KOGI STATE GOVERNMENT

Kogi State
HIV and AIDS
Strategic Plan
2025 – 2027

JULY 2025

FOREWORD

Over the past decade, Kogi State government, at all levels, multilateral and bilateral agencies and non-governmental organizations have been so committed to combatting Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in the 21 Local Government Areas of the State. The Kogi State AIDS Control Agency (KOSACA) provides overall coordination and leadership for the entire State HIV and AIDS response, while the State AIDS and STI Control Programme (SASCP) coordinate the health sector response in the State.

Despite the availability of highly effective response strategies for decades, HIV and AIDS is still a major public health issue in Kogi State, with the prevalence standing at 0.9%, Overall, the State has an estimated HIV burden of 190,913 and treatment coverage of 169,805. There is considerable variation in the prevalence of HIV across the 21 LGAs in Kogi State. The 2025-2027 State strategic plan for Kogi State (SSP) is the Fourt plan developed by the state with the support of NACA, AHF and CIHP. This plan was developed to guide the implementation of 95-95-95 initiatives. It is a well-articulated plan that was developed with the support of all relevant stake holders and taking into consideration all the gaps in HIV intervention programme in the previous years. The plan also takes into consideration the Kogi State government health priorities and the RNSF. Three Strategic priority areas were considered: Strategic Priority 1: Equitable and equal access to HIV services for all. Strategic Priority 2: Break down barriers to achieving HIV service outcomes and Strategic Priority 3: Fully resource and sustain efficient HIV responses and integrate them into relevant systems and Cross-cutting issues that should be addressed to implement this SSP. It is the mutual plan of action that the State government, partners and civil society must implement to achieve our desired goals of carrying forward the government’s commitment to achieving HIV free State

I am confident that our combined efforts will help the State to eliminate HIV/AIDS. I therefore, wish to call all the HIV and AIDS stakeholders, particularly our implementing partners to join hand to implement this plan so that our goals and objectives are fully achieved.

Dr Abdulazeez Adams Adeiza
Honourable Commissioner for Health

ACKNOWLEDGEMENT

The development of the Kogi State Strategic Plan for HIV Response is a significant milestone in our collective effort to achieve an HIV-free generation. This document reflects the commitment and collaboration of various stakeholders, whose contributions have been invaluable in shaping a comprehensive and sustainable framework for HIV prevention, care, and treatment in the state.

We extend our profound gratitude to His Excellency, the Executive Governor of Kogi State, for his leadership and unwavering support in strengthening the health sector. Special appreciation goes to the Honorable Commissioner for Health for championing the strategic direction and ensuring alignment with national and global HIV response goals.

Our sincere appreciation also goes to the Project Managers/Chief Executive Officers/Executive Secretaries/Chairpersons of State Agency for the Control of AIDS (KOSACA), the State Ministry of Health (SMOH), State AIDS and STIs Control Program (SASCP), State Primary Healthcare Development Agency (SPHCDA),Kogi State Health Insurance Agency, HMB, MDAs, The commitment of local government authorities, healthcare workers, implementing partners, civil society organizations (CSO) networks (NEPWHAN, ASWHAN, CiSHAN), SPHCB, and the private for their technical expertise and dedication throughout this process, and key population networks has been instrumental in ensuring a participatory and inclusive planning process.

I must also commend the commitment of our hardworking SSP consultant, Dr. Mary Ojonema Onoja-Alexander, who successfully led the process and gave clear direction in the development of the Kogi State Strategic Plan 2025-2027 and the oversight role played by NACA and the National Team of SSP Consultants led by Engr. Barr, Cyril Omoikhoje Ojeonu with Dr. Patrick Ikani as Co-Lead in the development of this document.

We recognize the immense contributions of our development partners, including the Global Fund, AHF and CIHP other donors, whose financial and technical support have been critical in shaping this strategic plan.

Finally, we appreciate the resilience of people living with HIV (PLHIV), community advocates, and all frontline health workers for their relentless efforts in combating HIV/AIDS. This strategic plan serves as a roadmap to achieving a healthier, more resilient Kogi State.

Mr. Ibrahim Anate
Ag. Executive Secretary KOSACA

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune deficiency Syndrome
AHF	AIDS Healthcare Foundation
ANC	Ante-natal care
ART	Antiretroviral Therapy
ARV	Anti-retroviral
BBFSW BCC	Brothel-Based Female Sex Worker(s) Behavior Change Communication
CAN	Christian Association of Nigeria
CBOs	Community-Based Organizations
CIHP	Centre for Integrated Health Programs
CiSNHAN	Civil Society Network for HIV/AIDS in Nigeria
CPT	Co-trimoxazole Preventive Therapy
CSOs	Civil Society Organizations
CSS	Community Systems Strengthening
CTX	Co-trimoxazole
DfID	United Kingdom Department for International Development
DHIS	District Health Information System
DOTS	Directly Observed Treatment – Short Course
Emtct	Elimination of Mother-to-Child Transmission of HIV
EID	Early Infant Diagnosis of HIV
FBOs	Faith-Based Organizations
FCT	Federal Capital Territory
FGoN	Federal Government of Nigeria
FLHE	Family Life and HIV Education
FMoH	Federal Ministry of Health
FMWA & SD	Federal Ministry of Women Affairs and Social Development
GBV GFATM	Gender Based Violence Global Fund to fight HIV/AIDS, TB and Malaria

HAD	HIV/AIDS Division
HAF	HIV/AIDS Fund
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HTS	HIV Testing Services
IBBSS	Integrated Biological and Behavioral Sentinel Surveys
IDPs	International Development Partners
IDU	Injection Drug Users
IEC	Information, Education, Communication
IMNCH	Integrated Maternal, Newborn, and Child Health
Ips	Implementing Partners
JMTR	Joint Mid-Term Review
KOSACA	Kogi State Agency for the Control of AIDS
LACAs	Local Action Committee on AIDS
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR-TB	Multi-Drug-Resistant TB
MPPI	Minimum Prevention Package Intervention
MIPA	Meaningful Involvement of People Living with HIV and AIDS
MSM	Men who have Sex with Men
MTCT	Mother-to-child transmission of HIV
NACA	National Agency for the Control of AIDS
NARHS	National AIDS and Reproductive Health Surveys
NASA	National AIDS Spending Assessment
SASCP	State AIDS/STI Control Programme
NBBFSW NBTS	Non-Brothel-Based Female Sex Worker(s) National Blood Transfusion Service
NDHS	Nigeria Demographic and Health Survey
NGOs	Non-Governmental Organizations
NHSSS	National HIV Sero-prevalence Sentinel Survey
SPHCDA	State Primary Health Care Development Agency
NSF	National Strategic Framework
NSP	National Strategic Plan
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PABA	People Affected By HIV/AIDS
PEP PEPFAR	Post-exposure prophylaxis President's Emergency Plan for AIDS Relief
PHC	Primary Health Care

PHDP	Positive Health, Dignity and Prevention
PLWHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-exposure prophylaxis
PWID	People Who Inject Drugs
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SACAs	State Action Committees on AIDS/State Agency for the Control of AIDS
SBCC	Strategic Behavioral Change Communication
SDPs	Service Delivery Points
LACA	Local Government Action Committee on AIDS
SMEDAN	Small and Medium Enterprises Development Agency of Nigeria
SMoH	State Ministry of Health
SRH	Sexual and Reproductive System
STIs	Sexually Transmitted Infections
TasP	Treatment as Prevention
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UNAIDS	United Nations Joint Program on HIV/AIDS
UNICEF	United Nations Children's Fund
VC	Vulnerable Children
VCA	Vulnerable Children and Adolescents
WHO	World Health Organization

EXECUTIVE SUMMARY

Background

HIV/AIDS remains a significant public health challenge in Kogi State, Nigeria, despite notable progress in prevention, treatment, and care. According to the 2018 Nigeria AIDS Indicator and Impact Survey (NAIIS), Kogi State has an HIV prevalence of approximately 0.9%, with 43,373 persons living with HIV (PLHIV) in the state. As of late 2024, about 36,066 PLHIV are currently receiving antiretroviral therapy (ART), reflecting ongoing efforts to expand treatment coverage and reduce HIV-related morbidity and mortality.

HIV Situation in Kogi State

Kogi State has HIV prevalence of approximately 0.9%, with over 43,373 people living with HIV (PLHIV) in the state. The prevalence among persons aged 35 and 39 years have the highest prevalence of 5.6% (while the women of reproductive age female 20 -24 years have a prevalence rate of 1.3%). Kogi State has a population of 43,373 of people living with HIV (PLHIV); however, only 24,867 them are on treatment (CIHP – 73.01%; AHF – 27.02%) representing 57.3% with a gap of 18,506 PLHIV yet to be diagnosed, linked-to-care and commenced on ART. Health care facilities (HCFs) that provide services to clients in Kogi State are 219, 105 and 36 for HTS, PMTCT and ART respectively. As of late 2024, 36,066 PLHIV are currently receiving antiretroviral therapy (ART), reflecting ongoing efforts to expand treatment coverage and reduce HIV-related morbidity and mortality. [1]

[1] NAIIS 2018 Technical Report
[2] Nigerian National Data Repository 2025

In 2025 June, the prevalence of HIV/AIDS in Kogi State is estimated at approximately 0.9% (based on the 2018 Nigeria HIV/AIDS Indicator and Impact Survey - NAIIS), with prevalence among females slightly higher than males, consistent with national trends. This translates to 36,,992 people living with HIV in the state. The prevalence among people aged 15-49 years accounts for most cases, approximately 80% of the total HIV-positive population in Kogi State. The annual incidence rate is estimated at about 0.05%, indicating that roughly 2,500 people become newly infected each year. The HIV epidemic in Kogi State disproportionately affects females, who constitute a significant majority of PLHIV, particularly women of reproductive age. Kogi State has a population of 36,922 people living with HIV (PLHIV) and all are on treatment. Healthcare facilities (HCFs) that provide comprehensive HIV services to clients in Kogi State are 35 (HTS, PMTCT and ART) respectively. While 39 health facilities provide only Treatment. [2]

The state government, under the leadership of Governor Alhaji Usman Ododo, is committed to ensuring that pregnant women living with HIV deliver HIV-negative babies and that PLHIV receive sustained treatment and support by providing free ANC, PMCT Delivery and free Antimalaria drugs through the Bacic Heath care Provision Fund (BHCPF) and the Kogi State Health Insurance Agency (KSHIA) funds.

In recent years, Kogi State has faced challenges related to the sustainability of HIV programs, especially following the US government's decision to pause funding for HIV initiatives in Nigeria. This funding gap prompted a high-level stakeholders' meeting convened by the Kogi State Ministry of Health to develop sustainable strategies for uninterrupted HIV service delivery. Key recommendations included integrating HIV care into mainstream health services. For instance,

[2] Nigerian National Data Repository 2025
[3] Kogi State Government of Nigeria <Annual Budget Estimate 2025

only ₦ 27,400,000 million was approved as budget for KOSACA in 2024 and this was not released; the money appropriated to KOSACA was further reduced to ₦27,400 million in 2025. [3]

Despite this progress, Kogi State remains among the states with a moderate HIV burden, requiring sustained and intensified efforts to prevent new infections, reduce AIDS-related deaths, and improve the quality of life for people living with HIV (PLHIV).

Strategic Approach to HIV Control in Kogi State

A broad multi-sectoral approach with well-coordinated strategies across sectors is essential to achieve the goal of ending HIV/AIDS in Kogi State. Preventing new infections is critical and requires sustained measures to protect all at-risk or vulnerable populations, including unborn children, newborns, youth, adolescents, and sexually active adults. Concurrently, efforts to suppress the virus in those already infected must be scaled up to avert new infections and reduce AIDS-related morbidity and mortality. Care and support services must be expanded to improve the quality of life for PLHIV.[3]

Effective HIV control goes beyond health facilities and must reach communities, institutions, workplaces, and other social settings. Central to this strategy is the delivery of combination prevention services and the elimination of mother-to-child transmission through comprehensive preventive interventions. The necessary knowledge and biomedical tools for prevention are available, but ensuring that youth, adolescents, and sexually active men and women are "HIV-competent" — knowledgeable and empowered to use these tools is critical for success.

Kogi State HIV and AIDS Strategic Plan 2025 – 2027 Development Process

[3] National Validated Health Sector Data 2025

The development of the Kogi State HIV and AIDS Strategic Plan (SSP) 2025–2027 was a highly participatory and consultative process involving diverse stakeholders. These included policymakers, federal and state government officials, technical experts from academia and other sectors, representatives of national and state HIV/AIDS technical working groups, civil society organizations, young people (adolescents and youth), PLHIV, people with disabilities, key populations, faith-based organizations, interest groups, and development partners. The process involved a comprehensive review of HIV trends in Kogi State and Nigeria, previous response efforts and their outcomes, existing state strategic plans, and current developments in the global HIV/AIDS landscape. The Kogi State HIV Strategic Plan (SSP) 2025–2027 is aligned with the Revised National Strategic Framework (NSF) 2019–2021, National HIV/AIDS Strategic Plan (NSP) 2023–2027, the Global AIDS Strategy 2021–2026, and relevant political declarations on HIV/AIDS. Stakeholder engagement included key informant interviews, focus group discussions, and a three-day physical workshop.

The Vision, Goal, and Strategic Priorities

The Vision of the Kogi SSP is to have an AIDS-free Kogi State with zero new infections, zero AIDS-related discrimination and stigma, and zero AIDS-related deaths.

The Goal of the SSP is to strengthen the state and national HIV response to facilitate ending AIDS in Kogi State by 2030.This goal will be operationalized through three strategic priorities:

Strategic Priority 1: Equitable and equal access to HIV services for all. Three results areas will constitute the primary focus under this Strategic Priority: (i) HIV prevention, (ii) HIV testing, treatment, care, viral suppression and integration, (iii) Prevention of vertical HIV prevention and paediatric HIV treatment.

Strategic Priority 2: Break down barriers to achieving HIV service outcomes. The four result areas that have been identified to address this Strategic Priority are: (i) Community-led response, (ii) Human rights, (iii) Gender equality and (iv) Young people

Strategic Priority 3: Fully resource and sustain efficient HIV responses and integrate them into relevant systems e.g. health, education, social services and protection, humanitarian and pandemic responses. This Strategic Priority will be addressed by three results namely: (i) Fully funded and efficient response, (ii) Integration of HIV into relevant systems for health, education, social services and protection, (iii) Humanitarian and pandemic situations

Cross-cutting issues that should be addressed to implement this SSP: These include (i) Leadership, state ownership, governance and advocacy, (ii) Partnerships multi-sectoral collaboration, and (iii) Data for impact, science, research and innovation.

Costing and Financial Resourcing of the Kogi SSP 2025 – 2027

The total cost for implementing the Kogi SSP 2025–2027 is estimated at ₦36,385,865,329.69 (USD [$ ($24,257,243.55), with HIV interventions accounting for 73.6.% (₦26,777,3111.27) of the proposed investments over the plan period. The cost of HIV program activities, including policy-based prevention, is estimated at (₦9,608,537,018.42).

A most of the funding is expected from domestic sources, with increased mobilization from both public and private sectors in line with Nigeria's "Alignment 2.0" agenda and the New Business Model (NBM). The HIV Trust Fund (HTF) **and 239 wards** supports mobilization from the private sector, while public sector financing will include the Basic Health Care Provision Fund (BHCPF), Health Insurance Scheme, and government budget allocations.

INTRODUCTION

Kogi State Profile

Kogi State is one of the 36 states in Nigeria, created in August 1991, and is in the North Central geopolitical zone of the country. The state capital is Lokoja. Kogi State comprises 21 Local Government Areas (LGAs) **and 239 wards** and is bounded by the following states, by Enugu in the South East , Benue in in the East, Nasarawa in the North East, Onodo in the South West, Edo in the East, Anambra in the South , and Ekiti in the South and by the Federal Capital Territory (FCT Abuja), The total land area of Kogi State is approximately 28,989 km², ranking it 20th in land mass among Nigerian states. [4,5]

According to the 2006 national population census, Kogi State had a population of about 3.3 million. Recent projections estimate the population to be approximately 4.47 million in 2016 and 5,748,847 million in 2025, reflecting steady growth driven by natural increase and migration of 1.5.[1, 3.] The population is almost evenly split by gender, with males accounting for about 49.9% (2,966,471) and females 50.1% (2,782,376) . The age distribution shows a youthful population, with nearly 40% under 15 years old and about 16.6% aged 15–24 years.[3].

The major ethnic groups in Kogi State are the Igala (about 30%), Ebira (25%), and Okun (20%), with the remaining 25% comprising other ethnic groups from across Nigeria and beyond. Islam and Christianity are the dominant religions, representing approximately 45% and 40% of the population, respectively, while traditional religions account for about 15% .[4,5]

Geography and Climate

[4] CityPopulation.de – Kogi State Population Statistics (2022)

[5] CityPopulation.de – Nigeria Administrative Divisions (2022)

Kogi State has a tropical climate with a rainy season from April to October and a dry season from November to March. The average maximum temperature is around 34.5°C, while the average minimum temperature is about 22.8°C. The state experiences significant flooding, particularly along the Niger and Benue rivers.

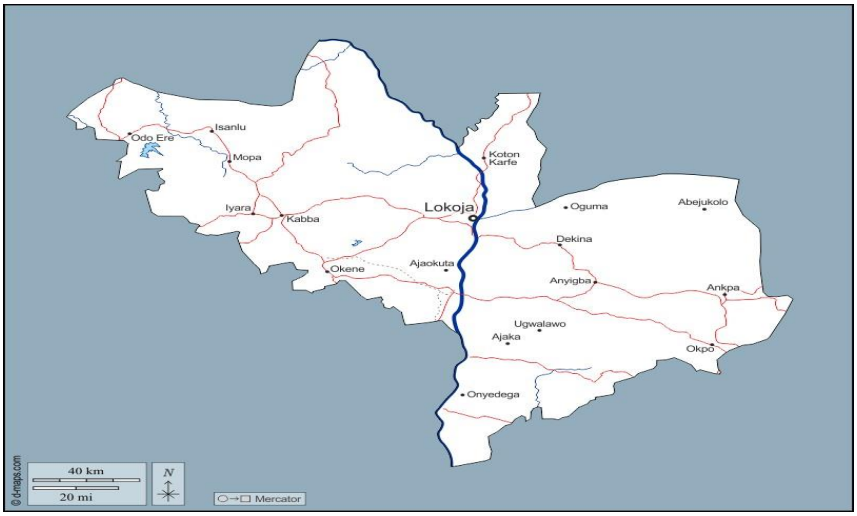
Economy

Kogi is known as the "Confluence State" due to the meeting of the Niger and Benue Rivers at Lokoja. Agriculture is the backbone of the state's economy, with major crops including sorghum, millet, rice, maize, cotton, groundnuts, cowpea, sugarcane, wheat, fruits, and vegetables. The state is also a significant irrigation hub. Livestock farming is common, with cattle, camels, sheep, goats, poultry, and fishery contributing to livelihoods. Besides agriculture, Kogi is a major commercial and industrial center, ranking as the second largest industrial hub in Nigeria and the largest in Northern Nigeria.[4]

There are over 400 privately owned medium and small-scale industries producing textiles, leather goods, footwear, cosmetics, plastics, pharmaceuticals, ceramics, furniture, and bicycles. [4] Formal employment accounts for only about 8% of the workforce, while over 90% of the population is engaged in the informal sector, including trading, agriculture, and self-employment.[3]

Governance

The state is led by a democratically elected governor working closely with the Kogi State House of Assembly. The current governor is Usman Ododo**.**



Health Infrastructure and Socioeconomic Indicators

Kogi State has a total of 1080 health facilities distributed across its 21 LGAs. These include 653 Primary Health Care facilities, 66 secondary health facilities, 4 tertiary hospitals, and 162 private hospitals, clinics, nursing, and maternity homes[4]. There are 218 registered Private Health Facilities within the state. *(DHPRS 2025).*

KOGI STATE HEALTH FACILITIES BY LEVEL OF CARE (DHPRS 2025)

	Health Facilities by Level of Care		
Level	**Private**	**Public**	**Total**
Primary	133	947	**1,080**
Secondary	85	66	**151**
Tertiary	-	4	**4**
Total	**218**	**1,017**	**1,235**

HEALTH TRAINING INSTITUTION IN KOGI STATE (DHPRS 2025)

Health Training Institutions	**Private**	**Public**	**Total**
Colleges of Medicine	-	2	**2**
Schools of Nursing & Midwifery	5	4	**9**
Schools of Health Technology	10	1	**11**

