Benue State, laws against gender violence in Ogun State amongst others.

An important achievement in getting laws approved was the work towards getting the hitherto State Action Committees on AIDS in the states to become Agencies. As a result of a mix of activities, ENR was able to facilitate the passage of agency bills in Akwa Ibom and Ogun States. These were the ENR focal states that had yet to pass agency bills prior to ENR commencing work in the states.

5 Improving Knowledge, Changing Attitudes and Ensuring Availability of Commodities for Effective HIV&AIDS Prevention

5.1 Summary of Achievements

ENR targets for this strand of work have all been exceeded. Complete knowledge for HIV&AIDS has increased; accepting attitudes towards PLHIV has improved and the programme also achieved its target for the distribution of its socially marketed safer sex commodities. Additionally, ENR supported the emergence of a nation-wide healthy market for condoms with a gradually increasing commercial segment. The presence of the free public sector supply and skilful management of the social market segment has ensured a very equity sensitive and sustainable condom market.

This strand of work is designed to promote HIV service uptake across the continuum of HIV prevention services. At programme inception, the system strengthening component accounted for 60% level of effort while HIV prevention actions accounted for 40%. This changed in December 2009 after the Inception review with HIV prevention commanding a higher level of effort at 60% compared to 40% for system inputs. The Inception review also saw the wording of the output redefined to *"Improved knowledge, change in attitudes and availability of commodities conducive to safer practices for effective HIV&AIDS prevention*" These two changes ensured better alignment between the inputs, expected results and overall outcome of the programme.

5.2 Expanding Comprehensive HIV&AIDS Knowledge in the Communities

The indicator used in tracking increase of HIV&AIDS comprehensive knowledge is the "*Proportion of females and males in ENR states with accurate knowledge of HIV&AIDS prevention using the UNAIDS prevention knowledge indicator".* It is a composite indicator that expects that a person provides the correct answer to five questions (domains). These include: 3 questions on the modes

of prevention of HIV transmission and the fact that HIV infection may not be physically evident in an infected individual; and 2 questions related to correct knowledge on myths and misconception about HIV. While the former have direct impact on risk taking and effective health seeking behaviour the latter aims to dispel commonly held false notions around the disease.

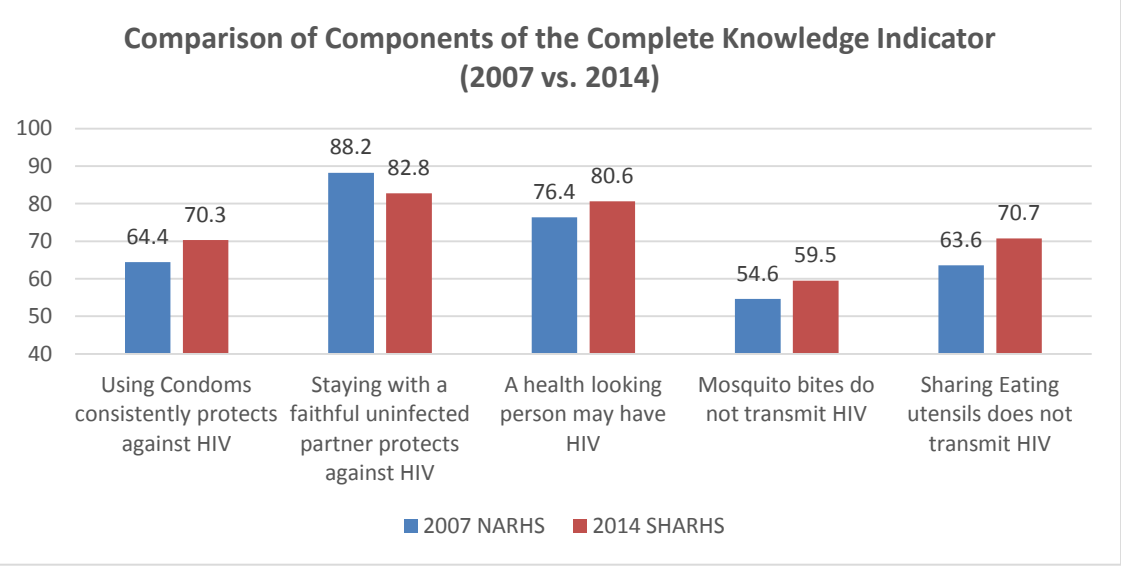
Table *11*: Proportion of females and males in ENR states with accurate knowledge of HIV&AIDS prevention using UNAIDS knowledge Indicator