Schools of Pharmacy	-	-	-
Total	**15**	**7**	**22**

Poverty remains a significant challenge, with about 33.28% of the population living below the poverty line[4]. Life expectancy in Kogi is estimated at 51 years for males and 52 years for females. Child health indicators are concerning under-five mortality is approximately 157 per 1000 live births, and maternal mortality stands at 1025 per 100,000 live births. Only 23% of deliveries are assisted by skilled health personnel, compared to the national average of 42%. [6,4]

Communicable diseases, particularly malaria and acute respiratory infections, remain leading causes of post-neonatal child mortality. Non-communicable diseases such as hypertension and diabetes are emerging health burdens but remain neglected in terms of care availability.[4]

HIV and AIDS Situation in Kogi State

HIV/AIDS remains a significant public health challenge in Kogi State, Nigeria, despite notable progress in prevention, treatment, and care. According to the 2018 Nigeria AIDS Indicator and Impact Survey (NAIIS), Kogi State has an HIV prevalence of approximately 0.9%, with over 43,373 people living with HIV (PLHIV) in the state. The prevalence among persons aged 35 and 39 years have the highest prevalence of 5.6% (while the women of reproductive age female 20 - 24 years have a prevalence rate of 1.3%). Kogi State has a population of 43,373 of people living with HIV (PLHIV); however, only 24,867 them are on treatment (CIHP – 73.01%; AHF – 27.02%) representing 57.3% with a gap of 18,506 PLHIV yet to be diagnosed, linked-to-care and commenced on ART. Health care facilities (HCFs) that provide services to clients in Kogi State are 219, 105 and 36 for HTS, PMTCT and ART respectively. As of late 2024, 36,066 PLHIV are

[6] Zaccheus Onumba Dibiaezue Memorial Libraries – Kogi State Profile

currently receiving antiretroviral therapy (ART), reflecting ongoing efforts to expand treatment coverage and reduce HIV-related morbidity and mortality. [7]

As of late 2024, 36,066 PLHIV are currently receiving antiretroviral therapy (ART), reflecting ongoing efforts to expand treatment coverage and reduce HIV-related morbidity and mortality. [8]

In 2025 June, the prevalence of HIV/AIDS in Kogi State is estimated at approximately 0.9% (based on the 2018 Nigeria HIV/AIDS Indicator and Impact Survey - NAIIS), with prevalence among females slightly higher than males, consistent with national trends. This translates to 36,992 people living with HIV in the state. The prevalence among people aged 15-49 years accounts for most cases, approximately 80% of the total HIV-positive population in Kogi State. The annual incidence rate is estimated at about 0.05%, indicating that roughly 2,500 people become newly infected each year. The HIV epidemic in Kogi State disproportionately affects females, who constitute a significant majority of PLHIV, particularly women of reproductive age. Kogi State has a population of 36,922 people living with HIV (PLHIV) and all are on treatment. Healthcare facilities (HCFs) that provide comprehensive HIV services to clients in Kogi State are 35 (HTS, PMTCT and ART) respectively. While 39 health facilities provide only Treatment. As of late 2024, 36,066 PLHIV are currently receiving antiretroviral therapy (ART), reflecting ongoing efforts to expand treatment coverage and reduce HIV-related morbidity and mortality. [9]

The state government, under the leadership of Governor Alhaji Usman Ododo, is committed to ensuring that pregnant women living with HIV deliver HIV-negative babies and that PLHIV receive sustained treatment and support by providing free ANC , PMCT Delivery and free

[7] CityPopulation.de – Nigeria Administrative Divisions (2022)
[8] CityPopulation.de – Nigeria Administrative Divisions (2022)
[9] CityPopulation.de – Nigeria Administrative Divisions (2022)

Antimalaria drugs through the Bacic Heath care Provision Fund (BHCPF) and the Kogi State Health Insurance Agency (KSHIA) funds.[2,3]

Scaling up HIV testing services is critical to achieving the first of the global 95-95-95 targets, which aims to increase HIV status awareness among PLHIV. HIV/AIDS accounts for about 5.18% of mortality among women of reproductive age in Nigeria. Other leading causes of mortality in this group include neonatal disorders (12.25%), malaria (12%), diarrheal diseases (11.36%), and lower respiratory infections (10.85%).[5]

Nationally, HIV prevalence among women of reproductive age was 1.6% in 2018, with an incidence rate of 0.9 per 1000 population. Nigeria, which comprises about 2% of the global population, accounts for 14% of maternal deaths worldwide. Every day, approximately 145 women of childbearing age die from maternal causes, with a maternal mortality rate of 512 per 100,000 live births (NDHS 2018).[3,5] The population it accounts for 14% of maternal deaths and every day 145 women of childbearing age dies with the Maternal Mortality rate at 512/100,000 live births according to NDHS 2018.

The Kogi State HIV and AIDS Strategic Plan 2025-2027 Development Process

The development of the first and second HIV/AIDS strategic plan for Kogi State 2006-2009 and 2010 to 2015 created the enabling environment for the coordination of the multi-sectoral HIV response in the State to effectively steer the governance and leadership in the reduction of new HIV infections. The state recorded levels of successes in the implementation of the 2006 – 2009 State Strategic Plan. Next was the KOSACA State Strategic Plan 2017–2021which was developed in line with the Revised National Strategic Framework III. NSF III provides an overarching framework for all States of the federation with the purpose of ensuring harmony in the SSP. The fourth strategic plan is the SSP 2025-2027

The development of KOSACA State Strategic Plan was highly participatory and a consultative process involving wide range of cross-cutting stakeholders, including policymakers, federal and state government officials, technical experts from the academic and other sectors, representatives if the national state HIV/AIDS technical working groups, representatives of civil society organization, young people (adolescents and youth), PLHIV, people with disabilities, key populations, faith-based organizations, interest groups, and development partners. The process involved review of HIV trend in Kogi State and Nigeria, previous state and national response efforts and results, the existing state strategic plans and current developments in the global HIV/AIDS landscape. The development of this SSP was informed by the Revised National Strategic Framework (NSF) 2019-2021, the National HIV and AID Strategic Plan 2023-2027, the Global AIDS Strategy 2021-2026 and the Political Declarations on HIV/AIDS. The stakeholder engagement process included Key Informants Interviews, Focus Group Discussions and a three-day physical workshop. The following are the summarized key steps:

- Formal Engagement of the Consultant
- Orientation of the Consultants, Project Managers on SSP development process by NACA
- Constitution of the Technical Working Group.
- Desk review of relevant National and State documents and by the Consultant.
- Limited field visits/phone call by the Consultant for Focus Group Discussion (FGD) and Key Informant Interview of selected CBOs, NGOs and Networks that have provided support to the state in the response
- Writing of the zero draft of the Responsive review
- Three days stakeholders meeting for validation and development of the costing of the SSP matrix with facilitation from NACA.

- The production of the final draft and costed the State Strategic Plan 2025-2027.
- One day Validation meeting.

2.0 HIV situation in Kogi State

The HIV prevalence in Kogi state was from 5.8% in 2010 to 1.4% in 2012. The Kogi State HIV prevalence was 0.9% compared to the national prevalence of 1.3% in 2018. The other findings are presented along the three priority areas as contained below.

***HIV incidence and prevalence*:**

The HIV epidemic in Kogi State is similar to that of the country which is a mixed epidemic partly driven by significant key populations, particularly female sex workers (FSW), including both brothel-based (BBFSW) and non-brothel based (NBFSW), men who have sex with men (MSM) and people who inject drugs (PWID), with substantial overlap with urban casual sexual networks. Prevalence among key populations is significantly higher than in the general population. The 2018 NAIIS report shows .The Nigeria AIDS Indicator and Impact Survey (NAIIS) 2018 identified the national HIV prevalence as 1.3% and Kogi State's prevalence as 0.9%, with important epidemiologic implications for the provision of antiretroviral therapy (ART) services for about 36,066 people living with HIV (PLHIV) currently on treatment in 35 ART clinics across Kogi State (91% of whom are on first-line ART).[7,8] reflecting ongoing efforts to expand treatment coverage and reduce HIV-related morbidity and mortality. The 2020 National Policy on HIV and AIDS and the Sustainable Development Goal (SDG) 3.3, which aims to end AIDS as a public health threat, demand urgent action to ensure that 95% of PLHIV are diagnosed, placed on

treatment to reduce immunosuppression, and supported through strategies that promote full disclosure and achievement of viral suppression defined as viral load <1,000 copies/ml .[10]

The scale-up of the 81% viral suppression rate currently achieved by PLHIV on ART requires commitment to improving disclosure through strategic design and evaluation. This includes examining the determinants and risks associated with disclosure to exceed the 2018 level of 69.7% of PLHIV who received adherence support, targeting 72% and 75% in 2023 and 2025 respectively, in alignment with Kogi State's specific focus in the National Operational Plan (NOP) III 2021–2025.[11]

A comparative regression analysis of validated data from 2016 to 2020 from the National Data Repository (NDR) of the Federal Ministry of Health (FMoH) showed that 7,477 (<31% male) and 16,432 (<69% female) PLHIV were on ART (95% CI) in 35 comprehensive healthcare facilities in Kogi State. These facilities are operated by the US President's Emergency Plan for AIDS Relief (PEPFAR)-funded Center for Integrated Health Programmes (81%) and AIDS Healthcare Foundation (AHF) (19%). The analysis revealed a 31% growth trajectory in new HIV infections in Kogi State, with 59% of PLHIV being females of reproductive age (15–49 years)/[12] . As at 2025, validated data from National Data Repository (NDR) of the Federal Ministry of Health (FMoH) showed that the state had viral Load testing coverage of 86% ,A Viral Load suppression coverage of 97%, for 7,477 (<31% male) and 16,432 (<66% female) PLHIV were on ART (100% CI) in 35 comprehensive healthcare facilities in Kogi State. These facilities are operated by the US

[10] WHO. Global HIV/AIDS Strategy 2021. Available from: https://www.phis3project.org.ng/wp-content/uploads/2024/05/NN-HIV-Surveillance-Report-March-2024-1.pdf
[11] National Data Repository (NDR) 2020, Kogi State HIV Program Data. Available from: http://kogistate.gov.ng/wp-content/uploads/Min.-of-Health-MTSS.pdf
[12] National Agency for the Control of AIDS (NACA), Key Populations Size Estimation Report, December 2023. Available from: https://naca.gov.ng/wp-content/uploads/2024/03/Final-KPSE-20-States-Report_-DEC-2023-2.pdf

President's Emergency Plan for AIDS Relief (PEPFAR)-funded Center for Integrated Health Programs (81%) and AIDS Healthcare Foundation (AHF) (19%). The analysis revealed a 31% growth trajectory in new HIV infections in Kogi State, with 59% of PLHIV being females of reproductive age (15–49 years)[13] .

Determinants of HIV and AIDS intervention scale-up include equitable access and risk factors linked to vulnerable and key populations, with emphasis on the self-efficacy of female PLHIV in uptake of ancillary antenatal care (ANC), postnatal care (PNC), and laboratory tests such as viral load and GeneXpert/Tuberculosis (TB) screening. WHO guidelines note that TB-suggestive symptomatic clients may delay until completion of isoniazid preventive therapy (INH).[14,15] Positive Health, Dignity, and Prevention (PHDP) interventions also play a critical role in improving outcomes among PLHIV.

Many factors have contributed to the HIV/AIDS epidemic in the state. These include initial denial, poor health-seeking behaviours, stigma and discrimination, increasing poverty, lack of economic and financial empowerment of women, some socio-cultural practices, and inadequate access to information.[16]

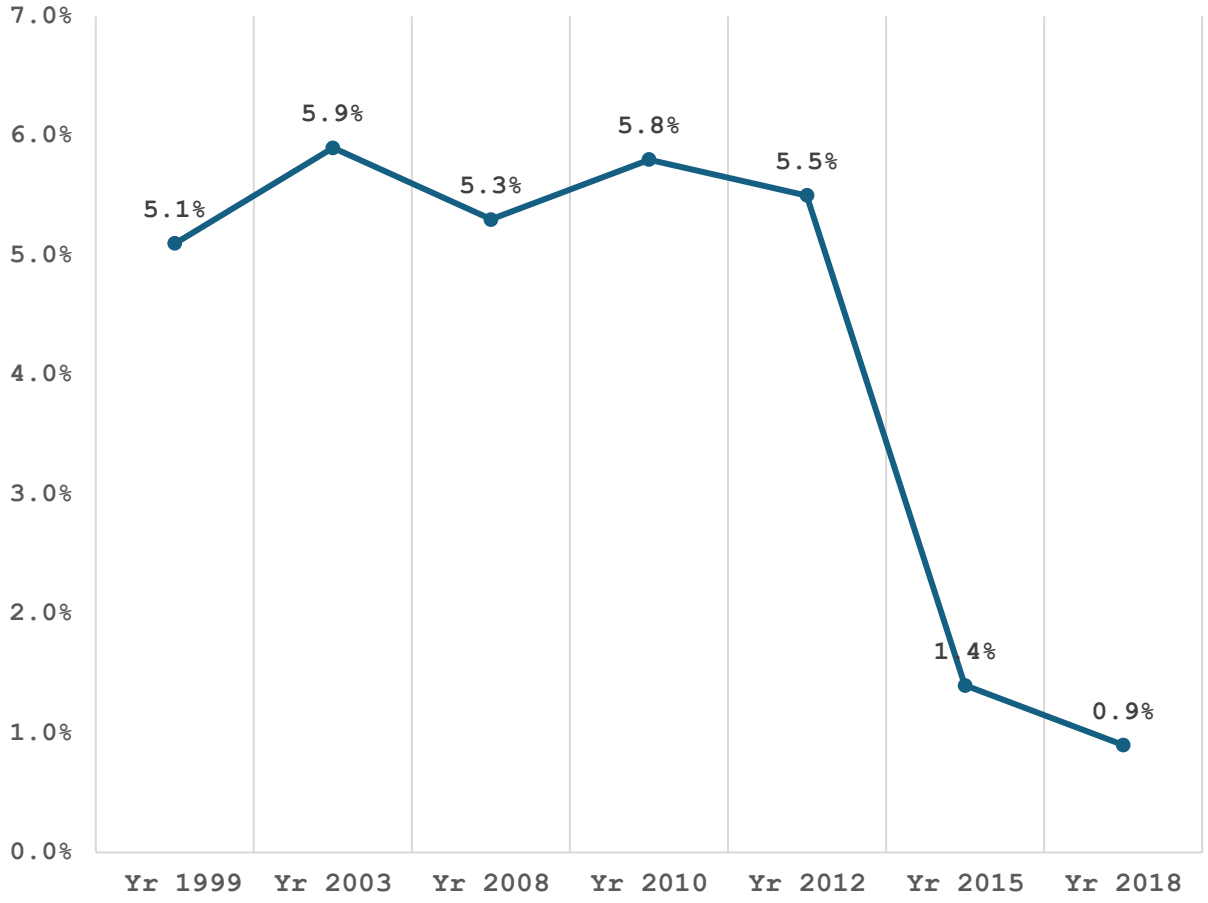
[13] National Agency for the Control of AIDS (NACA), Key Populations Size Estimation Report, December 2023. Available from: https://naca.gov.ng/wp-content/uploads/2024/03/Final-KPSE-20-States-Report_-DEC-2023-2.pdf

[14] WHO. Global HIV/AIDS Strategy 2021. Available from: https://www.phis3project.org.ng/wp-content/uploads/2024/05/NN-HIV-Surveillance-Report-March-2024-1.pdf

[15] U.S. Department of State, Nigeria Country Operational Plan 2022. Available from: https://www.state.gov/wp-content/uploads/2022/09/Nigeria-COP22-SDS.pdf

[16] Federal Ministry of Health (FMoH), National Data Repository (NDR) 2020, Kogi State HIV Program Data. Available from: http://kogistate.gov.ng/wp-content/uploads/Min.-of-Health-MTSS.pdf

Figure 1: Kogi State HIV Prevalence 1999 to 2018



1.1.1. ***People living with HIV and coverage of treatment services***

Globally and in sub-Saharan Africa 48% and 59% respectively of all new HIV infections occurred among women of reproductive age in 2019. [11] HIV positive Sero-status disclosure to sexual partner leads to safer sexual practice and emotional financial gains and also encourages partners to make informed reproductive health choices. HIV positive Sero-status disclosure has been recognized as a crucial goal in HIV Testing Services and also the male or partner involvement in Prevention of Mother-to-Child Transmission of HIV but remains a challenge. The Nigeria AIDS Indicator and Impact Survey (NAIIS) 2018 estimated that about 50,000 people are living with

HIV in Kogi State, with females accounting for approximately 58% (around 29,000) and males about 42% (approximately 21,000).[17] People aged 15–49 years constitute the highest proportion of those infected, representing about 80% of all cases in the state[1]. Although historical prevalence data for Kogi State are limited, HIV/AIDS has been a significant public health concern, with prevalence stabilizing around 0.9% as per recent surveys.[18]

Despite progress in reducing incidence and improving treatment coverage, Kogi State remains a moderate HIV burden state in Nigeria. Interventions on prevention and service delivery—such as HIV Testing Services (HTS), Prevention of Mother-to-Child Transmission (PMTCT), Home-Based Care (HBC), and impact mitigation programs—are primarily concentrated in metropolitan and peri-urban Local Government Areas (LGAs), including Lokoja and surrounding LGAs.[19] However, efforts led by the Kogi State Agency for the Control of AIDS (KOSACA), civil society organizations, and development partners have expanded awareness campaigns and treatment services into rural and hard-to-reach communities.[2]

The Kogi State government, under the Governor, His Excellency, Alhaji Ahmed Usman Ododo, is committed to increasing treatment coverage and ensuring that pregnant women living with HIV deliver HIV-negative babies. Security challenges in some parts of the state have affected access to treatment for some patients. To address stigma and encourage disclosure, the state House of Assembly recently passed an Anti-Stigma HIV Law, awaiting the governor's assent. This law is

[17] NIGERIA HIV/AIDS INDICATOR AND IMPACTSURVEY FACT SHEET MARCH 2019, NACA https://www.naca.gov.ng/wp-content/uploads/2019/03/NAIIS-PA-NATIONAL-FACTSHEET-FINAL.pdf
[18] Federal Ministry of Health (FMoH), National AIDS Indicator and Impact Survey (NAIIS) 2018.

[19] Kogi State Agency for the Control of AIDS (KOSACA) Annual Report, 2024.

expected to empower people living with HIV to disclose their status confidently and access care without fear of discrimination.[20]

1.1.2. *populations*

Table 1 presents the estimated size Key Populations (KP) in Kogi State with 10,366 FSW, 3,482 MSM and 8804 PWID, as obtained from the Key Population Size Estimate, 2018. Similarly, the HIV/STI Integrated Biological and Behavioural Surveillance Survey 2020 estimated the prevalence of HIV among KP as 15.5% for FSW, 25.0% for MSM, 10.2% for PWID and 28.8% for TG. HIV testing and status awareness among the KPs in the State has improved significantly ranging from 81.1% among PWID to 76% among FSW. However, antiretroviral therapy coverage was low, ranging from 19.5 to 26.3%. Men having Sex with Men had the highest partners' consistent use of condoms of 71.2%, while PWIDs has lowest condom use of 51,1%.

Table 1: HIV Statistics for Key Populations in Kogi State, 2024

	Sex Workers	**MSM**	**PWID**	**TG**	**Sources**
Population size estimate (#)	10,366	3,482	8804	1974	Key Population

					Size Estimate
HIV prevalence (%)	15.5	25.0	10.9	28.8	IBBSS 2021
Number tested	52,243	17,511	40,440	387	Kogi Non-Health Sector Data 2024
HIV testing and status awareness (%)	76	61.5	81.1	31.5	OSS Kogi 2024
Antiretroviral therapy coverage (%)	23.7	26.3	25	19.5	IBBSS 2021
Condom use (%)	53.4	71.2	51.1	70.9	KPPR 2024
Safe injecting practices (%)	-	-	82.9	-	OSS Kogi 2024

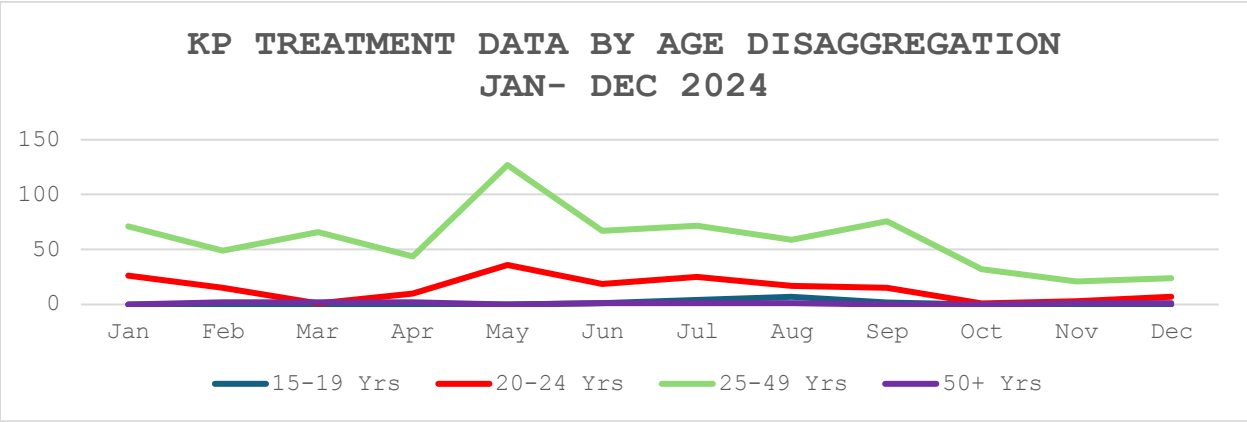


Figure 2: KP Treatment by Age Disaggregation January to December 2024 (Source: HIV and AIDS 2024 Validated Non-Health Sector Data)

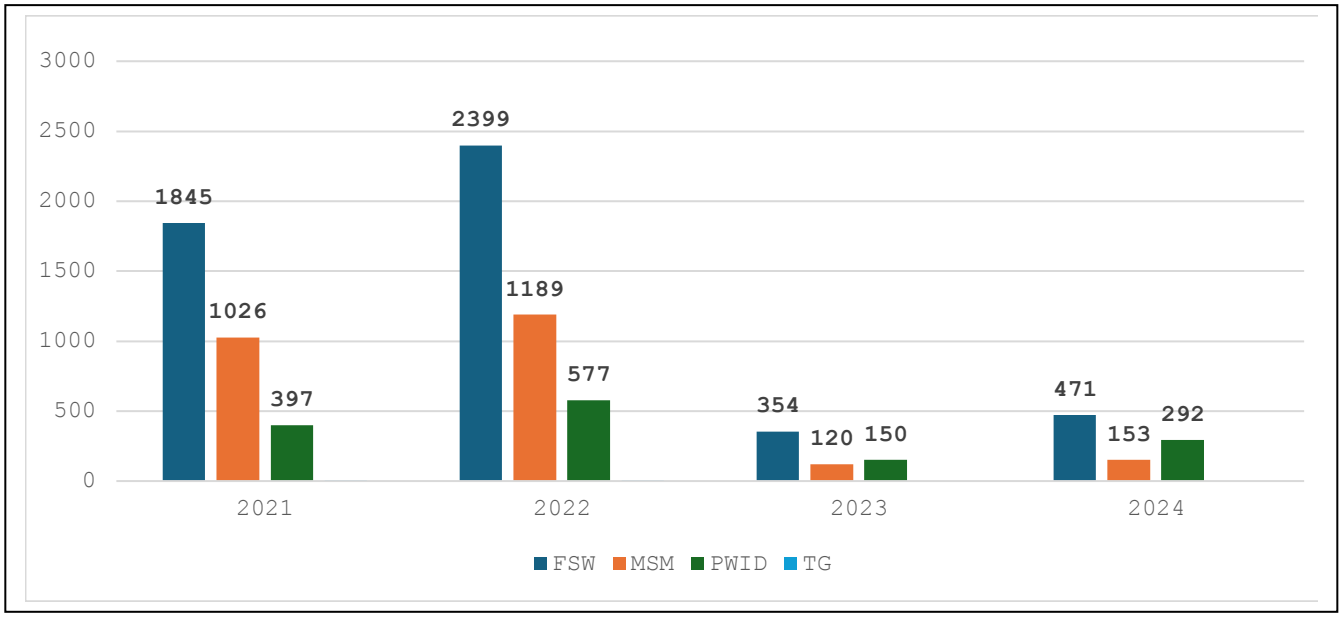
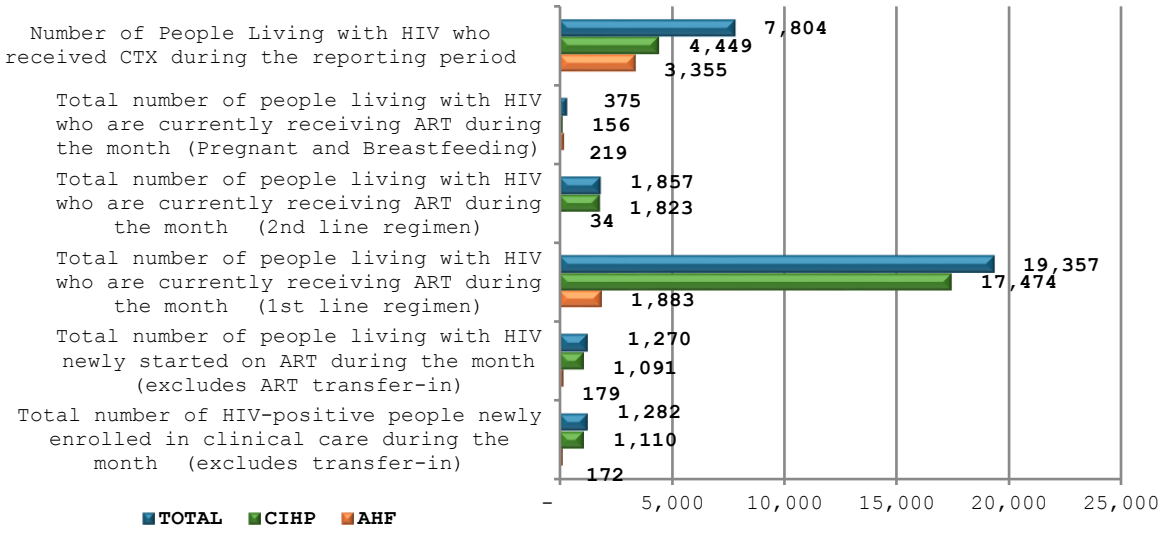
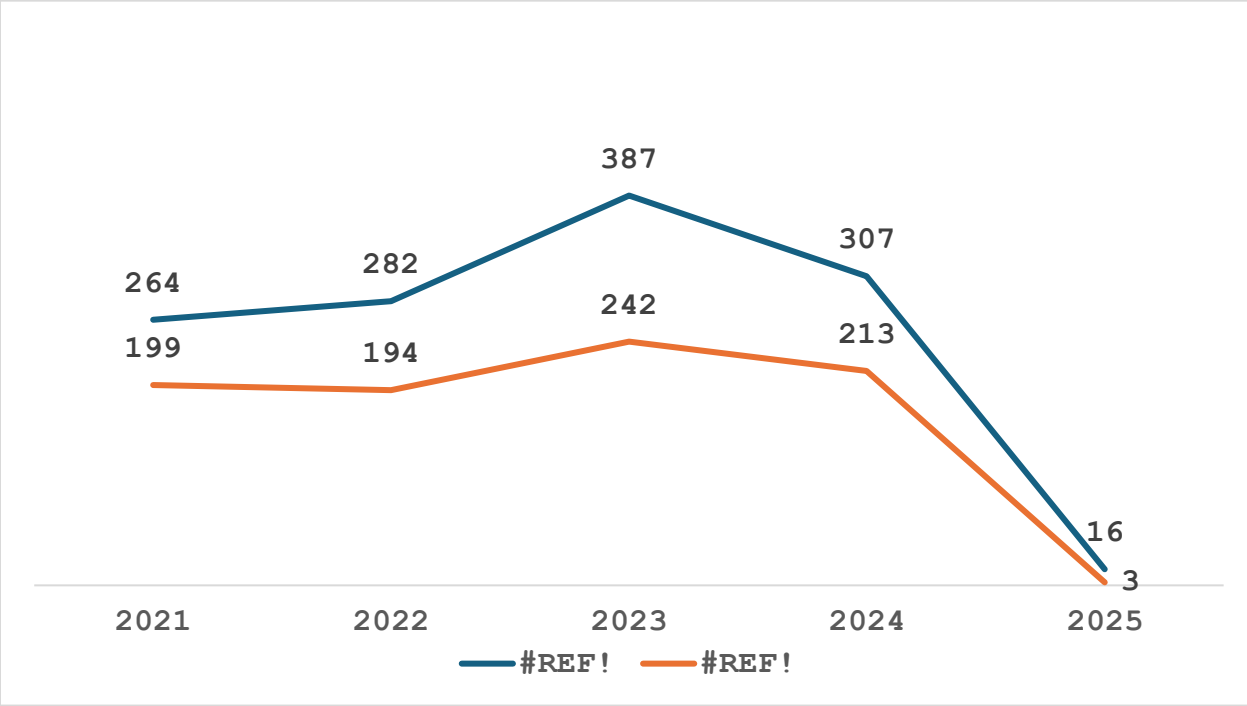


Figure 3: Trends in new infection by population groups: 2021-2024
(Source: HIV and AIDS 2020-2024 validated Non-Health Sector Data)

Figure 4: ART
(Source: HIV and AIDS 2024 1st Semester validated Health Sector Data)



1.1.3. *AIDS-related deaths*



1.2.**Factors Influencing HIV Trends in Kogi State**

The factors influencing HIV transmission in Kogi State are not different from the factors at national level, and they are broadly classified into biological, behavioural, interpersonal, household, community and macro levels. Key drivers of the HIV epidemic in Kogi State include: low personal risk perception, multiple concurrent sexual Partnerships, intense transactional and inter-generational sex, debilitating poverty level, marital infidelity, high risk of unprotected sexual activities particularly among youths, ignorance, and the belief that the epidemic has a cure or does not exist and negative cultural practices; female genital mutilation, serial monogamy and stubborn

persistence of HIV/AIDS-related stigma and discrimination also significantly contribute to the continuing spread of the Infection.[15,16]

(i). Biological factors

These are genetic factors that enhance the transmission of HIV such as sex. Women have higher chance of contacting the infection due to the delicate tissue and large surface area of the mucous membrane in the female genital track, which is subjected to tears and abrasion during sexual intercourse, leading to increased chance of HIV transmission males and females. Females also have higher chances of transmission because the male semen stays in their genital track for hours or days after intercourse, hence, increasing the contact time.

(ii). Behavioural risk factors:

These are interpersonal factors that increase the probability of HIV transmission, which are mostly related to high-risk sexual behaviors like unprotected sexual intercourse and having multiple sexual partners. These risks tend to be higher among certain occupations like long distance drivers, and the Key Populations. According to NDHS-2023,[8] 0.3% of women aged 15-49 years in Kogi had two or more sexual partners in the past 12 months and 0.5% had intercourse with a person who was neither their husband nor lived with them. Similarly, 9.9% of men aged 15-49 years in Kogi had two or more sexual partners in the past 12 months and 4.3% had intercourse with a person who was neither their wife nor lived with them. Among the men who had two more sexual partners, only 21.1% reported using condom during the most recent sexual intercourse. Among the men who had intercourse with in the past 12 months with a person who was neither their wife nor lived with them, only 71.5% reported using condom during the most recent sexual intercourse.

Poor knowledge of reproductive health and disease prevention also contributes to high-risks behaviors, as only 31.4% of women and 21.1% of men aged 15-24 years had good knowledge of HIV prevention in Kogi State

(iii). Interpersonal and household level factors: Gender-based violence (GBV),

Gender based violence accounts for 50% of all likelihood of HIV infection among women of reproductive age. Also, restrictive policies and early child and under-age marriage that impede access to HIV services. Stigma and discrimination are connected to punitive legal frameworks that undermine HIV prevention efforts among women of reproductive age decriminalizing sex work or empowering sex workers with skills and scholarship for public health, police and defense volunteer programmes could avert 33-46% of new HIV infections. More than half of the population of 36.9 million PLHIV are women of reproductive age accessing HIV services in Nigeria in 2018 1,700,000 if the PLHIV were within the ages of 15-49 years. Institutional stigma that is anticipated has prevented women of reproductive age from accessing HIV services commencing from linkage-to-care to adherence to antiretroviral therapy. They also suffer involuntary sterilization or forced abortion. UNAIDS 2018

Gender-Based violence (GBV): Some individual behaviours can lead to increased household risks of HIV transmission, for example, the tendency to commit GBV could increase the risk of sexual violence,[9] with resultant increase in the risk of HIV transmission. Figure 5 presents the trend in sexual violence among women aged 15-49 years in Kogi State based on NDHS 2008 to 2023. The risks of GBS can also be increased by interpersonal behaviours like drug abuse and inability of women to negotiate safer sex.

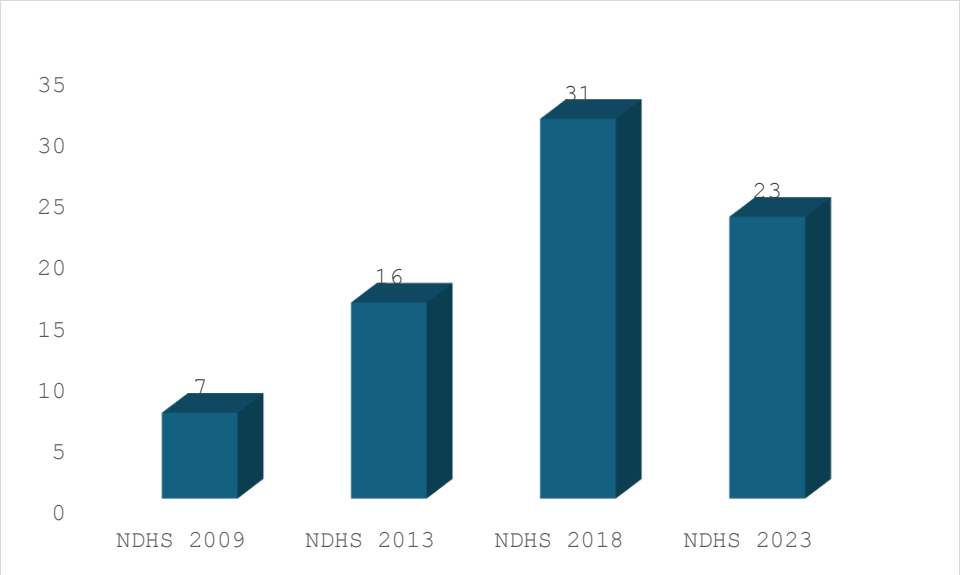


Figure 6: Women who ever experienced sexual violence in Kogi State by age group, 2008-2018 (Source Nigeria Demographic and Health Survey 2008, 2013, 2018 Kogi)

(iv). Community-level factors: Child marriage and female genital mutilation

Some cultural practices that are deeply rooted in some communities have been shown to increase the transmission of HIV. This includes practices like early marriage and female genital cutting. Early marriages prevent girls from acquiring education which give them the courage and confidence to make right decisions, including negotiating for safer sexual practices at family and societal levels. Girl child secondary education has been found to be associated with reduced HIV risks.[10] NDHS-2023 reports that 25.7% of women aged 15-19 years in Nigeria had no formal education, 12.3% had only primary education, 4.5% had secondary education and 1.6% had tertiary education. In Kogi State, only 5.6% of women participate in decision-making regarding sexual and reproductive health.

(v). Macro-level factors:

Cultural and religious factors macro and community levels have been known to influence HIV risks. Macro-level factors influencing HIV trends in Kogi State include economic constraints,

weak healthcare infrastructure, sociocultural norms, policy gaps, and migration patterns. The state's low domestic investment in HIV programs has resulted in heavy reliance on donor funding, limiting the sustainability of interventions. Inadequate healthcare infrastructure, a shortage of trained personnel, and frequent stockouts of antiretroviral therapy (ART) drugs disrupt access to treatment and contribute to poor adherence. Additionally, deep-rooted cultural and religious beliefs often discourage the uptake of HIV prevention services such as condom use, pre-exposure prophylaxis (PrEP), and voluntary medical male circumcision (VMMC), while stigma and discrimination prevent people living with HIV (PLHIV) from seeking timely care. Weak policy enforcement and bureaucratic challenges hinder the effective implementation of HIV-related policies, further limiting state-led ownership of the response. Furthermore, Kogi State's strategic location as a transit hub between the North and South facilitates increased mobility of high-risk populations, such as truck drivers, migrant workers, and commercial sex workers, leading to higher transmission rates. Addressing these macro-level challenges requires stronger government commitment, increased domestic financing, enhanced healthcare infrastructure, and multi-sectoral collaboration to ensure a more sustainable and effective HIV response.

Cultural and religious factors macro and community levels have been known to influence HIV risks. The social structure generally does allow for discussing issues related to sexuality openly, hence, limiting knowledge on the prevention of sexually transmitted diseases. Poverty on the other hand, predisposes women commercial sex activities with little or no capacity to negotiate safer sexual practices. Policies that are meant to protect people from these disadvantages lack supportive environments for implementation. These policies include the 2014 HIV and AIDS (anti-discrimination) Act; the 2015 Violence Against Persons Prohibition (VAPP); and the National Policy on Social Protection Against Emerging Issues of Interest including pandemics, like the

COVID-19 pandemic which worsens HIV care services globally, nationally and locally in Kogi .[15,16]

1.1. **Response Analysis**

Summary of the response review of SSP 2021 - 2025

The updated National HIV AIDS Strategic Plan 2023-2027 focuses on key actions such prevention of new infection and achieving HIV targets of 90-90-90 and 95-95-95 subsequently. Table 2 shows that Kogi State has performed considerably below the set targets for all HIV prevention indicators assessed. The level of knowledge about HIV prevention and transmission was below the target of 90% for both men and women aged 15-24 years, and among young people aged 15-24 years. Use of condom at last sexual intercourse among young people was reported as 2.1% in males and 31.4% in females, both of which are far below the 90% target.

In 2017 HIV was the leading cause of death for women of reproductive age between the ages of 15-49 years worldwide, however in 2006 the United Nations Political Declaration on ending AIDS provided enabling environment for countries to make commitments for adolescent girls and women of reproductive age focused on the reduction of the incidence of new HIV infections among them to below 100,000 by 2020 from 390,000 in 2015. UNAIDS 2019. Compared to 30.2 million level of morbidity due to HIV for women of reproductive age between the ages of 15-49 years only 298.2 million population of same age and sex disaggregation who died from maternal conditions and related causes.

According to UNAIDS 2018, in many countries women between the ages of 20-29 years face policy and legal barriers such as the age of consent which needs to be lowered like in the case of South Africa to promote increased knowledge of HIV services commencing from linkage-to-care upon a confirmatory HIV positive sero-status among women of reproductive age and also in at least 78 countries young women 20-29 years require the consent of parents or legal guardians to access sexual and reproductive health services. Empowering the supply-side of the provision of ART services can increase access to women between the ages of 30-49 years who are HIV positive while female sex workers (FSW) are 10 times more likely to acquire HIV than other women thus human rights-based approaches, minimum package of prevention intervention and universal health coverage targets linked to the sustainable development goals (SDGs) are critical to providing prevention and treatment.