	Sex	Baseline: (2007 NARHS)	2014 Target	SHAHRS 2014
3.1 Proportion of females and males in ENR states with accurate knowledge of HIV&AIDS prevention using the UNAIDS prevention knowledge indicator	Males	35%	44%	45.1%
	Females	23%	33%	37.8%

Source NARHS 2007 & 2012; SHARHS 2014

A review of the indicator shows that ENR exceeded the programme target as comprehensive HIV knowledge increased from 35% for male and 23% for females in 2007 to 45% for males and 38% for females in 2014. This translates to a 28% point increase for men and 64% for women over life of programme. An in-depth look at individual state performance revealed higher knowledge levels than in 2007 in most states. A breakdown of the composite Indicator shows progress across the 5 questions (domains mentioned earlier) with the level of knowledge on prevention methods and the fact that a person can be healthy looking and still have HIV scoring quite high. Lower figures were seen for the misconceptions. This improved knowledge represents the trigger for effective health action as seen in increased use of condoms during sexual intercourse or the uptake of HIV counselling and testing (HCT), as these have risen in response to the interventions as seen in the impact section.

Figure 3: comparison of component of the UNAIDS Complete Knowledge Indicator 2007 vs. 2014



5.3 Accepting attitude towards PLHIV

ENR also significantly exceeded the 2014 completion target as the level of stigma has reduced and the percentage of persons expressing accepting attitudes substantially increased from 27% for males and 24% for females as at 2007 to 53% for males and 51.7% for women by 2014. This implies that the programme target for this indicator which was 40% for males and 38% for females was achieved.

Table *12*: Proportion of females and males in ENR states with non stigmatising attitude towards PLWHA (ENR stigma Indicator)

	Sex	Baseline: (2007 NARHS)	Midterm 2012 NARHS	Target 2014	SHARHS 2014
3.2 Proportion of females and males in ENR states with non-stigmatizing attitudes towards PLWHA. (ENR stigma indicator)	Males	27%	43.9	40.0%	**53.0%**
	Females	24%	37.2	38.0%	**51.7%**

Data sources: NARHS 2007 & SHARHS 2014

Further analysis shows that the improvement was seen in most states.

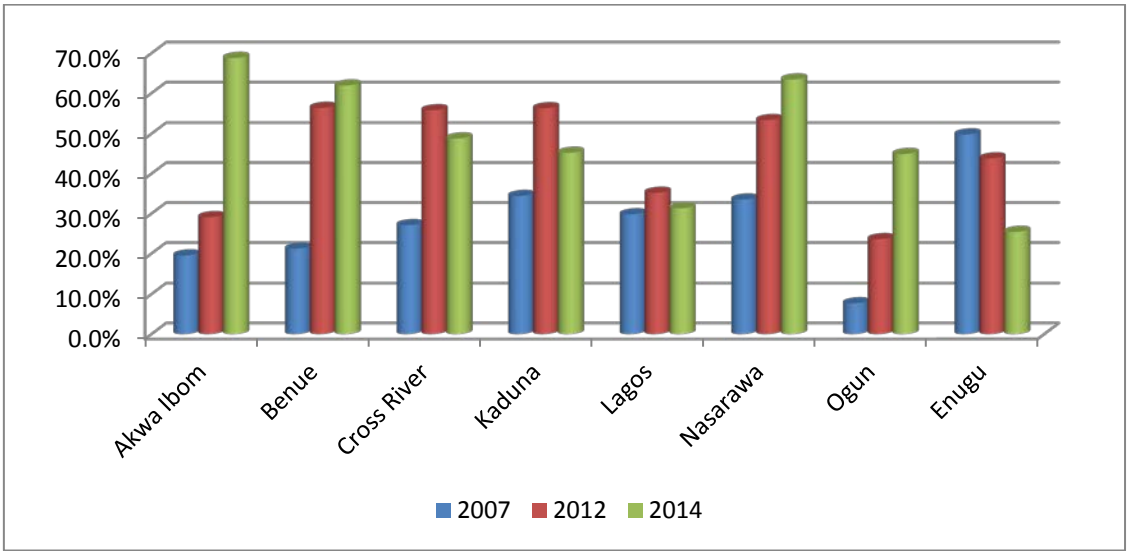


Figure 4: Percentage of Persons in States with accepting attitudes towards PLWHA in ENR focal states