The antiretroviral therapy provision in Nigeria is through the differentiation of service delivery (DSD) or community settings (Outside the HCF) for people living with HIV (PLHIV) who are stable on ART. The percentage of PLHIV on ART who are virally suppressed is 75% in Western and Central Africa but 81% globally and furthermore only 24% of all people living with HIV (PLHIV) are virally suppressed compared to 25% in Western and Central Africa however, only <50% of PLHIV on ART have received a viral load test result even with a fully implemented National Policy on routine viral load testing for adults and adolescents. [7]

Table 2: Trends in Selected HIV Prevention Measures in Kogi State: 2021 - 2025

Indicators	Target (2025)	Situation as at 2020/2021(Baseline)	End-Term Achievements (2024)	Data source
% of the general population with comprehensive knowledge of HIV transmission and prevention	90%	Female (37%); Male (26%) NDHS 2018	Female (46.2%); Male (45.8%)	NDHS 2024
% of young people (15 – 24 years) with comprehensive knowledge of HIV transmission and prevention	90%	Female (42.6%); Male (33.7%) NDHS 2018	Female 9.1(42.6%); Male (33.7%) 9.5	NDHS 2024
% of women and men aged 15-49 who have had sexual intercourse with more than one non-marital, non-cohabiting partner in the past 12 months who used a condom during their last sexual intercourse	90%	Female 33.3 Male 35.3 MICS 2016-17	Female 24.7 Male 32	NDHS 2024

% of never-married sexually active young people (15-24 years) who used a condom at last sexual intercourse	90%	Female 46.6 Male 61.4 MICS 2016-17	Female 52.8 Male 34.9	NDHS 2024
% of women and men with STIs who sought treatment from a health facility or health professional in the past 12 months	90%	Women (33.1%); Men (30.8%)	Women (33.1%); Men (30.8%)	NDHS 2018

The National HIV and AIDS Strategic Plan (2023-2027) targets 90% of vulnerable and KPs to adopt appropriate HIV risk reduction behaviours by 2027. However, while 91% of female sex workers (FSW) reported condom use during their last sexual intercourse, uptake among men who have sex with men (MSM) and people who inject drugs (PWID) remained significantly lower, reflecting the challenges in harm reduction and prevention interventions in kogi state. Similarly, only 6% of PWID in Kogi State consistently used sterile needles in the last three months, far below the 90% target, increasing their vulnerability to HIV transmission. Pre-exposure prophylaxis (PrEP) uptake was also low across key populations, with only 11% of PWID, 27% of MSM, 20% of FSW, and 24% of transgender individuals accessing PrEP services, compared to the 90% target for each group.

These gaps highlight the need for strengthened harm reduction programs, increased awareness, and improved access to HIV prevention services for key populations in Kogi State. Addressing

stigma, discrimination, and policy barriers will be essential in scaling up prevention interventions and ensuring that vulnerable groups have the resources and support needed to adopt safe practices.

Table 3: Trends in Selected HIV Prevention Indicators among Key Populations in Kogi State: 2021 – 2024

Indicators	Target (2025)	Situation as at 2020/2021(Baseline)	End-Term Achievements (2024)	Data source
% of FSW who used condoms at the last sexual intercourse	90%	67% NDHS 2018	87%	NDHS 2024)
% of MSM who used condom at last anal sex with a male partner	90%	49% NDHS 2018)	69%	NDHS 2024)
% of PWID who used condom use at last sexual intercourse	90%	67% NDHS 2018)	79.8%	NDHS 2024)
% of PWID who used sterile needles consistently in the last 3 months	90%	67%	77	IBBS 2021
% of key populations using PrEP in priority population	90%		FSW 20% MSM 27% TG 24%	IBBS 2021

			PWID 11%	
% of FSW, MSM, and PWID who tested for HIV and received their test results within the last 12 months	100%	FSW (86.2%); MSM (78.9); PWID (65.3%) (IBBSS 2014)	FSW 69% MSM 58.5% PWID 37.2%	IBBS 2021

As shown in Table 4 below, the proportion of PLHIVs that know their status as at the end of 2021 was 98% compared to the set target of 95%. The proportion of PLHIV on ART who received their viral load test result increased from 86% in 2020 to 88% in 2024. This achievement was lower than the set target of 95%. The proportion of PLHIV on ART who were virologically suppressed (<1000c/ml) was 96% in 2020 and 97% in 2024.

Table 4: Trends in Selected HIV Testing and Treatment Indicators in Kogi State: 2021 - 2025

Indicators	Target (2025)	Situation as at 2020/2021(Baseline)	End-Term Achievements (2024)	Data source
% of PLHIV that know their status	95%	73% (Health sector report ,2020)	98%	2024 Health sector report
% of PLHIV currently on ART	95%	61%(Health sector report ,2020)	93%	2024 Health sector report
% of PLHIV on ART with a viral load test result	95%	69%(Health sector report ,2020)	89%	2024 Health sector report

% of PLHIV on ART are virologically suppressed (<1000c/ml)	95%	86% (Health sector report ,2020)	89%	2024 Health sector report
% of people in HIV care who were clinically screened for TB in an HIV care setting	100%	NA	60%	2024 Health sector report

Table 5: Trends in Selected PMTCT Indicators in Kogi State: 2021 - 2025

Indicators	Target (2025)	Situation as at 2020/2021 (Baseline)	End-Term Achievements (2024)	Data source
% of pregnant women tested for HIV and received their test results in the last 12 months	95%	86% (Health sector report 2020)	88.5%	Health sector report 2024

Rate of Mother to Child transmission (MTCT) of HIV at 6 weeks of birth	0%	1.6% (Health sector report 2020)	0.8%	Health sector report 2024
% of HIV-positive pregnant women who received ART	95%	82% (Health sector report 2020)	94.4%	Health sector report 2024
% of infants born to HIV-positive women who received ARV prophylaxis	95%	Data not available	72%	Health sector report 2024
% of HIV-exposed babies receiving virological test for HIV within 2 months of birth	95%	Data not available	74.6%	Health sector report 2024

As Table 5 above shows that Kogi State has made some progress with its PMTCT program. The proportion of pregnant women who tested for HIV and received their test results in the last 12 months shows an increase of 86% in 2020 to 88.5% 2024. The proportion of HIV-positive pregnant women who received ART was from 82% in 2020 to 94.4% in 2021. However, data was not available for HIV-exposed babies who had early infant diagnosis in 2020. The rate of MTCT at 6 weeks of birth reduced slightly from 1.6% in 2020 to 0.83.

A major challenge in Kogi State's HIV response, like the national landscape, is the over-reliance on donor funding for interventions and program implementation. The low domestic investment at the state and LGA levels has hindered the sustainability and local ownership of the HIV response. The HIV expenditure for the State in 2024 was estimated as ₦ 80,160,810.00, amount solely from donors (GF, CIHP and AHF) with no contribution from public or private sources. Recognizing this gap, the State has intensified efforts towards the mobilization of domestic resources for the HIV response through its annual operational and strategic plans over the years.

Increasing state-led investment in HIV programming in Kogi State, is critical to ensuring sustainable service delivery, reducing dependence on external aid, and improving access to HIV prevention, care, and treatment services.

Currently, the HIV implementation structure has limited the full involvement of statutory government agencies, affecting their technical capacity and ownership of the response. Under the Alignment 2.0 framework, NACA, NASCP, UNAIDS, GF, PEPFAR, and CSOs aim to transition HIV service delivery to a locally driven model, where Kogi State takes leadership in resourcing, managing, and implementing HIV interventions. This shift will strengthen state-level coordination, health financing, and sustainability strategies, ensuring long-term impact and effective HIV response across communities.

3.0 DEVELOPMENT CONTEXT, GUIDING PRINCIPLES, AND STRATEGIC AGENDA

3.1 Development Context for the Strategic Plan

The Kogi State HIV and AIDS Strategic Plan 2023-2027 is informed by the following national and state-level policies, frameworks, and guidelines:

i. National Health Policy, 2016: The policy aims to reduce HIV incidence by addressing barriers through universal access to comprehensive HIV prevention, treatment, care, and

support services. Kogi State aligns with this policy to end AIDS as a public health problem by 2030.

ii. National Policy on HIV/AIDS 2020: Kogi State adopts the multisectoral approach outlined in the national policy, focusing on eliminating new infections, providing treatment and care, and protecting the rights of people living with HIV (PLHIV). The state will prioritize reducing stigma and discrimination against PLHIV.

iii. HIV and AIDS (Anti-discrimination) Act, 2014: Kogi State commits to enforcing this Act to protect the rights and dignity of PLHIV, ensuring that HIV-related discrimination is eliminated in workplaces, health facilities, and educational institutions.

iv. National Policy on the Health and Development of Adolescents and Young People in Nigeria (2020-2024): Kogi State will implement this policy to reduce morbidity and mortality among adolescents and young people, with specific targets to improve HIV knowledge and reduce risk behaviors.

v. (v) HIV Programming in Adolescent and Young People in Nigeria -- an Investment Case 2021-2025: Kogi State will strengthen HIV prevention, treatment, and care for adolescents and young people, focusing on achieving the 95-95-95 targets by addressing their unique social and cultural contexts.

vi. Violence Against Persons Prohibition (VAPP) Law 2015: Kogi State will enforce the VAPP Law to eliminate violence and provide protection and remedies for victims, particularly women and girls who are disproportionately affected by gender-based violence.

vii. (vii) National Policy on Social Protection: Kogi State will integrate HIV services into social protection programs to reduce poverty and improve the quality of life for PLHIV and vulnerable populations.

viii. Generation of Negative Adolescents and Young People (Gen-N) Campaign RoadMap: Kogi State will participate in the Gen-N campaign to destigmatize HIV services and increase the uptake of HIV prevention, treatment, and care among adolescents and young people.

ix. National HIV and AIDS Community Care and Support Guidelines (2020-2023): Kogi State will adopt these guidelines to ensure that PLHIV, key populations, and vulnerable groups receive comprehensive medical, psychosocial, and economic support.

x. National HIV and AIDS Access to Justice Guidelines & Capacity Building Manual: Kogi State will ensure that PLHIV and key populations are aware of their rights and have access to legal support when their rights are violated.

xi. "Alignment 2.0": Kogi State will align with the national agenda to strengthen ownership of the HIV response, reduce duplication, and improve service integration.

xii. Sustainable Development Goals (2015-2030): Kogi State will work towards achieving SDG target 3.3, which aims to end the AIDS epidemic by 2030.

xiii. Global AIDS Strategy, 2021-2026: Kogi State will align with the global strategy to achieve zero discrimination, zero new HIV infections, and zero AIDS-related deaths.

xiv. Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030: Kogi State will commit to achieving the 95-95-95 targets and eliminating HIV-related stigma and discrimination.

xv. Global Alliance for Ending AIDS in Children by 2030: Kogi State will work towards ensuring that no child living with HIV is denied treatment and that new infections in infants are prevented.
xvi. Global Health Sector Strategies on HIV, Viral Hepatitis, and Sexually Transmitted Infections (2022-2030): Kogi State will integrate HIV services into primary healthcare to expand universal health coverage.
xvii. National PMTCT Scale-up Plan 2022: Kogi State will intensify efforts to prevent mother-to-child transmission of HIV and strengthen PMTCT program management.
xviii. National Domestic Resource Mobilization and Sustainability Strategy for HIV 2021-2025: Kogi State will work towards increasing domestic funding for the HIV response to ensure sustainability.
xix. Report of the Gender Assessment of the HIV Response in Nigeria (2022): Kogi State will address gender inequalities and gender-based violence as critical enablers of the HIV epidemic.

3.2 Guiding Principles

The Kogi State HIV and AIDS Strategic Plan is guided by the following principles:

i. Political leadership and state ownership: Strong political leadership and ownership of the HIV response at the state level, with a commitment to transparent and prudent management of resources.
ii. Partnerships and multi-sectoral collaborations: Collaboration between government, civil society organizations, PLHIV networks, and development partners to strengthen the state's HIV response.
iii. Rights-based and gender-responsiveness: Ensuring that HIV programming respects gender equality and the rights of all individuals, particularly vulnerable populations.
iv. Meaningful involvement of people living with HIV and AIDS: Engaging PLHIV in the design and implementation of HIV programs to ensure their needs are met.
v. Strategic investment programming: Investing in evidence-based interventions to maximize the impact of resources allocated to the HIV response.
vi. Optimization of the health system: Strengthening the health system to deliver integrated HIV services effectively.
vii. Stakeholder involvement, engagement, and participation: Engaging communities and the private sector in the HIV response to achieve the state's goals.
viii. Research and innovation: Using data and research to improve the targeting and impact of HIV services.

3.3 Strategic Agenda

3.3.1 Vision

An AIDS-free Kogi State with zero new infections, zero stigma and discrimination, and zero AIDS-related deaths.

3.3.2 Goal

Strengthen the state's HIV response to facilitate ending AIDS in Kogi State by 2030.

This goal will be operationalized through three strategic priorities:

i. Strategic Priority 1: Equitable and equal access to HIV services for all.
ii. Strategic Priority 2: Break down barriers to achieving HIV service outcomes.
iii. Strategic Priority 3: Fully resource and sustain efficient HIV responses.

4.0 STRATEGIC PRIORITY I: MAXIMISE EQUITABLE AND EQUAL ACCESS TO HIV SERVICES AND SOLUTIONS

4.1 Result Areas and Major Interventions

4.1.1 Result Area I: HIV Prevention

The general population continues to account for a significant proportion of new infections notwithstanding relatively lower prevalence when compared to key populations. This means that services need to be targeted at the general population – particularly women and girls who appear to be quite vulnerable. Similarly, adolescents would need access to youth friendly centers and services because that demographic is very vulnerable.

At present, there are six Youth Friendly Centers (YFCs) in tertiary and secondary institutions of learning in Kogi State. it is therefore, essential to expand the reach to adolescents and youth through the strengthening of youth friendly services as efforts, chiefly at community level, aimed at women and girls and the broader general population, towards optimisation of the linkages to and integration in the primary health care system.

Major Interventions

- ✓ Expand HIV prevention programs for key populations, including men who have sex with men, sex workers, and people who inject drugs.
- ✓ Intensify harm reduction programs, including needle-syringe programs and opioid substitution therapy.
- ✓ Scale up comprehensive prevention services for adolescent girls and young women, including access to contraception and sexual health education.
- ✓ Strengthen access to gender-responsive and age-appropriate comprehensive sexuality education.
- ✓ Promote the use of pre-exposure prophylaxis (PrEP) for individuals at high risk of HIV infection.

4.1.1.1: Combination HIV prevention for KPs, Expand and strengthen HIV prevention programmes for men who have sex with men, including the rapid expansion of access to and uptake of PrEP, Undetectable=Untransmittable (U=U) programming, condom and lubricant programming; sexual and reproductive health services; mental health and psychosocial services, violence prevention; legal support, community-led outreach; and use of new communication technologies and empowerment

KEY ACTIVITIES

1.1.1i: Scale-Up of PrEP Access and Uptake – Conduct targeted community outreach, awareness campaigns, and mobile service delivery to increase access to and uptake of PrEP among men who have sex with men (MSM)

Sub activities

a) Train peer educators and outreach workers from the sex worker community.

b) Daily tracking and reporting of PrEP activity across the suppoted sites

c) Weekly review of PrEP

data with the stakeholders

4. 1.1.1ii: U=U Awareness and Adherence Support – Implement educational sessions and digital campaigns to promote the Undetectable = Untransmittable (U=U) message, along with adherence support programs for people living with HIV.

Sub activities

a) Create one-off training content for healthcare providers

b) Conduct training sessions for 390 healthcare providers

c) Organize quarterly workshops for 1500 people living with HIV in 21 LGAs

d)Host quarterly seminars for 100 key populations and stakeholders

e) Develop social media content (posts, graphics, videos

f) Implement and manage quarterly social media campaigns

g) Identify and train 42 peer facilitators (2 per LGA)

h) Set up and facilitate 45 peer support groups

k)Train 239 adherence counselors

i) Provide one-on-one adherence counseling in all 21 LGAs to PLHIV

j) Track engagement metrics (social media, workshops)

by Conducting biannual surveys and evaluations to assess program effectiveness among 90% of the target population"

4.1.1.1-iii :. Comprehensive Condom and Lubricant Distribution – Establish and strengthen condom and lubricant distribution points in key community locations, including bars, clubs, and clinics serving MSM populations.

Sub Activities

a) Conduct needs assessment for commodities

b) Make requisition from DMA

c) Distribute and monitor commodities usage

4.1.1.2: major Interventions

Intensify and expand comprehensive programs for and with sex workers nationwide, especially among the most affected sex workers, to address persistent gaps through expanded community-led outreach, condom and lubricant programming; increased access to PrEP, sexual and reproductive health services; violence prevention, mental health and psychosocial services, legal support and empowerment

Key activities

4.1.1.2-i Community-Led Outreach and Peer Education – Train and support sex worker-led organizations to conduct targeted outreach, provide HIV prevention education, and link peers to essential health services.

Sub activities

a) Train peer educators and outreach workers from the sex worker community.

b) Distribute IEC (Information, Education, and Communication) materials tailored to sex workers' needs.

c)Organize community dialogues and sensitization sessions to reduce stigma and discrimination.

d)Establish referral mechanisms for sex workers to access health, legal, and social services."

4.1.1.2-ii Condom and Lubricant Access Expansion – Establish distribution networks in hotspots, drop-in centers, and sex worker-friendly establishments to ensure consistent access to condoms and lubricants.

Sub activities

a) Identify and map sex worker hotspots to establish distribution points.

b) Procure and distribute condoms and lubricants through drop-in centers, community networks, and outreach programs

c) Set up condom dispensers in strategic locations frequented by sex workers.

d) Develop partnerships with NGOs, health facilities, and local businesses for sustainable condom and lubricant supply.

4.1.1.2-iii PrEP Uptake and Adherence Support – Implement mobile clinics and peer-led interventions to increase awareness, accessibility, and adherence to PrEP among sex workers.

Sub Activities

a) Conduct awareness campaigns on the benefits and availability of PrEP for sex workers.

b) Train healthcare providers on sex worker-friendly PrEP counseling and service delivery.

c) Establish peer-led PrEP adherence support groups to encourage consistent usage.

d) Develop reminder tools (SMS, phone calls, peer check-ins) to support adherence."

4.1.1.2-iv Violence Prevention and Legal Support – Develop safe reporting mechanisms, provide legal literacy training, and establish partnerships with law enforcement to address violence against sex workers.

Sub Activities

"a) Conduct legal literacy sessions to educate sex workers on their rights.

b) Establish safe spaces and confidential reporting mechanisms for survivors of violence.

c) Train peer educators and paralegals to provide basic legal assistance and referrals.

d) Build partnerships with law enforcement and human rights organizations for better legal protection."

4.1.1.2v-Integrated SRH and Mental Health Services – Set up sex worker-friendly clinics offering sexual and reproductive health services, STI screening, mental health counseling, and psychosocial support.

Sub Activities

a) Provide free or subsidized STI screening, family planning, and other SRH services at drop-in centers.

b) Train healthcare workers to deliver non-discriminatory and stigma-free services to sex workers.

c) Organize workshops on stress management, coping mechanisms, and self-care.

d)Develop peer support groups for sex workers to share experiences and access emotional support."

4.1.1.2-vi Increase accessibility of HIV prevention service package

Sub Activities

a) Procure HIV complete service package for the state

4.1.1.2-iv

Key activities

Violence Prevention and Legal Support – Develop safe reporting mechanisms, provide legal literacy training, and establish partnerships with law enforcement to address violence against sex workers**.**

Sub Activities

a) Conduct legal literacy sessions to educate sex workers on their rights.

b) Establish safe spaces and confidential reporting mechanisms for survivors of violence.

c) Train peer educators and paralegals to provide basic legal assistance and referrals.

d) Build partnerships with law enforcement and human rights organizations for better legal protection."

4. 1.1.2-v key Activities

Integrated SRH and Mental Health Services – Set up sex worker-friendly clinics offering sexual and reproductive health services, STI screening, mental health counseling, and psychosocial support.

Sub Activities

a) Provide free or subsidized STI screening, family planning, and other SRH services at drop-in centers.

b) Train healthcare workers to deliver non-discriminatory and stigma-free services to sex workers.

c) Organize workshops on stress management, coping mechanisms, and self-care.

d)Develop peer support groups for sex workers to share experiences and access emotional support."

4.1.1.2-vi Key Activities

Increase accessibility of HIV prevention service package

Sub Activities

a) Procure HIV complete service package for the state

4.1.1.3: Intervention

Intensify and redouble efforts to scale up comprehensive harm reduction for people who inject drugs in all settings, including promoting needle-syringe programmes, opioid substitution therapy, a medication used to block the effects of opioid overdose and interventions for alcohol and noninjecting drug use; as well as prevention, diagnosis and treatment of TB and viral hepatitis, increased access to PrEP, community-led outreach, mental health and psychosocial services, and psychosocial support

4**.1.1.3-i Key Activities**

1. Expand Needle-Syringe Programs (NSPs) and Opioid Substitution Therapy (OST)- Establish or strengthen community-based NSPs and OST services to ensure safe injection practices and reduce transmission of HIV, TB, and hepatitis.

Sub Activities

a) Establish and strengthen needle and syringe distribution points in high-risk areas.

b) Train outreach workers to provide harm reduction education alongside distribution.

c) Conduct awareness campaigns on safe injecting practices and overdose prevention.

d) Partner with pharmacies and clinics to integrate NSPs into existing healthcare services."