5.4 Other non Logframe Benefits of Direct Community Interventions

In addition to achieving the three targets for the output, some of the processes used by the programme had extensive positive spill over effect on beneficiaries. Health Promotion using IPC agent is one of the methods used by the programme to increase knowledge, reduce stigma and improve the uptake of HIV services is the direct community level interventions carried out by community volunteers trained and engaged to deliver such services. 3,651 Community HIV&AIDS Interpersonal Communication and Health promotion (C-HIPC) agents were trained in the six years of the programme. These HIPC agents represent significant resources for the communities and their states. In Lagos states for example, these IPC agents were in the forefront of the Ebola contact tracing working with the state Ministry of Health, Kaduna state uses the over 500 IPC agents as the foundation for its harmonised health promotion activities across PMTCT, immunisation and other MNCH activities.

Total Number IPCs in ENR States

	Total
Akwa Ibom	350
Benue	885
Cross River	262
Enugu	230
Kaduna	657
Lagos	456

These HIPC agents working across all 8 focal states successfully made a total of 12.5 million interpersonal contacts over the six years duration of the programme.

Table *13*: Number of Interpersonal Contacts by Persons Directly Engaged by ENR during the ENR Programme

Intervention mix	2010	2011	2012	2013	2014 (Q1-Q3)	Total
IPC (thru IPC conductors)	1,029,325	3,042,610	4,337,377	3,604,334	4,565,803	**12,013,646**
IPC (thru FBO)	975	60,152	204,780	264,097	127,696	**530,004**
Total	**1,030,300**	**3,102,762**	**4,542,157**	**3,868,431**	**4,693,499**	**12,543,650**

At the beginning of the programme, the main focus was on demand creation for HIV testing and counselling and the use of condoms. After the results of the NARHS 2012, increasing levels of comprehensive HIV&AIDS knowledge and reducing stigma were scaled up. In addition an adaptation of the C-HIPC to direct House to House approach (H-HIPC) was done with the view of achieving further scale of contact particularly at states which had low levels of knowledge in the NARHS 2012 (Ogun, Akwa Ibom and Nasarawa). The novel approach of conducting a house to house campaign to inform persons in hard-to-reach areas on HIV&AIDS knowledge yielded results.

A total of 689,715 and 1,021,486 persons were reached in Akwa Ibom and Nasarawa States respectively with comprehensive message on HIV knowledge and stigma reduction focused on

accurate & comprehensive message on HIV knowledge (5/5) and stigma reduction (4/4) in the States. This helped achieved the significant level of knowledge and reduced stigmatising attitudes seen in SHARHS 2014.

In ensuring the sustainability of effective behaviour change communication interventions in the focal States beyond the life of programme, the C-HIPC approach was also integrated into the training of frontline community workers including the LACAs and the health education and agriculture frontline workers in the states. In the agriculture sector, agriculture extension workers in the local government areas work in the communities to improve the farming practices of the rural dwellers. These groups of workers have been trained and are including HIV messages in their discourse with the rural dwellers. The success in application of HIPC also led to various LACAs now making use of this method to reach the people in the communities with their HPDP2 funds. Presently Benue, Kaduna, Nasarawa and Cross River states have IPC agents being managed directly by the local government authorities through their LACAs. The table below shows the number of MDAs in the various states that had commenced the use of these methodologies.

Table *14*: Mapping of integration of IPC into MDAs

States	Type of MDAs	Number trained
Benue	Ministry of Agriculture	46
	Ministry of Youths and Sports	90
	Ministry of Culture and Tourism	23
	Bureau of Establishment	36
	Ministry of Health	50
	LACA in 23 LGAs	459
Cross River	LACA in 4 LGAs (Akapuyo, Etung, Akanmkpa and Calabar municipal)	66
	14 Health facilities in Calabar South	20
Enugu	LACAs in 5 LGAs(Udi, Oji River, Udenu, Uzo Uwani and Enugu East)	7 per LGA(35)
Kaduna	Ministry of Agriculture	105
	LACA in all LGAs	534
Lagos	Ministry of Agriculture	100
	LACA in Alimosho LGA	16
Nasarawa	Ministry of Agriculture	65
	Ministry of Information and Orientation	30
	Ministry of Health	57
	LACA in 6 LGAs(Lafia, Awe, Doma, Wamba, Karu and Nasarawa Eggon)	20 per LGA(120)
Ogun	Ministry of Agriculture	40

5.5 Commodity Social Marketing

At the commencement of the programme, ENR was committed to distributing at least 1.2 billion male condoms over the life of programme. The year on year distribution of condoms through the ENR programme is outlined in the table below shows that the programme has exceeded its LOP target.

Table *15*: Total Condoms Distributed through the ENR Programme (October 2014)

	2009	2010	2011	2012	2013	2014	Total
Gold Circle	195,543,936	205,833,600	204,334,784	212,500,724	177,238,656	192,780,560	1,188,232,260
Lifestyle	993,532	1,063,400	370,008	2,160	839,160	644,112	2,476,804
Sample/Free Condoms	6,779,610	5,253,538	5,520,816	4,735,440	9,619,056	10,157,920	42,066,380
Total	203,317,078	211,087,138	209,855,600	217,236,164	187,696,872	203,582,592	1,232,775,444

While there were no lives of project targets (LOP) for female condoms and lubricants. The total number distributed for these is shown in the table below. The distribution of lubricants and female condoms exceeded all the annual targets since programme inception in 2009. This high distribution level for female condoms was large due to cooperation between ENR and another SFH programme, the Universal Access to Female Condom (UAFC) Programme.

Year	Female Condom	Lubricants
2009	203,858.00	140,000.00
2010	841,920.00	124,425.00
2011	1,301,040.00	167,825.00
2012	1,106,208.00	201,495.00
2013	408,672.00	173,460.00
2014	553,234.00	150,325.00
Total	**4,414,932.00**	**957,530.00**

Table16: Number of Other Safer Sex Commodities Distributed by ENR by Year

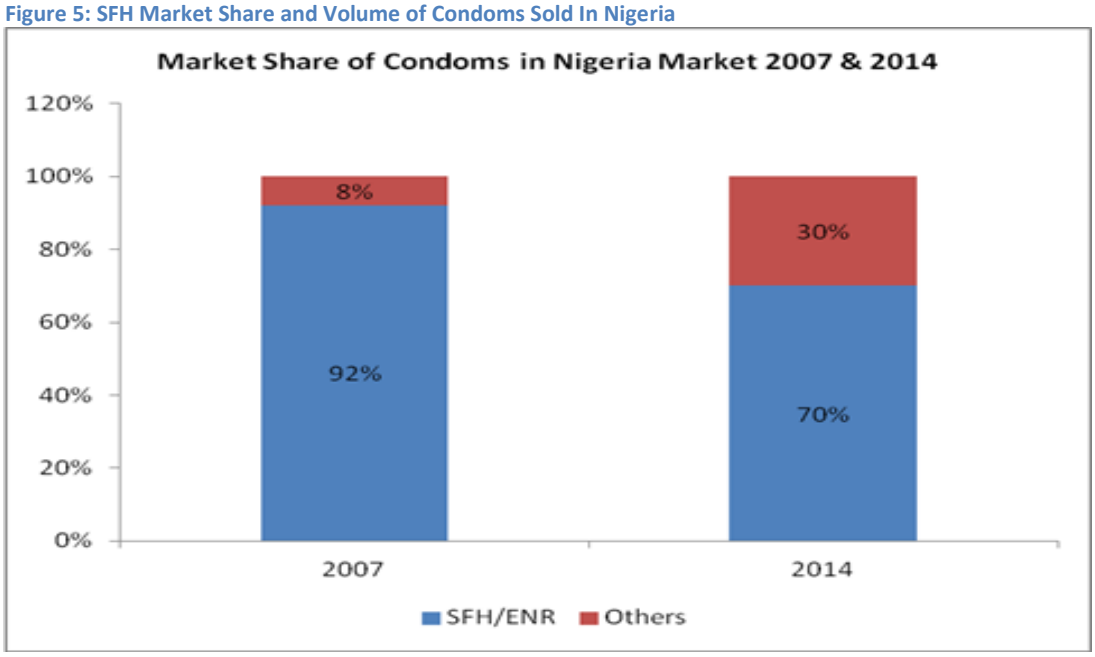
Ensuring long term Sustainability of the Nigeria Condom market

An explicit objective of the programme from inception and linked to the previous DFID Promoting Sexual Reproductive Health and HIV Reduction (PSRHH) programme was to develop a healthy commodities (condoms and lubricants) market. This implies a market that not just ensures availability of affordable condoms in both urban and rural location across Nigeria but a sustainable market on the longer term. This requires a market with strong commercial segment of at least 20%, one with free of fee for at least 10% and reducing the social market /cost recovery segment which at 2007 was about 95% to no more than 70%. This is critical for both MARPs and general population programming and the wider Nigeria AIDS response and to some

extent family planning security. Achieving this objective and the expansion of the total market represents a major success of the ENR programme and DFID support to Nigeria.