4.1.1.3-ii Key Activities

Increase Access to Overdose Prevention and Response Services- Provide training on the use of naloxone, a medication to block opioid overdoses, and distribute naloxone kits to people who inject drugs and their peers.

Sub Activities

a) Establish OST clinics offering methadone, buprenorphine, and other substitution therapies.

b) Train healthcare providers on OST service delivery and patient management.

c) Expand access to naloxone (opioid overdose reversal medication) and train peers on its use.

d) Implement community-based overdose prevention programs."

4.1.1.3-iii Key Activities

Enhance Community-Led Outreach and Peer Support Programs-Mobilize and train peer educators to conduct harm reduction outreach, linking people who inject drugs to healthcare, PrEP, mental health, and psychosocial support services.

Sub Activities

a) Train and deploy peer educators to conduct harm reduction outreach.

b) Provide one-on-one and group mental health counseling.

c) Develop peer support networks for individuals undergoing recovery or OST.

d)Collaborate with community organizations to reduce stigma and discrimination"

4.1.1.3-iv Key Activities

Integrate TB, Viral Hepatitis, and HIV Services into Harm Reduction Programs-Offer routine screening, diagnosis, and treatment for TB, hepatitis B and C, and HIV within harm reduction sites and drug treatment centers. Key Population

Sub Activities

a) Provide free or subsidized TB and hepatitis B/C screening and treatment for people who inject drugs.

b) Expand access to PrEP services through community clinics and outreach programs.

c) Train health workers to offer integrated HIV, TB, and viral hepatitis services.

d) Develop referral pathways for people who inject drugs to access specialized care."

4. 1.1.3-v Key Activities

Strengthen Mental Health and Psychosocial Support Services- Develop tailored counseling, rehabilitation, and psychosocial support services to address substance use disorders, mental health conditions, and co-occurring health challenges.

Sub Activities

a) Train peer educators and outreach workers to deliver harm reduction education.

b) Offer individual and group mental health counseling sessions.

c) Develop peer support networks to reduce stigma and promote harm reduction practices.

d) Implement substance use disorder interventions tailored to people who inject drugs."

4.1.1.13

Intervention

4.1.1.13: End prevention inequalities by using granular data to accurately estimate sizes of key and priority populations who are not receiving the HIV prevention services they need and develop and implement focused strategic roadmaps in collaboration with affected communities to scale up combination prevention packages that are tailored to their needs

4.1.1.13-iv Scale Up Combination Prevention Packages

Sub activities

a) Design tailored prevention packages that include PrEP, condoms, harm reduction, and STI screening.

b) Strengthen community-led delivery models for HIV prevention services.

c)Expand access to prevention services through digital platforms and peer networks.

d)Secure funding and partnerships for sustainable program expansion.

4.1.1.13-vii Sustain Scale up HIV & TB GHR State response Team

Sub Activities

"a) Build the capacity of key population-led organizations to advocate for their needs.

b) Establish community advisory boards to guide prevention program implementation.

c)Conduct advocacy campaigns to reduce stigma and policy barriers affecting key populations.

d)Foster multi-sectoral collaboration to integrate HIV prevention into broader health and social services."

4.1.1.13-viii Logistics support for the GHR/SRT

Sub Activity

"a) Build the capacity of key population-led organizations to advocate for their needs.

b) Establish community advisory boards to guide prevention program implementation.

c)Conduct advocacy campaigns to reduce stigma and policy barriers affecting key populations.

d)Foster multi-sectoral collaboration to integrate HIV prevention into broader health and social services."

4.1.2 Result Area 1.2: HIV testing, treatment, care, viral suppression and integration

4.1.2.1: Intervention

Reduce inequalities by using granular data to identify and address the characteristics that lead to inequalities in testing, treatment and care access and outcomes

4.1.2.1-i Key Activities

Collect and Analyze Granular Data to Identify Inequalities

Sub Activities

a)Conduct population-based surveys and routine health data analysis to identify disparities in HIV testing, treatment, and care.

b) Disaggregate data by key characteristics such as age, gender, socioeconomic status, geographic location, and key population status.

c) Use geospatial mapping to identify underserved regions and high-burden areas.

d) Engage affected communities to validate data findings and ensure inclusivity in data interpretation."

4. 1.2.1-ii Key Activities

Identify and Address Barriers to HIV Testing Among Key and Priority Populations

Sub Activities

a) Conduct qualitative research (focus group discussions, key informant interviews) to understand barriers to testing.

b) Develop and implement community-led strategies to increase access to HIV testing in high-burden and underserved areas.

c) Expand the use of self-testing kits and community-based testing to reach marginalized populations.

d) Strengthen linkages between testing services and treatment initiation to prevent loss to follow-up."

4.1.2.1-iii Key Activities

Improve Equity in HIV Treatment Access and Retention IPs

Sub Activities

a) Identify factors contributing to delayed treatment initiation and poor retention in care.

b) Implement differentiated service delivery models (e.g., community-based ART distribution, multi-month dispensing) for high-risk populations.

c)Reduce structural barriers by integrating HIV services into primary healthcare and social support programs.

d) Strengthen peer-led adherence support programs to improve retention and viral suppression."

4.1.2.1-iv key Activities

Address Socioeconomic and Structural Barriers to Care Health Worker/facilities in (Public & Private)

Sub Activities

a)Provide transportation and financial assistance programs for individuals facing economic barriers to HIV services.

b). Develop stigma-reduction campaigns targeting healthcare providers and communities.

c) Advocate for policy changes that eliminate discriminatory practices in healthcare settings.

d) Strengthen social protection programs (e.g., food assistance, housing support) for people living with HIV."

4.1.2.1-v Key Activities

Monitor and Evaluate Interventions to Ensure Equity in HIV Outcomes

Sub Activities

a) Establish real-time monitoring systems to track progress in reducing disparities.

b) Use community feedback mechanisms to continuously improve service delivery models.

c) Conduct regular program evaluations to assess the effectiveness of interventions in reducing inequalities.

d) Scale up successful, data-driven strategies to ensure sustainable impact in addressing inequalities."

4.1.2.2: Interventions

Rapidly maximize the impact of affordable, effective HIV testing technologies and practices, increase the uptake of differentiated HIV testing strategies where available (particularly HIV self-testing, community-led testing services, partner services and social network approaches) and strengthen the linkage of people who access testing services to HIV prevention and treatment services.

4.1.2.2-i Key Activities

Expand Access to Affordable and Effective HIV Technologies

Sub Activities

a)Conduct market assessments to identify cost-effective and high-impact HIV testing technologies.

b) Advocate for regulatory approval and integration of innovative testing technologies into national programs.

c). Strengthen procurement and supply chain systems to ensure consistent availability of affordable HIV test kits.

d.) Train healthcare workers and community providers on the use of new HIV testing technologies."

4.1.2.2-ii key Activities

Increase Uptake of Differentiated HIV Testing Strategies Health Worker/facilities in (Public & Private)

Sub Activities

a) Develop and implement demand creation campaigns for HIV self-testing, community-led testing, and partner testing.

b). Strengthen community health workers and peer-led models to enhance outreach and service delivery.

c). Scale up mobile and home-based HIV testing services for hard-to-reach populations.

d). Integrate HIV testing into other health services, such as family planning and TB screening, to increase uptake."

4.1.2.2-iii Key Activities

Sub Activities

a) Support community organizations in delivering peer-led HIV testing and counseling services.

b). Provide training and resources for community-led initiatives to ensure quality and confidentiality in testing services.

c). Establish mobile and pop-up HIV testing clinics in high-burden communities.

3d). Develop community-based monitoring systems to track the effectiveness of testing programs."

4.1.2.2-iv Key Activities

Enhance Social Network and Partner-Based HIV Testing Approaches

Sub Activities

a) Implement index testing and partner notification services to increase testing among partners of people living with HIV.

b) Promote social network-based testing to reach individuals at high risk through trusted connections.

c). Address concerns privacy and stigma by developing discreet and confidential partner-testing services.

d) Strengthen referral systems between social network-based testing and HIV prevention or treatment services."

4.1.2.2-v key Activities

Strengthen Linkages to HIV Prevention and Treatment Services Health Worker/facilities in (Public & Private)

Sub Activities

a) Develop digital and community-based referral systems to ensure timely linkage to care.

B) Train peer navigators and case managers to support individuals in accessing prevention and treatment services.

C) Implement follow-up mechanisms, including SMS reminders and peer support, to ensure service retention.

D). Monitor linkage rates and address barriers that prevent people from accessing treatment and prevention services."

4.1.2.2-vi Key Activities

Strengthening HTS, care, treatment and viral load suppression complete service package for the state PLHIV

Sub Activities

"a) Procure HTS, care and treatment complete service package for the state

4.1.2.5: Major Intervention

Scale up and fully resource community-led service delivery and monitoring, which has been proven to improve HIV and wider health outcomes of PLHIV and KPs

4.1.2.5-i Key Activities

Strengthen the Capacity of Community-Led Organizations for HIV Service Delivery"

Sub Activities

a) Provide technical and financial support to community-based organizations (CBOs) to expand their HIV service delivery.

b) Conduct training for community health workers and peer educators on HIV prevention, treatment, and care.

c) Develop standardized guidelines and protocols to ensure high-quality community-led service delivery.

d) Establish mentorship programs to strengthen leadership and management skills among community-led organizations.

4.1.2.5-ii Key Activities

Expand Community-Led HIV Prevention, Testing, and Treatment Services

Sub Activities

"a)Scale up community-led HIV testing, including self-testing distribution and mobile outreach services.

b.) Support peer-led ART distribution and adherence support to improve retention in care.

c) Integrate HIV services with other community health services, such as sexual and reproductive health and mental health support.

d) Strengthen referral pathways between community-led services and health facilities for continuity of care."

4.1.2.5-iii key Activities

Secure Sustainable Funding and Resources for Community-Led HIV Programs

Sub Activities

a) Advocate for increased government and donor funding for community-led HIV service delivery.

b). Establish partnerships with private sector organizations to secure additional resources.

c) Develop innovative financing mechanisms, such as social enterprises, to support community-led initiatives.

d) Strengthen grant-writing and financial management skills of community organizations to improve funding access.

4.1.2.5-iv Key Activities

Strengthening Community-Led Monitoring and Data-Driven Advocacy

Sub Activities

"a) Train community members to collect, analyze, and report data on HIV service gaps and barriers.

b) Establish community-led scorecards and feedback mechanisms to monitor service quality and equity.

c) Use community-generated data for advocacy with policymakers and funders to improve service delivery.

d) Develop digital platforms for real-time community-led data collection and reporting." -
-

4.1.2.5-v Key Activities

Foster Policy and Structural Support for Community-Led Service Delivery

Sub Activities

a) Advocate for policies that formally recognize and integrate community-led service delivery into national HIV programs.

b) Engage policymakers in dialogue to address legal and structural barriers limiting community-led health services.

c) Establish multi-stakeholder platforms to enhance collaboration between governments, donors, and community-led organizations.

d) Develop national and regional guidelines to standardize and support the scale-up of community-led HIV services."

4. 1.2.6: Major Intervention

Strengthen the capacity of the education sector to meet the needs of young people living with and affected by HIV, including through scaling up access to school health and nutrition programmes, linkages to health and social protection services, and provision of good-quality comprehensive sexuality education 1.2.6-

4.1.2.6.i key Activity

Integrate Comprehensive Sexuality Education (CSE) into School Curricula

Sub Activities

a) Provide technical and financial support to community-based organizations (CBOs) to expand their HIV service delivery.

b) Conduct training for community health workers and peer educators on HIV prevention, treatment, and care.

c) Develop standardized guidelines and protocols to ensure high-quality community-led service delivery.

d) Establish mentorship programs to strengthen leadership and management skills among community-led organizations"

4.1.2.6-ii key Activities

Expand School-Based Health and Nutrition Programs

Sub Activities

a)Scale up community-led HIV testing, including self-testing distribution and mobile outreach services.

b.) Support peer-led ART distribution and adherence support to improve retention in care.

c) Integrate HIV services with other community health services, such as sexual and reproductive health and mental health support.

d) Strengthen referral pathways between community-led services and health facilities for continuity of **care."**

4.1.2.6-iii Key Activities

Strengthening Linkages Between Schools and Health and Social Protection Services

Sub Activities

a)Advocate for increased government and donor funding for community-led HIV service delivery.

b). Establish partnerships with private sector organizations to secure additional resources.

c) Develop innovative financing mechanisms, such as social enterprises, to support community-led initiatives.

d) Strengthen grant-writing and financial management skills of community organizations to improve funding access."

4.1.2.6-iv Key Activities

Creating Safe and Inclusive Learning Environments for Young People Living with HIV

Sub Activities

"a)Train community members to collect, analyze, and report data on HIV service gaps and barriers.

b) Establish community-led scorecards and feedback mechanisms to monitor service quality and equity.

c) Use community-generated data for advocacy with policymakers and funders to improve service delivery.

d) Develop digital platforms for real-time community-led data collection and reporting."

4.1.2.7: Major Intervention

Expand and promote equitable, affordable access to high-quality medicines, health commodities, science, technology, innovations and solutions for PLHIV, KPs and other priority populations

4.1.2.7-iii Key Activities

Scale Up Access to HIV Testing, Monitoring, and Diagnostic Technologies

Sub Activities

a) Expand availability of rapid HIV self-testing kits and point-of-care viral load monitoring.

b) Strengthen laboratory networks to improve timely access to CD4 count and viral load testing services.

c) Promote community-led and decentralized testing services to reach underserved populations.

d) Advocate for subsidies and insurance coverage for essential HIV diagnostics and monitoring services.

4.1.2.9: Major Intervention

Address the impact of social and structural drivers of the HIV epidemic, including unequal gender norms and power dynamics, and human rights violations affecting access to and uptake of HIV treatment and care efforts

4.1.2.9-iii Key Activities

Combat Stigma, Discrimination, and Violence Against People Living with HIV (PLHIV) and Key Populations

Sub Activities

a) Develop and implement anti-stigma campaigns targeting healthcare providers, workplaces, schools, and communities.

b). Establish support groups and safe spaces for PLHIV and KPs to share experiences and access psychosocial support.

c). Train healthcare providers on stigma-free and non-discriminatory HIV service provision.

d). Strengthen monitoring and reporting mechanisms for human rights violations and discrimination in healthcare settings."

4.1.2.11: Major Intervention

Expand rights-based community contact tracing and scale up access to the latest technologies for tuberculosis screening, diagnosis, treatment and prevention for PLHIV and ensure optimal linkages to HIV care

4.1.2.11-iKey Activities

Strengthening Community-Based TB Screening and Contact Tracing

Sub Activities

a) Train community health workers (CHWs) and peer educators to conduct TB contact tracing among PLHIV and key populations (KPs).

b) Implement door-to-door and mobile outreach TB screening programs in high-burden areas.

c). Develop digital tracking and notification systems to ensure timely follow-up of TB contacts and linkage to care.

d). Establish community-based TB testing sites to expand access to diagnostic services."

Advocate for Policy and Financial Support to Strengthen the Education Sector's Response to HIV
Policy Makers "a)Advocate for policies that formally recognize and integrate community-led service delivery into national HIV programs.

b) Engage policymakers in dialogue to address legal and structural barriers limiting community-led health services.

c) Establish multi-stakeholder platforms to enhance collaboration between governments, donors, and community-led organizations.

d) Develop national and regional guidelines to standardize and support the scale-up of community-led HIV services."

4.1.2.11

Major Intervention

4. 1.2.11: Expand rights-based community contact tracing and scale up access to the latest technologies for tuberculosis screening, diagnosis, treatment and prevention for PLHIV and ensure optimal linkages to HIV care

Key Activities

1.2.11-i Strengthen Community-Based TB Screening and Contact Tracing

Sub Activities

"a) Train community health workers (CHWs) and peer educators to conduct TB contact tracing among PLHIV and key populations (KPs).

b) Implement door-to-door and mobile outreach TB screening programs in high-burden areas.

c). Develop digital tracking and notification systems to ensure timely follow-up of TB contacts and linkage to care.

d). Establish community-based TB testing sites to expand access to diagnostic services."

4. 1.2.12. Major Intervention

4.1.2.12: Scale up integrated services for HIV, syphilis, viral hepatitis, sexually transmitted infections and other infections in antenatal and postnatal services and other settings, where needed

Key Activities

4.1.2.12-ii Enhance Prevention Strategies for Mother-to-Child Transmission (PMTCT) of HIV, Syphilis, and Hepatitis

Sub activities

"a) Provide integrated PMTCT services, including ART, hepatitis B immunoglobulin (HBIG), and penicillin treatment for syphilis.

b). Strengthen linkages between maternal health services and family planning to prevent unintended pregnancies among women living with HIV.

c). Ensure newborns receive early infant diagnosis (EID) for HIV and timely immunization for hepatitis B at birth.

d. Conduct health education and counseling on STI prevention, risk reduction, and safe pregnancy practices."

4.1.2.12-iv Key Activity

Strengthening Health Workforce and Facility Readiness for Integrated Service Delivery

Sub Activity

"a) Train midwives, nurses, and obstetricians on delivering integrated HIV/STI/hepatitis care within ANC/PNC settings.

b). Equip maternal health clinics with essential diagnostic tools, medicines, and supplies for integrated care.

c). Implement task-shifting models to allow community health workers (CHWs) to support integrated screening and treatment services.

d). Establish referral networks between ANC/PNC services and specialized HIV/STI/hepatitis treatment centers."

4.1.2.13: Major Intervention

Leverage both HIV and broader health investments to transform data recording and reporting systems of vertical programmes and adapt integrated health data systems (including with other sectors such as social welfare and protection) to identify gaps, barriers and solutions to achieve effective integrated health services for people living with and at risk of HIV

4.1.2.13-iii Key Activity

Improve Real-time Data Use for Decision-making and Service Delivery Optimization

Sub activity

"a) Implement data dashboards and analytics tools to provide real-time insights on service uptake, treatment outcomes, and emerging health trends.

b). Develop an early warning system using predictive analytics to identify service gaps, stockouts, and emerging disease outbreaks.

c). Facilitate regular review meetings with policymakers, program managers, and community representatives to use data for decision-making.

d). Strengthen patient feedback loops by integrating community-led data reporting mechanisms into health programs."

4.1.3.1 Result Area 3: Vertical HIV transmission, paediatric AIDS

4.1.3.1. Major Interventions

Major Intervention

Implement innovative tools and strategies to find and diagnose all children living with HIV, including the use of point-of-care early infant diagnostic platforms for HIV-exposed infants, and rights-based index, family and household testing and self-testing to find older children and adolescents living with HIV not on treatment

4.1.3.1-i Key Activities

Expand Point-of-Care Early Infant Diagnosis (POC EID) for HIV-Exposed Infants

Sub Activity

"a)Scale up the use of POC EID platforms (e.g., GeneXpert, m-PIMA) in primary healthcare and maternal and child health (MCH) facilities.

b). Train healthcare providers on the proper use of POC EID technologies for timely HIV diagnosis.

c). Develop guidelines to ensure all HIV-exposed infants receive POC EID testing within the first six weeks of life.

d). Strengthen sample transport and referral networks to ensure rapid turnaround of HIV test results and prompt linkage to care."

4.1.3.2. Major interventions

4. 1.3.2: Use tools such as the stacked bar analysis to identify and address when and where new child infections are occurring, and use age-disaggregated data to identify and close the gaps in HIV testing and treatment for children and adolescents

4. 1.3.2-vi Key Activities

Improve vertical transmission and paediatric AIDS complete service package for women and children

Sub Activity

a) Procure complete service package for paediatric AIDS and vertical HIV transmission

4.2 Core Targets and Result Framework

By the end of 2027:

1. 95% of people at risk of HIV infection have access to and use effective prevention options.
2. 95% of women of reproductive age have their HIV and sexual health service needs met.
3. 95% of pregnant and breastfeeding women living with HIV have suppressed viral loads.
4. 95% of HIV-exposed children are tested by two months of age.
5. 95% of PLHIV receive preventive treatment for tuberculosis.

Table 6: Result Framework: Equitable and Equal Access to HIV Services

	Indicators	**Baseline (End of 2024)**	**Source**	**End-Term, (End of 2027)**	**Assumption**	**Data Source**
1	Number of people at risk of HIV infection have access to and use appropriate, prioritized, person-centred and effective combination prevention options.	65%	NDHS 2024	75%	Mid-point between baseline achievement and End term Target	NDHS, spectrum projections
2	Percentage of women of reproductive age have their HIV and sexual and reproductive health service needs met.	NA				
3	Percentages of pregnant and breastfeeding women living with HIV have suppressed viral loads.	8.3	NDARS estimates	60	Midpoint years, consistent funding	95%
4	Percentage of HIV-exposed children are tested by two months of age and again after cessation of breastfeeding.	85	NDARS estimates	90	Midpoint years, consistent funding	95%
5	Testing and treatment targets are achieved within all subpopulations, age groups and geographic settings, including children living with HIV.	95%	NASCAP 2023	95%	Mid-point between baseline achievement and End term Target	NASCAP 2023
6	Number of people living with HIV receive preventive treatment for TB.	67	Programme data NDARS 2024		Mid-point between baseline achievement	NDARS 2024

	Indicators	Baseline (End of 2024)	Source	End-Term, (End of 2027)	Assumption	Data Source
					and End term Target	
7	Percentage of people living with HIV and people at risk are linked to people-centred and context-specific integrated services for other communicable diseases, non-communicable diseases, sexual health and gender-based violence, mental health, drug and substance use, and other services they need for their overall health and wellbeing.	Not Available	-	-	Mid-point between baseline achievement and End term Target	90%

5.0 STRATEGIC PRIORITY II: BREAK DOWN BARRIERS TO ACHIEVING HIV OUTCOMES

5.1 Result Areas and Major Interventions

5.2.1.1: Fully implement the Greater Involvement of People living with AIDS (GIPA) principle to put the leadership of PLHIV at the centre of HIV responses, ensure that networks of PLHIV and KPs are represented in decision-making bodies, empower PLHIV, AYP and KP so they can influence the decisions that affect their lives, and ensure PLHIV, AYP and KP have access to technical support for community mobilization, strengthened organizational capacities, and leadership development

5.2.1.1-i Key Activities

Strengthening the Leadership and Representation of PLHIV, AYP, and KPs in Decision-Making Bodies PLHIV

Sub Activities

"a)Establish and support advisory boards and committees that include PLHIV, AYP, and KP representatives in national and local HIV policy-making processes.

b) Ensure PLHIV and KP networks are actively involved in the development, implementation, and review of national HIV strategies and guidelines.

c) Provide mentorship and leadership training for PLHIV, AYP, and KP representatives to enhance their advocacy and decision-making skills.

d) Advocate for policies that institutionalize the participation of PLHIV and KPs in government-led and donor-funded HIV response programs.

5.2.1.1-ii Key Activities

Building the Organizational Capacity of PLHIV, AYP, and KP Networks Key Population

Sub Activities

a) Conduct capacity-building workshops on governance, resource mobilization, financial management, and program implementation for PLHIV and KP-led organizations.

b) Provide technical assistance to community-based organizations (CBOs) and networks of PLHIV and KPs to strengthen their organizational structures and sustainability.

c) Facilitate partnerships between PLHIV networks and key stakeholders, including government agencies, donors, and civil society organizations.

d) Develop and distribute toolkits and guidelines on community-led HIV responses to enhance the effectiveness of PLHIV and KP-led initiatives.

5.2.1.1-iii Key Activities

Enhancing Community Mobilization and Advocacy for PLHIV, AYP, and KPs

Sub Activities

a)Support peer-led advocacy campaigns to challenge stigma, discrimination, and legal barriers affecting PLHIV, AYP, and KPs.

b) Organize national and regional forums for PLHIV, AYP, and KPs to engage with policymakers, service providers, and development partners.

c) Establish community dialogues and support groups to amplify the voices of PLHIV and ensure their concerns inform service delivery.

d) Strengthen media engagement to promote positive narratives about PLHIV leadership and visibility in HIV response efforts.

5.2.1.1-iv Key Activities

Expanding Access to Technical Support and Leadership Development for PLHIV, AYP, and KP

Sub Activities

a) Develop mentorship programs linking experienced PLHIV and KP leaders with emerging advocates to enhance skills and confidence.

b) Provide training on human rights, policy advocacy, and HIV program monitoring for PLHIV, AYP, and KPs to influence decision-making.

c) Establish dedicated funding mechanisms to support leadership development and community-led HIV initiatives for PLHIV and KP groups.

d) Facilitate exchange programs and study tours for PLHIV leaders to learn from best practices in community-driven HIV responses.

5.2.1.1-v Key Activities

Institutionalizing the GIPA Principle in state and Local HIV Responses

Sub Activities

a) Advocate for the formal inclusion of the GIPA principle in national HIV policies, guidelines, and service delivery frameworks.

b) Develop accountability mechanisms to monitor and evaluate the involvement of PLHIV, AYP, and KPs in decision-making processes.

c) Ensure that HIV program funding includes dedicated resources for PLHIV-led initiatives and community-based interventions.

d) Train government officials, healthcare providers, and development partners on the importance of meaningful PLHIV and KP engagement in HIV responses.

5.2.1.2: Major Intervention

Support community-led monitoring and research and ensure that community-generated data is used to tailor responses to the needs of PLHIV and KPs, including young KPs.

5.2.1.2-i Key Activities

Establishing and Strengthening Community-Led Monitoring (CLM) Mechanisms

Sub Activities

"a) Train PLHIV and KP-led organizations on data collection, analysis, and reporting to ensure effective community-led monitoring.

b) Develop standardized tools and guidelines for community-led monitoring of HIV service delivery and human rights violations.

c) Set up community advisory groups to oversee and validate data collection and ensure accountability in the HIV response.

d) Collaborate with national health agencies and service providers to integrate community-led data into routine health system monitoring.

5. 2.1.2-ii Key Activities

Conducting Community-Led Research on PLHIV and KP Needs

Sub Activities

a) Support participatory action research led by PLHIV and KPs to document service gaps, stigma, and access barriers.

b) Facilitate focus group discussions, key informant interviews, and surveys to gather qualitative and quantitative community insights.

c) Partner with academic institutions and research organizations to enhance the credibility and impact of community-led studies.

d) Ensure that findings from community-led research inform the design and adaptation of HIV prevention, treatment, and support programs.

5.2.1.2-iii Key activities

Strengthening Data Utilization and Advocacy for Policy Change

Sub Activities

a) Organize national and local forums to present community-generated data to policymakers, donors, and program implementers.

b) Develop advocacy briefs and policy recommendations based on community-led research to influence HIV programming and funding.

c) Establish partnerships with media outlets to amplify community voices and push for evidence-based policy changes.

d) Engage legal and human rights organizations to use community-generated data in addressing rights violations against PLHIV and KPs.

5 2.1.3: Major Intervention

Scale up community-led service delivery to the majority of HIV prevention programmes are led by PLHIV, KPs, women and young people and that all HIV testing, treatment and care programmes include community-led services

5.2.1.3-i Key Activities

Expanding Community-Led HIV Prevention Programs

Sub Activities

a)Train PLHIV, KPs, women, and young people as peer educators and community health workers to lead HIV prevention efforts.

b) Establish and strengthen community-based distribution of HIV prevention tools, including condoms, lubricants, PrEP, and harm reduction services.

c) Develop and implement peer-led outreach programs targeting hard-to-reach populations, including female sex workers, people who use drugs, and LGBTQ+ individuals.

d) Integrate comprehensive sexuality education into community-led prevention programs to address misinformation and stigma.

5.2.1.3-ii Key Activities

Strengthening Community-Led HIV Testing Services

Sub Activities

a) Expand access to HIV self-testing through community distribution networks, including drop-in centers and mobile outreach.

b) Train community health workers to provide pre- and post-test counseling and link individuals to confirmatory testing and care services.

c) Establish mobile and door-to-door HIV testing services, particularly for underserved populations in rural and high-risk urban areas.

d) Strengthen index testing and partner notification approaches led by trained community members to improve case identification and linkage to care.

5.2.1.3-iii Key Activities

Enhancing Community-Led HIV Treatment and Care Services

Sub Activities

a) Support community ART refill groups and decentralized drug distribution to improve adherence and retention in care.

b) Train PLHIV and KP-led organizations to provide adherence support, treatment literacy, and psychosocial support for newly diagnosed individuals.

c) Establish peer-led support groups, including mentor mother programs for pregnant WLHIV and young people living with HIV.

d) Integrate mental health and substance use support into community-led HIV care programs to address co-occurring health issues.

5.1.2 Result Area 2: Human Rights

Major Interventions

- End stigma and discrimination against PLHIV and key populations.
- Reform HIV-related laws and policies to protect the rights of PLHIV.

5.1.3 Result Area 3: Gender Equality

Major Interventions

- Address gender-based violence and inequalities that increase vulnerability to HIV.
- Promote women's economic empowerment and access to health services.

5.1.4 Result Area 4: Young People

Major Interventions

- Increase the engagement of young people in HIV programs and decision-making.
- Provide youth-friendly HIV services, including comprehensive sexuality education.

5.2 Core Targets and Result Framework

By the end of 2027:

1. 30% of HIV testing and treatment services are delivered by community-led organizations.
2. Less than 10% of PLHIV and key populations experience stigma and discrimination.
3. 90% of HIV services are gender-responsive.

Table 7: Result Framework: Breakdown Barriers to Achieving HIV Service Outcomes

"NOTE: Data not available for the state so national data is used here"

S/N	**Indicator**	**Baseline Data**	**Midpoint Achievement**	**End-Term Target**	**Source**
1	30% of testing and treatment services are to be delivered by community-led organizations.	Data not available	15%	30%	NACA
2	80% of service delivery for HIV prevention programs for key populations and women to be delivered by community-, key population-, and women-led organizations.	Data not available	40%	80%	NACA
3	60% of the programs support the achievement of societal enablers to be delivered by community-led organizations.	Data not available	30%	60%	NEPWHAN, NACA
4	Less than 10% of states have punitive legal and policy environments that lead to the denial or limitation of access to services.	54%	34%	<10%	NACA, Stigma Index
5	Less than 10% of people living with HIV and key populations experience stigma and discrimination.	34%	20%	<10%	Stigma Index
6	Less than 10% of women, girls, people living with HIV, and key populations experience gender-based inequalities and all forms of gender-based violence.	31%	20%	<10%	UNICEF/MWA
7	Less than 10% of people support inequitable gender norms	Data not available	20%	<10%	UNAIDS
8	90% of HIV services are gender responsive.	Data not available	45%	90%	UNAIDS

6.0 STRATEGIC PRIORITY III: FULLY RESOURCE AND SUSTAIN EFFICIENT HIV RESPONSES AND INTEGRATE THEM INTO SYSTEMS FOR HEALTH, SOCIAL PROTECTION, HUMANITARIAN SETTINGS AND PANDEMIC RESPONSES

6.1. Result Areas and Major Interventions

Rationale: International resources account for a large significant proportion of all resources allocated to HIV response in kogi state, is similar to what happen in the whole country. The HIV/AIDS interventions resources in the state is largely provided by PEPFAR (CIHP), AHF and Global Fund, with PEPFAR being the leading contributor. Governments must be committed to HIV funding. Currently, financing the HIV response in Kogi State from the continued support of international partners. Kogi state government, like many other states in Nigeria, continue to rely on the support of partners towards achieving the 2030 targets of a state free of AIDS; it must be noted that such reliance is not sustainable with the current wave of dwindling donor support. HIV programme in Humanitarian settings is not a major scenario in Kogi State.

The three results areas that strengthen this Priority Area 3 are the following:

a) Result Area 1: Fully funded and efficient response

b) Result Area 2: Integration of HIV into systems for health and social protection

c) Result Area 3: Humanitarian settings and pandemics

6.1.3.1.1 Result Area 3: Fully Funded and Efficient HIV Response in Kogi State

6.1.3.1.1. Strengthen inclusive governance and policy implementation

Kogi State will improve coordination and inclusivity in its HIV response by strengthening the Kogi State Agency for the Control of AIDS (KOSACA) and revitalizing State and LGA-level HIV Technical Working Groups (TWGs). People living with HIV (PLHIV), key populations (KPs), women, youth, and CSOs will be actively involved in the design, implementation, and monitoring of policies and programs, ensuring their voices shape priorities.

6.1.3.1.: Mayor Interventions

Enable increased efficiency, equitable and inclusive governance, policies and delivery platforms to achieve the NSP's targets and sustain the gains made to date in the HIV response and ensure affected communities including KPs and other vulnerable populations are at the forefront of the decision-making processes

6. 3.1.1-i Key Activities

Advocacy visit to ministry of Local Government and Chieftaincy Affair on the need to fund HIV activities at the various local government level of the state.

Sub Activities

a) Conduct a one day advocacy visit to the Hon. Commissioner for Health on the need to fund HIV activities

6.3.1.1-ii Key Activity

Enhance Equitable Access to HIV Services through strengthened delivery platforms

Sub Activities

a) 3 Days capacity building training to provide high quality HIV services for 30 Health workers

6.3.1.1-iii Key Activities

Enhance Social Protection

Sub Activities

a) 5 Town criers to carry out announcement for 7 days on enhance social protection

b) 2 days in a week Giggles on Radio and Television

6.3.1.1-iv Key Activities

Humanitarian and Pandemic Preparedness

Sub Activities

a) Conduct a 3-days meeting to develop and regularly update Emergency Response plan by 40 stakeholders drawn from these line Ministries: MOH, MOI,SPHCDA, KSHIA, MOE,MOJ, MLGCA, MOWA, MOHA, KOSACA and Civil Societies particularly CISHAN

b) Establish coordination Mechanism by Conducting a 2-days Review meeting for 25 participants

6.3.1.1-v Key Activities

Monitoring and Evaluation PLHIV

Sub Activities

a) 3 -days Capacity training of 30 health information management staff on the use of Data to track the performance of HIV programs and identify gaps and make inform decision to improve service delivery

b) Conduct a 1-day training of 30 stakeholders on impact assessment to evauate the effectiveness in HIV programs in different settings including Humanitarian and Pandemic contexts.

6.1.1.2. Expand strategic partnerships for increased domestic financing

To overcome funding constraints, Kogi State will build cross-sectoral partnerships with ministries of health, finance, education, youth and social development, and the private sector. This will support advocacy for the inclusion of HIV funding in the state annual budget, improved inter-ministerial collaboration, and better alignment of donor and public investments with community needs.

6.3.1.2: Major Intervention

Expand partnerships to address the structural and macroeconomic barriers to increased domestic public spending on HIV and health as societal and economic priorities

6.3.1.2-i Key Activities

Human Rights and Stigma Reduction

Sub Activities

a) 1 -Days workshop of 30 stakeholders on Promoting human rights-based approach

b) Conduct a 1-day Serminar of 25 stakeholders on the reduction of Stigmatization and discrimination of people living with HIV

c)Conduct 1 day training 30 stakeholders on the policy to protect the Rights of people living with HIV. Stakeholders drawn from State Legislatures, MOH, SPHCDA, KSHIA, MOE, MOI,MOJ, MLGCA, MOWA, MOHA, KOSACA, Donors and Civil Societies particularly CISHAN

6.3.1.2-ii Key Activities

Strengthened multi-sectoral Engagement for sustainable HIV financing

Sub Activities

a) 1 day quaterly meeting of 25 stakeholders on the need to strenghened multi-sectoral engagement for sustainable HIV financing

b) 1 Days Advocacy visits to Government, Donors on the sustainability of HIV funding.

6.3.1.2-iii Key Activities

Address Structural Barriers to Domestic HIV financing

Sub Activities

a) Conduct a 1 day advocacy visit to the Government and critical stakeholders on the need to fund HIV activities.

b) A 1 day sensitization campaign on media house on the need to address structural barriers to HIV financing

6.3.1.2-iv Key Activities

Strengthened Public-Private partnerships for Health Sector investment

Sub Activities

a) Conduct 2-Days stakeholders engagement workshop for 25 participants

b) 3-Days capacity Building of 35 stakeholders on the need to strengthened public-private partnerships for health sector investment for both public and private sector stakeholders.

6.1.1.3. Secure predictable, long-term funding for community-led responses

The State will advocate for dedicated funding windows (earmarked budget lines or grants) to support community-led organizations providing HIV prevention, care, and support services.

Efforts will include working with LGAs, donor agencies, and philanthropic actors to institutionalize and scale funding for grassroots-led initiatives.3.1.3: Promote and increase the volume and predictability of long-term, direct funding for community-led responses, including through establishing funding earmarks across countries and public funding of community-led responses

6.3.1.3: Maor Intervention

Promote and increase the volume and predictability of long-term, direct funding for community-led responses, including through establishing funding earmarks across countries and public funding of community-led responses

6.3.1.3-i Key Activities

Advocacy visit to the government to create policies to earmark funds

Sub Activities

a) conduct a 2 days advocacy visits to government officials to increase direct funding.

6.3.1.3-ii Key Activity

Community led public Awareness Campaigns

Sub Activities

a) Conduct a 1-day awareness campaign about the importunacy of community led responses through workshops, seminars and social media

6.3.1.3-iii Key Activities

Provide training for community leaders on fundraising strategies and financial management

Sub Activities

a) Conduct a 2 day capacity building training for 20 community leaders and stakeholders

6.3.1.3-iv Key Activity

Develop frameworks to assess the effectiveness of funded initiatives, ensuring accountability and transparency

Sub Activity

a) Conduct a 2 days quarterly meeting of 25 Stakeholders on the need to assess the effect of funding, accountability and transparency

6.3.1.3-v Key Activities

Conduct a 4-Days Bi-monthly-annually mentoring visit by SACA and LACA & CBOs

Sub Activity

a) Conduct a 2 days quarterly meeting of 25 Stakeholders on the need to assess the effect of funding, accountability and transparency

6.3.1.4. Promote investment transparency and reset public-private partnerships (PPP)
Kogi State will improve transparency in the use of HIV-related funds and work with local private sector actors, especially those in hospitality, transport, and extractive industries—to co-invest in health outreach, workplace HIV programs, and access to prevention commodities.

6.3.1.4: Major Intervention

Promote increased domestic and international investments in the public sector, management processes, greater transparency and accountability, and reset public-private partnerships towards equitable outcomes

6.3.1.4-i Key Activities

Strengthen public sector investment in HIV and health programs

Sub Activities

a) Conduct a 1 day meeting of 25 stakeholders to develop open data system for tracking health system

6.3.1.4-ii Key Activities

Strengthening the role of civil society

Sub Activities

"a) conduct a 1-day sensitization meeting of 20 stakeholders to strengthen the role of civil society.

6.3.1.4-iii Key Activities

Improve public sector management processes for efficient resources utilization

Sub Activities

a) conduct a 1-day advocacy visit to advocate for corporate social responsibility (CSR) investments targeted at strengthening public health system.

6.1.1.5. Prioritize funding for high-impact interventions for key and vulnerable populations

Limited state resources will be directed to scale-up of proven interventions—such as community-based testing, ART distribution, prevention services for AGYW and KPs, and addressing gender-based violence. Emphasis will be placed on underserved areas such as rural riverine communities, mining sites, and transportation corridors.

6.3.1.5: Major Intervention

Focus resources on highly effective and efficient interventions for priority gaps and populations, including increased funding for scaling programmes for KPs and other vulnerable populations in addressing structural drivers

6.3.1.5-i Key Activities

Identify and prioritize key gaps and populations for targeted HIV interventions.

Sub Activities

"a) conduct a 2 day state and local government assessment for 20 stakeholders to identify service gaps and population most at risk

b) conduct a 1-day meeting of 30 stakeholders to develop data-driven strategies to allocate resources efficiently based on epidemiology.

6.3.1.5-ii Key Activities

Scale-up HIV prevention, treatment and care programs for KPs and vulnerable populations

Sub Activities

a) conduct 2 days stakeholders meeting of 25 health personnels on the need to strengthen linkage to care programs to improve retention in HIV treatment among vulnerable population.

b) Advocacy visit to government on how to increase funding for tailored HIV prevent programs including PrEp, harm reduction and condom distribution.

6.3.1.5-iii Key Activities

Address structural Drivers that exacerbate HIV vulnerability

Sub Activities

a) conduct a 1-day review meeting of 20 stakeholders on the policy and legal reforms eliminate barriers to healthcare access for KPs and marginalized groups.

b) conduct 2 days stakeholders meeting of 20 health professionals on the need to strengthen gender-based violence (GBV) prevention and response mechanisms to protect vulnerable individuals from HIV risk.

6.1.1.6. Use digital and mobile platforms to improve service delivery

The State will expand use of mobile health (mHealth), social media, and USSD tools to increase awareness, track adherence, provide client reminders, and enable anonymous reporting and referrals. This is especially important for youth and hard-to-reach populations in LGAs like Ibaji, Bassa, and Lokoja.