Compared to 2007, when an SFH assessment revealed the total condom market in Nigeria at 190 million units, with about 20 brands of condoms and 176 million, or about 92% of the market was donor supported, ENR ended in December 2014 with volume of 270 million units and donor supported social market segment reducing to 190 million unit or 70% of the market. This is no small achievement particularly in the context of increasing and maintaining programme volumes at around 200 million and also the significant implication to the sustainability of Nigeria's AIDS response as donor support to the sector continue to dwindle. ENR estimates that 20% of the market is commercial while about 10% is met by government and donors (mainly free condoms for the poorest of the poor).

Figure 5: SFH Market Share and Volume of Condoms Sold In Nigeria



5.6 Improved Stewardship for Prevention HIV Initiatives at both National and State levels

When the programme began in 2009, quite a substantial amount of funding for HIV programming in the country was targeted to treatment services. This resulted in very little prevention intervention with the resultant high level of new infections. One of ENR's first activities it supported was the development of the second National and State Strategic plans for HIV&AIDS. During the development, ENR exerted considerable influence to ensure that the plans were prevention focused. In doing this, ENR supported both the country and ENR's focal states at the time to develop strategic plans that set high targets for HIV prevention programming. The next step was to develop strategies for the implementation of the strategic plans. ENR supported its focal states to develop state level strategic prevention plans. Subsequently it contributed to the development of the National Prevention Plan. These have regularly been updated with ENR support. The latest National Prevention Plan (2014-2015) has recently been developed with ENR support to cover interventions going forward into 2015.

Other policy documents that ENR contributed to include:

- The Minimum Prevention Package intervention (MPPI) which prescribes the minimum package of services that a person in Nigeria is expected to receive. In order for persons to have been considered as reached; the guides for implementation of interventions targeted at MARPS;
- The national communication plan for HIV that aims to ensure that behaviour change communications through the mass media are coordinated to achieve the desired goals;
- The National Condom Strategy that outlines the strategic priorities and key interventions needed to ensure the availability of and access to male and female condoms for the Nigerian people.

Other areas of Stewardship Strengthened include Support for the National and State Prevention Technical Working Groups: Beyond the support for development of guidance documents, ENR also supported the development of systems that would improve the coordination of the prevention programme. Technical Working Groups in Nigeria have been found to be effective tools for supporting the government to coordinate and harmonise responses at state and national levels. ENR as a result of this, supported the development of Prevention Technical Working Groups in its focal states. These PTWGs in the states have matured over the years, led the development of and implementation of state prevention plans monitored their implementation and supported the maintenance of quality prevention initiatives including media and direct community level interventions.

Improving Capacity for Effective HIV Prevention Methodologies: ENR also supported development of various manuals for the correct implementation of prevention interventions that are now nationally owned. These include Community HIV&AIDS Interpersonal Communication (C-HIPC) Guide, Society Tackling AIDS through Rights (STAR), and Peer education Plus (PEP). These have been incorporated into National strategies, and are being used for by various partners and CSOs in conducting prevention interventions even those that are not focused on HIV.

Improving Sustainability of Mass media HIV&AIDS Programming

The major strategy of the mass media work was to improve the capacity of the radio and television broadcast stations in the ENR states to design, develop and air quality effective HIV&AIDS programming that entertains as well as informs their audience. As the programme ended in December 2014 there is considerable evidence of the ability and willingness of the stations to provide such programming, with most programmes aired by the partner stations designed, developed and funded by the stations with no financial support from any donor. Over 433 different programmes were developed by the partner stations country wide over LOP and aired for free.