6.1.1.1.7. Develop Kogi-specific HIV sustainability financing strategies

A state-specific HIV financing strategy will be developed, focusing on increasing state health allocations, leveraging state health insurance (KGSHIA), encouraging private sector donations,

and integrating HIV services into broader UHC and PHC reforms. This strategy will be aligned with the state development and health financing frameworks.

6.1.1.8. Strengthen HIV data systems for equity and accountability

Kogi will invest in improving data systems (e.g., DHIS2, LAMIS, CPIMS) to generate and use disaggregated data by age, sex, LGA, and population group. This will inform decision-making, enable performance tracking, and ensure that resources reach the most underserved, including young women, mobile populations, and children affected by HIV.

6.1.2 Result Area 2: Integration of HIV into Systems for Health and Social Protection (Kogi State Context)

Contextualized Major Interventions

6.1.3.2.1. Integrate HIV into the broader state health system using a people-centered, gender-responsive-approach

Kogi State will integrate HIV services into the Primary Health Care (PHC) platform and the State Health Insurance Scheme (KGSHIA) to enhance service coverage, reduce stigma, and ensure a holistic approach. Efforts will focus on making services responsive to the unique needs of adolescents, women and girls, and people with disabilities, ensuring they access treatment and prevention services in dignified, non-discriminatory settings.

6.3.2.1: Major Interventions

Integrate HIV into systems for health and ensure that the integrated approaches are comprehensive, people-centered (with integrated and fully resourced community-led responses

and systems) and gender-transformative and that they reduce inequalities and uphold people's right to health.

6.3.2.1-i Key Activities

Policies creating that align HIV responses with boarder health and social protection frameworks

Sub activities

a) Conduct a 1-day Review meeting on policy development and strategies for 25 senior officers

b) conduct a 1-day Community engagement meeting in order to ensure that HIV services meet the needs of the populations they serve with 25 local government stakeholders.

6.3.2.1-ii Key Activities

Implementation of social protection programs that provide financial support to those affected by HIV

6.3.2.1-iii Key Activities

Fostering partnership between health education and social services to address the multifaceted needs of people living with HIV

Sub Activities

a) conduct 2 days stakeholders inter ministerial training of 25 stakeholders to address the multifaceted needs of the PLWH

b) conduct a 3 days sensitization to 10 secondary schools in Lokoja LGA

6.3.2.1-iv Key Activities

Financial Strategies that reduce out-of-pocket expenses for HIV related services

Sub Activities

a) conduct 1 day advocacy visit to the state government on the need to adopt a financial strategies that will reduce out-of-pocket expenses for HIV related services

b) conduct 2 days' financial strategies training of 30 relevant stakeholders for the need to reduce out-of-pocket expenses

6.3.2.1-v Key Activities

Data integration to enhance the effectiveness of HIV response

Sub Activities

a) conduct a 3 adys quarterly meeting of 20 HMIS officers to collect and analyse data on HIV outcomes within health and social protection frameworks.

6.1.2.2. Strengthen health system capacity for HIV service delivery

The state will enhance human resources for health (HRH) by training healthcare workers on HIV case management, stigma reduction, and integration of TB and hepatitis services. Procurement and supply chain systems will be improved in collaboration with the Kogi State Ministry of Health, KOSACA, and SPHCDA to ensure availability of HIV commodities, including ART, PEP, and PrEP. Investments will be made in supervision, data systems (e.g., LAMIS, DHIS2), and facility governance to improve care quality and accountability.

6.1.2.3. Expand community-led differentiated service delivery

Tailored community-based HIV services such as mobile testing, community ART refill groups, peer navigation, and youth-focused outreach will be scaled in underserved LGAs such as Ibaji,

Lokoja, and Mopamuro. Emphasis will be placed on engaging community-based organizations (CBOs), PLHIV networks, and youth-led groups to extend reach and effectiveness.

6.1.2.4. Advance multi-sectoral alignment and social protection for vulnerable groups Kogi will strengthen collaboration between the Ministries of Health, Women Affairs, Education, Social Development, and Humanitarian Services to link HIV-affected individuals with social protection schemes. Initiatives such as cash transfers, school enrolment support for orphans and vulnerable children (OVC), and economic empowerment for caregivers will be expanded, especially for adolescent girls and young women in high-risk areas.

6.1.3 Result Area 3: Humanitarian Settings and Pandemic Preparedness (Kogi State Context)

Contextualized Major Interventions

6.1.3.1. Integrate HIV services into emergency preparedness and response planning Given Kogi State's vulnerability to annual flooding (notably in Ibaji, Koton-Karfe, and Lokoja), HIV services will be incorporated into the State Emergency Management Agency (SEMA) preparedness plans. HIV-related services (ART continuation, PEP, HIV testing, condoms) will be included in emergency relief packages and coordinated through mobile clinics and rapid response teams.

6.3.3.1: major Interventions

Promote policy, frameworks and legislation that ensure national emergency response plans are tailored to specific contexts and provide the initial minimum package and then expand to provide comprehensive HIV services to all people affected by humanitarian emergencies who are living with HIV or at-risk of HIV, regardless of residency or legal status

6.3.3.1-i Key Activities

Need assessment of Humanitarian settings and pandemics

Sub Activities

a) conduct a 3 days training of 30 stakeholders on rapid assessments to identify the immediate needs of affected populations.

6.3.3.1-ii Key Activities

Emergency response planning, developing contingency plans that outline response strategies and resources allocation

Sub Activities

a) Organised a 2 days meeting of 20 stakeholders to develop contingency plans for the state.

6.1.3.2. Include internally displaced persons (IDPs) and flood-affected populations in HIV frameworks

Flood-displaced persons and mobile populations in riverine LGAs will be included in the state's HIV programming, with adaptable service delivery models. This will include support for community-based HIV care in IDP camps and temporary settlements, as well as scaled access to gender-based violence (GBV) services

6.3.3.2: Majoy intervention

Integrate refugees, internally displaced and other humanitarian-affected populations into national HIV policy frameworks, programmes and funding proposals, reflecting their diverse needs, including support and scale-up of community-led responses and adapted service delivery

6.2 Core Targets and Result Framework for Kogi State (By 2027)

1. **State-HIV-Investments**

   Increase domestic HIV financing to at least **₦14,737,993,138.55 million (~USD $9,825,328.76) annually** by 2027 through dedicated budget lines, domestic resource mobilization, and health insurance integration.

2. **Access-to-Social-Protection**

   Ensure **at least 45%** of people living with, at risk of, and affected by HIV (especially women, OVCs, and KPs) receive at least one form of social protection benefit (e.g., educational support, healthcare subsidies, conditional cash transfers).

3. **Access to HIV Prevention in Humanitarian Settings**

   Achieve **95% coverage** of people at risk of HIV in flood-prone or emergency-affected communities with effective, people-centered HIV prevention packages (condoms, PrEP, peer education).

4. **Integrated Services for Co-infections and GBV**

   Ensure **90%** of people in humanitarian settings access **integrated services** for TB, hepatitis C, HIV, and GBV (including PEP, EC, psychosocial support).

5. **Emergency Preparedness**

   Ensure **95%** of HIV-affected individuals are included in **health emergency and pandemic preparedness** plans, with guaranteed access to ART, continuity of care, and protective supplies during outbreaks such as COVID-19 or Lassa fever.

Table 8: Result Framework: Fully Resourced and Sustained HIV Response

Indicators	Baseline (End of 2024)	Source	Mid-Term (Mid-2025)	Assumption	End-Term (End of 2027)	Assumption	Data Source
1. Increase State HIV investments to USD 610,000,000 per year by 2027	$801,917	KSSP 20221-2025	$ 6,635,240.30	Mid-point	$9,825,328.76	The indicative cost of the KSSP 2021-2025 was utilized with year-on-year increases at $0.03 billion	KSSP
2. 45% of people living with, at risk of and affected by HIV and AIDS have access to one or more social protection benefits.	Base line budget 500,000,00	*Budget for emergency 2024 SMoH for health related component	-	Mid-point	45%	20% to be achieved from the baseline with a 2.5% increment annually	NASSCO
3. 95% of people within humanitarian settings at risk of HIV use appropriate, prioritized, people-centered and effective combination prevention options.	Data not available	State Ministry of Humanitarian Affairs (SMHA)	50%	Midpoint, no wars or disasters	95%	50% to be achieved from the baseline with a 22.5% scale-up yearly	FHMA
4. 90% of people in humanitarian settings have access to	Data not Available						

integrated TB, hepatitis C and HIV services, in addition to programs to address gender-based violence (including intimate-partner violence), which include HIV post-exposure prophylaxis, emergency contraception and psychological first aid.							
5. 95% of people living with, at risk of and affected by HIV are better protected against health emergencies and pandemics including COVID-19.	Data not available		50%	Midpoint, no Pandemic	95%	50% to be achieved from the baseline with a 22.5% scale-up yearly	State NCDC

CROSS CUTTING

7.1 Leadership, Country Ownership, Governance, and Advocacy

Strengthening leadership will help reinforce and advance the principles, targets and commitments in this plan. To ensure that the country is on track to ending AIDS by 2030, leadership at the national and sub-national levels is imperative; including community leadership by PLHIV, key and priority populations, civil society organizations, the private sector, faith-based organisations, traditional leaders, the academia and international partners. Political leadership and actions in the spirit of leaving no one behind should focus on ensuring that people who are currently underserved have equitable access to acceptable, accessible and quality HIV services as well as social and legal protection. All these must be informed by evidence generated through research and program data.

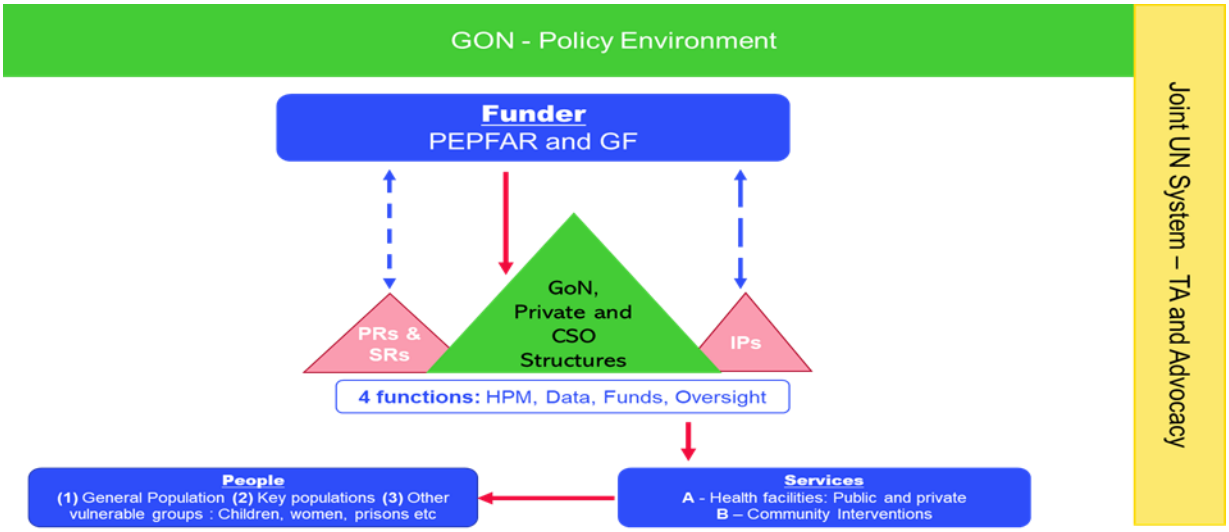


Figure 4: Sustainable delivery architecture/The New Business Model

(Source: NACA, 2022: New Business Model for the Nigerian HIV/AIDS National Response. 2023-2030)

Overview of the New Business Model in Kogi State

The **New Business Model (NBM)** represents a major shift in how Kogi State will engage with its HIV response from 2023–2030. As part of the national **Alignment 2.0 agenda**, Kogi State will lead the gradual **transition from donor-driven service delivery** to **state-led ownership**, with development partners offering **technical assistance (TA)** instead of direct implementation by 2027.

The model emphasizes building the **institutional capacity of Kogi State's HIV structures**—including KOSACA, LACA units, SMOH, SPHCDA, CSOs, and community systems—to assume full responsibility for the planning, coordination, resourcing, implementation, and oversight of HIV programs by 2030.

The 3 results areas that speaks to this Priority area are the following:
a) Leadership, State Ownership, Governance, and Advocacy
b) Partnerships, Multi-sectorality, and Collaboration
c) Data for Impact, Science, Research, and Innovation

Result Area 7.1.4.1: Leadership, Country Ownership, Governance, and Advocacy

7.1.4.1. Interventions for Kogi State

Strengthen state political leadership for HIV response4.1.1: Strengthen the engagement of the country leadership to support the effective and efficient implementation of the national HIV and AIDS response

The Commissioner for Health and the Board for KOSACA will be actively engaged in annual HIV performance reviews, accountability forums, and the mobilization of political will to sustain HIV as a public health priority.

7.1.4.1.1-i Key Activities

Enhance High level political commitment for the State HIV response

Sub Activities

a) Organize regular high level policy dialogue with 30 Govt officials to reinforce the importance of HIV as State Priority

b) Advocate for the inclusion of HIV programs in State development plans and policies

c) Strenghten systems to ensure quarterly dissemination of HIV program report to the Executive Governor

d) Interaction with HOPE-GOV, SwAP and BHCPF to stimulate the Mobilization of funds for key HIV activities (following withdrawal of HIV Funds by USG)

7.1.4.1.1-ii key Activities

Strengthening Multisectoral Coordination for HIV response in the State

Sub Activities

a) Ensure Quarterly Coordination meetings for 30 persons to discuss activities and progress

b) Develop Inter-ministerial Action Plans to integrate HIV programs into Education and Social Welfare

7.1.4.1.1-iii key Activities

Improve HIV Financing and resource mobilization at the State Level

Sub Activities

a) Advocate for an increase in domestic HIV funding through the State budget and a sustainable financing mechanism

b) Develop partnership with Private sector to co-fund and support State HIV response initiative

c) Establish a transparent tracking system to monitor HIV funding allocation and ensure accountability in resource utilization

7.1.4.1.1-iv key Activities

Strengthening monitoring, evaluation and accountability mechanisms •

7.1.4.1.1-vKey Activities

Promote public awareness and advocacy for State HIV Leadership

Sub Activities

a) Strengthen data management systems to improve tracking of progress and impact.

b) conduct Annual performance reviews of the State HIV response and share findings with key Stakeholders, 30 participants

c) Train stakeholders on using driven approaches for policy and decision making

Sub-Activities

a) Organize State level HIV advocacy campaigns led by government leaders to raise public awareness.

b) Build partnerships with community leaders and faith based organisations to strengthen grassroots advocacy

C) Develop and implement anti-stigma and antidiscrimination policies to protect people living with HIV

d)Engage media outlets to amplify government commitment to HIV Prevention, care and treatment

7.1.4.2. : Major Intervention

Strengthen state capacity for leadership of the HIV programmes at the state level

7.1.4.1.2-i Key Activity

Build institutional and technical capacity for State-Led HIV Programs

KOSACA will train KOSACA and LACA personnel in strategic planning, program management, financial accountability, and donor coordination. Strengthening the governance systems for supervising CBOs, overseeing HIV delivery, and integrating HIV into state planning documents (e.g., SDPs, SHDP).

Sub Activities

a) Conduct capacity-building workshops for State and LGA health officials on HIV program planning, implementation and monitoring

b) Develop standardized guidelines and protocols to improve coordination and delivery of HIV services at State level

c) Strengthen the ability of State health departments to collect, analyze and use data for evidence-based decision making

d)Strengthen technical working groups within the State health ministries to oversee HIV program implementation and evaluation

7.1.4.1.2-ii Key Interventions

Enhance multisectoral collaboration for State-led HIV Response Policy Makers

Sub Activities

a) Strengthen state-level HIV coordination committees that include government agencies, civil society, and private sector representatives.

b) Develop inter-agency collaboration mechanisms between health, education, social welfare, and finance sectors to integrate HIV services.

c) Strengthen partnerships between state governments and donor organizations to mobilize resources for HIV programs.

d) Promote community-led and state-supported HIV interventions to ensure inclusive and localized responses.

7.4.1.1.2-iii key Activities

Strengthen State-Level HIV Program Financing and Resource Mobilization

Sub Activities

"a)Advocate for increased state budget allocations for HIV prevention, treatment, and care services.

b) Develop innovative financing mechanisms, such as health insurance schemes and public-private partnerships, to sustain HIV programs.

c) Strengthen financial management systems to ensure accountability and efficient utilization of HIV funds at the state level.

d) Build the capacity of state health officials to develop competitive funding proposals for international HIV funding sources.

7.1.4.1.2-iv key Activities

Improve Monitoring, Evaluation, and Data-Driven Decision-Making

Sub Activities

a) Train 45 state health personnel on data collection, reporting, and analysis for improved HIV program monitoring.

b) Implement real-time surveillance systems to detect and respond to emerging HIV trends at the state level.

c) Use HIV program data to inform policy decisions, resource allocation, and service scale-up strategies.

a)Establish state-level HIV data management systems to track service delivery, treatment adherence, and epidemiological trends.

b) Train state health personnel on data collection, reporting, and analysis for improved HIV program monitoring.

c) Implement real-time surveillance systems to detect and respond to emerging HIV trends at the state level.

d) Use HIV program data to inform policy decisions, resource allocation, and service scale-up strategies.

7.1.4.1.2-v Key Activities

Strengthen Political Commitment and Advocacy for HIV Leadership at the State Level

Sub Activities

a) Conduct high-level advocacy with state governor and policymakers to prioritize HIV in state health agendas.

b) Organize annual HIV summits at the state level to review progress, share best practices, and set new targets.

c) Engage community leaders, faith-based organizations, and influencers to support HIV awareness and stigma reduction efforts.

d) Establish state-led campaigns to promote HIV prevention, testing, and treatment, leveraging local media and digital platforms

7.1.3. Increase domestic HIV financing and budget absorption

Establish a specific **budget line for HIV** in the Kogi State health budget. Integrate HIV services into the **Kogi State Health Insurance Scheme (KGSHIA)** and mobilize resources from LGAs, the State House of Assembly, and corporate CSR to fund HIV prevention and care.

7.1.4.1.3: result area 4

Improve domestic resource mobilization and utilization for national HIV and AIDS response

7.1.4.1.3-i Key Intervention

Strengthening Government Commitment to Increase Domestic HIV Funding

Sub Activities

a)Advocate for increased allocation of State and subnational budgets for HIV programs.

b) Establish a dedicated HIV/AIDS fund within the State health financing framework.

c) Develop policies that mandate a percentage of domestic revenues (e.g., taxes, levies) to support HIV services.

d) Engage parliamentarians and policymakers to champion sustainable HIV financing."

7.1.4.1.3-ii Key Activities

Expand Public-Private Partnerships for HIV Financing Policy Makers

Sub Activities

"a)Establish HIV-focused corporate social responsibility (CSR) initiatives with private sector organizations.

b) Develop tax incentives for businesses that invest in HIV prevention, treatment, and care programs.

c) Engage financial institutions to create innovative financing mechanisms, such as HIV bonds or health insurance schemes.

d) Partner with the private sector to co-finance procurement of HIV commodities, such as antiretroviral therapy (ART) and diagnostics."

7.1.4.1.3-iii Key Activities

Increase Efficiency in HIV Program Budgeting and Spending

Sub Activities

a)Establish HIV-focused corporate social responsibility (CSR) initiatives with private sector organizations.

b) Develop tax incentives for businesses that invest in HIV prevention, treatment, and care programs.

c) Engage financial institutions to create innovative financing mechanisms, such as HIV bonds or health insurance schemes.

d) Partner with the private sector to co-finance procurement of HIV commodities, such as antiretroviral therapy (ART) and diagnostics."

7.1.4.1.3-iv Key Activities

Leverage Innovative Domestic Financing Mechanisms

Sub Activities

a)Develop a health insurance scheme that includes HIV services as part of essential benefits.

b) Introduce a State HIV solidarity fund, supported by voluntary contributions from individuals and businesses.