6 Addressing Challenges and Lessons Learnt

Working with Government of Nigeria

The programme built a body of learning on what it takes to work with GoN both at State and Federal levels. This include how to develop a shared vision on issues with government counterpart, navigate the often bureaucratic nature of government and how to strengthen public institution combining both the formal and informal system of mentoring and skill transfer. Some of the Specific areas worth of mention includes:

Achieving result in a multi-tier government system

Programmes and interventions often deploy at the Federal level with the expectations that this cascade naturally to the states and LGAs. However as democratisation deepens, the programme learnt that states are becoming more autonomous and therefore a tailored approach worked better than a generic one. An inference would be a programme such as this in the future may need to actually develop a nest of state level logframe that recognise the various peculiarities of each state. In addition as the nature of support required with Federal MDAs is quite different from that of states, adaptation will be critical in the implementation of this sort of support in the future. This implies a balancing between more mentoring, less training; more tools, less equipment; more collaboration, less manpower at Federal as compared to the states.

A lot of flexibility of programming is required particularly in the multicultural and diverse environment of Nigeria. Therefore planning a programme requires a great degree of flexibility as things that are rapidly adopted in one state maybe resisted in others. The flexibility requires that the strategies be adapted to the setting and focusing on the overall objective.

Integration of HIV services in the health sector

DFID programme design that allows for flexibility in implementation and the importance of such in a labile context of HIV programming and Nigeria geopolitical space was central to ENR success. Initially designed to focus its institutional efforts on strengthening the NACA and SACAs, it was possible to incorporate the emerging consensus on the need to better integrate HIV services with other essential health services into the programme strategy. As a result of this, ENR developed State specific strategies that informed the programme's increased support to Ministry of Health. Donors need to continue this inbuilt flexibility into any future programme design.

Legislative Advocacy and facilitating the legislation of Laws

Getting a law passed in Nigeria is challenging, when there is no strong champion for the initiative. It is always better to seek out a strong well known and influential person either in the legislature, the executive or some other sector to facilitate engagements for the passage of the anti-stigma bill.

Other lessons include

Strategy of staff embedment

Embedment is a vehicle for building capacities in a sustained manner. A large element of ENR programme success can be attributed to the embedment of its State Teams, which has ensured better contextual understanding and informed ideas on how performance by SACAs can be improved. Embedding staff has also facilitated immediate knowledge transfer and has been important in ensuring ownership and therefore sustainability of programme interventions. It has ensured the commitment of beneficiaries who were often the ones driving interventions. However, there is also a danger that some of the focus of the programme gets lost and does not guarantee that responsibilities taken on by programme staff will be taken forward by beneficiaries.

Mentoring Requires Evident Long and Short Term Gains

Mentoring is beneficial when organisations see long term benefits. However, it is often a painstaking process to make them understand the benefits. A number of CSOs that had seemed resistant to change suddenly became enthusiastic when it was noticed that those that had been compliant were attracting support. This now led to them also seeking aid to advance themselves. It may therefore be a good idea to develop models that others can observe and emulate.

Programme implementers need to regularly question the assumptions made in the design of their programmes and determine if these assumptions have held. The assumption that the HAF CSO grants will occur in the life of the project did not hold true. This initially led to apathy as the CSOs saw no benefits to their efforts in developing themselves. The redesigning of efforts to focus on other sources of funding paid off as they as now more sustainable than they would have been if they had depended on the grant alone.

Reaching the hard to reach with Health Promotion

The House to House campaign, though intensive is extremely effective in reaching the population with health messages, particularly those related to increasing knowledge. While IPC interventions are effective, they tend to be limited by scale and also the chance of meeting same people over and over is high rather than meeting new people at every sessions. While IPC works very well for focused intervention and behaviour change, population wide change in increased health knowledge is easier to achieve using the house to house approach.

7 Select published Manuscripts in Peer review Journals and Knowledge Materials developed

Marital Status and HIV Prevalence in Nigeria: Implications for Effective Prevention Programmes for Women: *Samson B. Adebayo1,2, Richard I. Olukolade, Omokhudu Idogho, Jennifer Anyanti, Augustine Ankomah: Advances in Infectious Diseases* 3(3): 210–218 (DOI: 10.4236/aid.2013.33031)
www.scirp.org/journal/PaperInformation.aspx?PaperID=36614#.VIl6LDHF9NM

Study on the patterns and trend in contraceptive use in South-South and North-Western zones of Nigeria: 2003–2011: *Ezire O, Idogho O, Theophilus A, Ikani S, Oluigbo o (2014) in Open Journal of Contraception August 2014 Volume 2014:5 Pages 65—72; 20145:65-72. DOI: 10.2147/OAJC.S49541*

The Promise and Peril of Pre-Exposure Prophylaxis (PrEP):Using Social Science to Inform PrEP Interventions among Female Sex Workers: *Jennifer L Syvertsen, Angela M Robertson Bazzi, Andrew Scheibe, Sylvia Adebajo, Steffanie A Strathdee, Wendee M Wechsberg: African Journal of Reproductive Health* 18(3): 74–82 www.ajrh.info/home/abstract.php?id=107

Barriers to Repeated Use of Female Condoms among Women and Men of Reproductive Age in Nigeria
Ezire O, Oluigbo O, Archibong V, Okekearu I, Anyanti J. Journal of AIDS and HIV Research 5(6): 206–213(DOI:10.5897/JAHR2013.0239)
www.academicjournals.org/article/article1381155035_Ezire%20et%20al.pdf

Comparison of Audio Computer Assisted Self-interview and Face-to-face Interview Methods in Eliciting HIV-related Risks among Men Who Have Sex with Men and Men Who Inject Drugs in Nigeria: *Sylvia Adebajo, Otibho Obianwu, George Eluwa, Lung Vu, Ayo Oginni, WaimarTun, Meredith Sheehy, Babatunde Ahonsi, Adebobola Bashorun, Omokhudu Idogho ,Andrew Karlyn: PLoS ONE* 9(1): e81981 (DOI: 10.1371/journal.pone.0081981)
www.plosone.org/article/info:doi/10.1371/journal.pone.0081981#abstract0

Population-based prevalence of hepatitis B and C virus, HIV, syphilis, gonorrhoea and chlamydia in male injection drug users in Lagos, Nigeria : *W Tun, L Vu, S B Adebajo, L Abiodun, M Sheehy, A Karlyn, J Njab, B Ahonsi, B K Issa, O Idogho in International Journal of STD & AIDS (Impact Factor: 1.04). 07/2013; 24(8). DOI: 10.1177/0956462413477553*

Determinants of Condom Use by Men in Extramarital Relationships in Nigeria: *Augustine Ankomah, Samson B Adebayo, Jennifer Anyanti, Olaronke Ladipo, Bright Ekweremadu HIV/AIDS Research and Palliative Care* 5: 97–109 (DOI: 10.2147/HIV.S38965)
http://www.dovepress.com/determinants-of-condom-use-by-men-inextramarital-relationships-in-nig-peer-reviewed-article-HIV

Attitudinal and Behavioural Factors Associated with Extramarital Sex among Nigerian Men: Findings from a National Survey - *Lung Vu1, Waimar Tun2, Andrew Karlyn, Sylvia Adebajo, Babatunde A. O. Ahonsi*: *International Journal of Sexual Health* 23(4): 258–268 (DOI:

10.1080/19317611.2011.617810)
http://www.tandfonline.com/doi/abs/10.1080/19317611.2011.617810#.VJHtWxAfhBU

HIV-related Risk Perception among Female Sex Workers in Nigeria : *Augustine Ankomah, Godpower Omoregie, Zacch Akinyemi, Jennifer Anyanti,Olaronke Ladipo, Samson Adebayo - HIV/AIDS Research and Palliative Care* 3: 93–100 (DOI: 10.2147/HIV.S23081)
http://www.dovepress.com/hiv-related-risk-perception-among-female-sexworkers-in-nigeria-peer-reviewed-article-HIV

The Impact of Exposure to Mass Media Campaigns and Social Support on Levels and Trends of HIV-related Stigma and Discrimination in Nigeria: Tools for Enhancing Effective HIV Prevention Programmes:
R. Fakolade, S.B. Adebayo, J. Anyanti, A. Ankomah: Journal of Biosocial Science (42): 395–407 (DOI: 10.1017/S0021932009990538)
http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=7448664&fileId=S0021932009990538

Understanding Self-appraisal of HIV-infection Risk among Young Adults in Nigeria: Evidence from a National
Survey: *Samson Babatunde Adebayo, Jennifer Anyanti, Augustine Ankomah, Godpower Omoregie, and Fatima Mamman-Daura - African Journal of AIDS Research* 9(1): 51–61 (DOI:10.2989/16085906.2010.484526)
http://www.tandfonline.com/doi/abs/10.2989/16085906.2010.484526#.VImMwzHF9NM

8 The Enhancing Nigeria Response to HIV&AIDS HQ Programme Team

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55	Ifenyiwa Okeke	Behavioural Change Communication Technical Advisor	Cross River
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