7.1.4.1.3-v Key Activities

Strengthen Multi-Sectoral Collaboration for Sustainable HIV Financing

Sub Activities

"a) Integrate HIV funding discussions into State economic and development planning frameworks.

b) Enhance collaboration between health, finance, and social protection ministries to streamline HIV budgeting.

c) Engage development partners in transitioning HIV funding responsibilities to the State government

7.2: Result Area 7.1.4.2 Partnerships, Multi-Sectorality, and Collaboration

Kogi State's HIV response will be strengthened through **multi-sector collaboration**, ensuring that HIV is no longer the sole responsibility of the health sector but a **whole-of-government and whole-of-society** concern.Build synergy among the Ministries of Health, Education, Women Affairs, Social Development, Youth, Justice, Budget & Planning to align HIV response with broader state development goals. Establish an inter-ministerial HIV steering committee to oversee joint programming

7.1.4.2.1: Key Intervention

Strengthen collaboration among all Ministries Departments and Agencies of government Build synergy among the Ministries of Health, Education, Women Affairs, Social Development, Youth, Justice, Budget & Planning to align HIV response with broader state development goals. Establish an inter-ministerial HIV steering committee to oversee joint programming

4.2.1-i Establish and institutionalize a multisectoral mechanism

Sub Activities

a) Create a national HIV and health Multisectoral committee involving all relevant MDAS

b) Develop a formal framework for collaboration, defining roles for each Ministry and Agency

c) Conduct regular interministerial meetings to allign policies and strategies for improved coordination

d) Leverage the existing Technical workings Groups within Ministries to integrate HIV and Health

"

7.1.4.2.1-ii Key Activities

Adopt and implement Integrate Policies and programs across MDAs

Sub Activities

a) Strengthen legal framework that supports interagency collaboration for health and HIV response

b) develop joint actions plans between Ministries (E.g. Health, Finance, Labour and Social Welfare) to align efforts

7.1.4.2.1-iii Key Activities

Enhance information sharing and data integration among MDAs, KOSACA and IPs

Sub Activities

"a) Train 30 MDA personnel on best practices for data utilisation in decision making and policy formulation

b) standardize reporting mechanisms to improve coordination, transparency and accountability among MDAs

7.1.4.2.1-iv Key Activities

Strengthen Joint resource Mobilization and Funding Strategies

Sub Activities

a) Advocate for the dedicated budget lines within Multiple Ministries to support HIV programme

7.1.4.2.1-v Key Activities

Data sharing, reporting mechanisms for accountability

Sub Activities

"a) Strengthened routine State HIV monitoring and evaluation systems to track performance and impacts

b) Periodic Joint Assessment and Reporting to ensure alignment with National and Global HIV Target

7.1.4.2.2: Key Intervention

Strengthen the multilateral governance and coordination for effective national HIV and AIDS response

7.1.4.2.2-i Key Activities

Establish and Strengthen State HIV/AIDS structure

Sub Activities

a) Regular Stakeholder meetings to define roles and responsibilities for Government Ministries, CSOs and IPs

7.3: Data for Impact, Science, Research, and Innovation (Kogi Context)

To ensure an evidence-driven and efficient response, Kogi State must improve data collection, utilization, and integration for decision-making at both state and LGA levels.

Key Interventions for Kogi State

7.4.3.1: Strengthen the State HIV response through generation and use of data

Build the capacity of state-level M&E officers to collect, analyze, and use data through platforms like DHIS2, LAMIS, and CPIMS. Expand data coverage from public to private and community-based service points.

7.1.4.3.1-i Key activities

Enhance HIV Data Collection and Management Systems

Sub Activities

a)Establish a centralized State HIV data repository to streamline data collection and storage.

b) Strengthen use of standardized HIV data collection tools for health facilities, community-based organizations, and stakeholders.

c) Train healthcare workers, program managers, and data officers on accurate data collection and reporting.

d) Strengthen digital health systems by integrating HIV data with broader health information management systems.

7.1.4.3.1-ii Key Activities

Improve Data Analysis and Utilization for Evidence-Based Decision-Making

Sub Activities

a) Conduct periodic State HIV epidemiological and behavioral surveys to assess program impact.

b) Train policymakers and program managers on data interpretation and application in HIV planning and resource allocation.

7.1.4.3.1-iii Key Activities

Strengthening Monitoring, Evaluation, and Accountability Mechanisms

Sub Activities

a) Conduct routine data quality assessments (DQAs) to ensure accuracy and reliability of reported HIV data.

b) Organize quarterly data review meetings to assess program performance and make necessary adjustments.

c) Establish community-led monitoring initiatives to ensure service quality and accessibility for key populations.

7.1.4.3.1-iv Key Activities

Promote Data-Driven Innovation and Research in HIV Response

Sub Activities

a) foster collaborations with academic institutions and research organizations to generate new HIV-related insights.

b) implement innovative digital soluions, such as mobile health applications for HIV self-reporting and adherence tracking.

c) Strengthen partnerships with private sector and technology firms to enhance real-time data analytics and artificial intelligence in HIV research."

7.1.4.3.1-v Key Activities

Improve Data Sharing, Transparency, and Policy Alignment

Sub Activities

a)Establish State HIV data-sharing policies to facilitate collaboration among government agencies, donors, and implementing partners.

b) Organize multi-stakeholder data dissemination forums to present findings and guide evidence-based policy adjustments.

c) Integrate HIV data into broader health and socio-economic reports to enhance policy relevance.

d) Ensure data privacy and protection by implementing secure systems and ethical guidelines for HIV-related information management

7.4.3.2: Mayor Intervention

Support the generation of data-derived evidence to inform the national HIV programme design and implementation

7.1.4.3.2-i Key Activities

Strengthening HIV Data Collection and Management Systems

Sub Activities"

a)Train healthcare workers on accurate and consistent data entry.

b)Establish a centralized database for real-time data monitoring.

c)Conduct periodic data quality assessments to ensure accuracy.

d)Generate routine reports to identify trends and gaps.

7.1.1.4.3.2-iiKey Activities

Strengthening HIV Surveillance and Research

Sub Activities

a)Conduct population-based HIV surveys to assess prevalence.

b)Perform cohort studies to track long-term treatment outcomes.

c)Use GIS mapping to identify HIV hotspots for targeted interventions.

7.1.1.4.3.2-iii Key Activities

Enhance Monitoring and Evaluation (M&E) Systems

Sub Activities

a)Strengthen monitoring of key performance indicators (KPIs) aligned with national targets.

b)Train program staff on data-driven decision-making.

c)Strengthen updates of electronic health records (EHR) into HIV service delivery.

d)Conduct mid-term and end-term evaluations of HIV programs.

e)Use dashboards and visualization tools for real-time monitoring

7.1.4.3.2-iv Key Activities

Promote Data Utilization for Policy and Programmatic Decisions

Sub Activities

a) Organize stakeholder forums to disseminate research findings.

b) Develop policy briefs based on data insights.

c)Advocate for evidence-based resource allocation.

d)Support decision-makers in interpreting and applying data.

e) Establish a feedback loop between researchers and policymakers.

7.1.4.3.2-v Key Activities

Strengthening Community-Based Data Collection and Engagement

Sub Activities

a) Train community health workers on participatory data collection.

b) Establish community advisory groups for data validation.

c)Implement mobile data collection systems for real-time updates. Use qualitative methods (e.g., focus groups) to understand community needs.

d)Develop community scorecards to track service delivery quality.

8.0 COORDINATION STRUCTURE AND PROCESS

8.1 Coordination Structure for the HIV and AIDS Response in Kogi State

Kogi State operates a **multi-sectoral, decentralized HIV/AIDS coordination system** aligned with Nigeria's **"Three Ones" principle**—one HIV/AIDS strategic framework, one coordinating body (SACA), and one monitoring and evaluation system. This structure ensures that the state response is aligned with the National Strategic Plan (NSP), coordinated effectively across levels, and inclusive of all key stakeholders.

State-Level Coordination

At the state level, the Kogi State Agency for the Control of AIDS (KOSACA) serves as the central coordinating body for all HIV/AIDS activities. KOSACA is responsible for:

- Leading the implementation of the Kogi State HIV/AIDS Strategic Plan.
- Coordinating all stakeholders involved in the HIV response including State Ministries, Departments and Agencies (MDAs), CSOs, FBOs, and development partners.
- Facilitating the mobilization of resources, monitoring and evaluation of interventions, and reporting to NACA and state authorities.
- Hosting the State HIV Technical Working Groups (TWGs) on thematic areas such as prevention, treatment, OVC, key populations, gender, monitoring & evaluation, and human rights.

KOSACA Is an Agency under the Kogi State Ministry of Health and reports directly to the Commissioner of Health and is governed by a Board chaired by the Commissioner of Health, who ensures high-level political oversight and accountability.

Local Government Coordination

At the local level, the Local Action Committees on AIDS (LACAs) coordinate HIV responses across Kogi's 21 LGAs. Each LACA operates under the leadership of the Local Government Chairman and:

- Oversees community-level planning and implementation of HIV programs.
- Coordinates ward-based community structures and peer support groups.
- Supports local data collection, mobilization for testing, prevention campaigns, and referral mechanisms.

LACAs liaise regularly with KOSACA and contribute to the state's data system and M&E processes.

Health Sector Coordination

The Kogi State Ministry of Health (SMOH) coordinates the health sector response through the State AIDS and STI Control Programme (SASCP), which is embedded within the Department of Public Health. SASCP:

- Works closely with SPHCDA to deliver HIV services at PHCs and secondary health facilities.
- Supports training, supervision, and supply chain management for HIV commodities.

- Leads integration of HIV with TB, hepatitis, sexual and reproductive health, and maternal/child health programs.

SASCP collaborates with LGA Disease Surveillance and Notification Officers (DSNOs), HIV focal persons, and health partners to support the continuum of care.

Civil Society and Community Engagement

Kogi State maintains strong collaboration with civil society and community actors through local chapters of NEPWHAN, Coalitions of Civil Society Networks, faith-based groups (e.g., NIFCOB-AIDS), and the Kogi Private Sector Coalition on AIDS (KOPSACA). These groups are active in:

- HIV prevention, stigma reduction, and community outreach.
- Monitoring rights-based service delivery, including for KPs and women.
- Advocacy for accountability, funding, and program expansion.

The Kogi Civil Society Network on HIV/AIDS (KOGIHIVNET) interfaces with KOSACA and represents community interests at TWG meetings and planning sessions.

Linkages with National Coordination Mechanisms

KOSACA and SASCP participate in national forums convened by NACA, including:

- The **National AIDS Council (NAC)**, chaired by the President and attended annually by state governors or representatives.
- **Expanded Theme Group (ETG)** meetings with key donors, government ministries, and UN partners.

- Regular reporting through NNRIMS and donor-linked platforms such as DHIS2, NOMIS, and LAMIS.

Kogi also contributes to the National Joint Annual Review of the HIV response, where state performance is assessed, and best practices are shared.

Legislative and Oversight Support

At the state level, oversight of HIV activities is provided by the Kogi State House of Assembly Committee on Health. This committee ensures policy alignment, budgetary provisions, and political accountability for HIV programming.

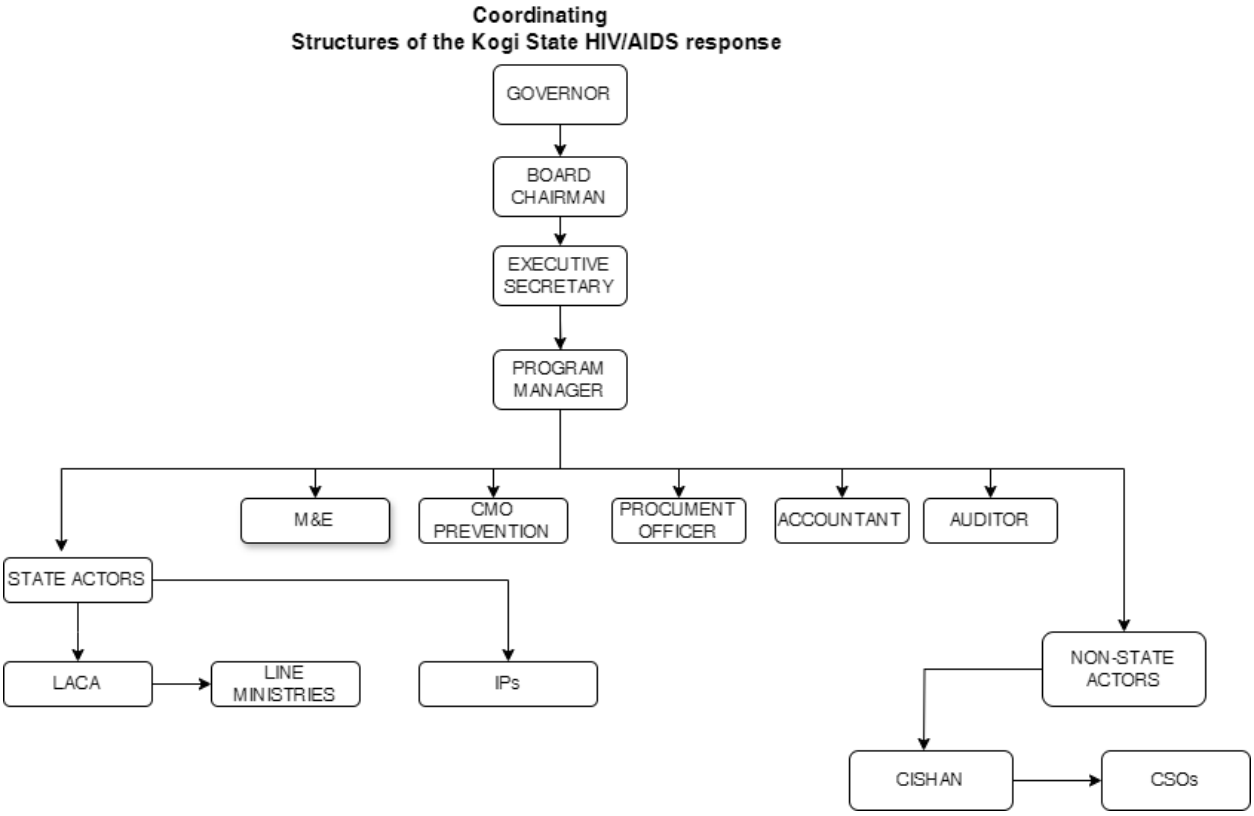


Figure 7: Coordinating Structures of the Kogi State HIV/AIDS response

8.2 Strengthening Multi-sectoral Coordination in Kogi State

I. Harmonized State-Level Operational Planning

Kogi State will strengthen its alignment with the National Strategic Plan (NSP 2023–2027) by institutionalizing a harmonized, multi-sectoral operational planning process. KOSACA will lead the development and implementation of a State Annual HIV Operational Plan that integrates the activities of all relevant Ministries, Departments, and Agencies (MDAs), CSOs, FBOs, and development partners. This plan will also include provisions for joint annual reviews and performance monitoring to improve accountability and ensure transparent use of HIV resources across LGAs.

II. Strengthening the State Strategic Information Management System

Kogi State will expand its HIV-related strategic information framework to include disaggregated, real-time data from public, private, and community sources. Tools such as DHIS2, LAMIS, CPIMS, and NOMIS will be fully utilized across facilities and LGAs to support data-driven decision-making and allow early identification of service delivery gaps. Special attention will be given to capturing data on key populations, gender-based violence, and social protection linkages.

III. Capacity Building of Coordination Structures

- **KOSACA** will be strengthened through targeted capacity-building in program management, monitoring and evaluation, domestic resource mobilization, and inter-sectoral coordination.
- **LACAs** across all 21 LGAs will be equipped with operational tools, personnel, and training to improve their effectiveness as grassroots coordinating entities.

- **SASCP and SPHCDA** will work together to integrate HIV services into the PHC system and lead the coordination of the health sector response at the LGA level.
- Collaboration among line ministries (Women Affairs, Youth, Education, Justice, and Social Development) and other stakeholders will be institutionalized via technical working groups and inter-ministerial task teams.
- **Community-based systems and implementing partners** will be supported to align their M&E efforts with the state's unified data and planning frameworks.

9.0 COSTING AND FINANCIAL RESOURCING OF THE KOGI STATE HIV STRATEGIC PLAN (2023–2027)

Overview

Just as the National HIV/AIDS Strategic Plan (NSP) includes a financial roadmap, Kogi State will adopt a similar approach by developing a costed HIV Strategic Implementation Plan tailored to local needs and population dynamics. This will provide a realistic framework for resource mobilization, investment prioritization, and sustainability planning.

9.1 Costing Approach Adapted for Kogi State

Kogi State will adopt a hybrid costing approach, combining elements of the One Health Tool (OHT) for biomedical service delivery and an Excel-based framework for estimating social, rights-based, and structural interventions.

Key components to be costed include:

- **HIV prevention, testing, and treatment services** (in line with national targets: 95-95-95 by 2027).
- **Gender equality, youth-focused programs, and human rights-based interventions**.
- **Community-led response and demand creation for testing, PrEP, ART adherence**.
- **Program management costs** include coordination, advocacy, planning, and supervision.
- **Capacity building for health workers, LACA teams, data officers, and civil society groups**.
- **Health system strengthening** (infrastructure, M&E, logistics, HRH, supply chain).

Assumptions will reflect:

- Kogi's projected population, based on 2023 state estimates (approx. 5.7 million).
- The official currency exchange rate used for the costing is ₦1500 to the dollar.
- Service delivery through existing PHC and secondary health systems.
- Utilization of health workers across state and LGA levels, calculated in FTEs (Full-Time Equivalents).
- Standard unit costs of commodities (sourced from WAMBO/GF pricing) and personnel (aligned with current health salary structures in Kogi).

9.1.2 Indicative Costing for Kogi State HIV Response (2025–2027)

Estimated Total Cost: NGN **₦ ₦36,385,865,329.69** billion (~USD **$ $24,257,243.55 0)** Over five years (subject to validation).

- **Breakdown by strategic priority**:

- **74%** for direct HIV services: testing, ART, prevention for KPs and AGYW.
- **18%** for health systems support: HRH, data, supply chain, infrastructure.
- **8%** for program management and structural interventions: GBV, human rights, advocacy.

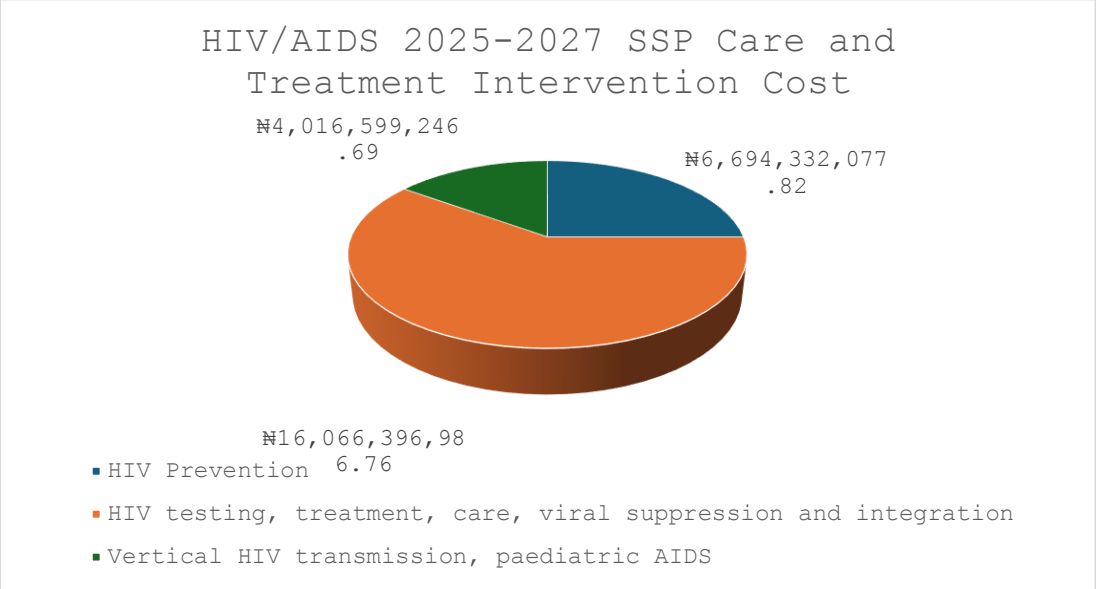


Figure 9: SSP Intervention Summary Total Cost 2025 to 2027 (in Naira)

Kogi State will engage in cost-sharing with partners, advocate for increased domestic allocation, and explore innovative financing mechanisms (e.g., PPPs, earmarked health taxes, social protection integration).

The year-by-year total cost resource investment requirements for the implementation of the HIV/AIDS 2025-2027 SSP are presented in Figure 5 in Naira and Figure 6 in USD.

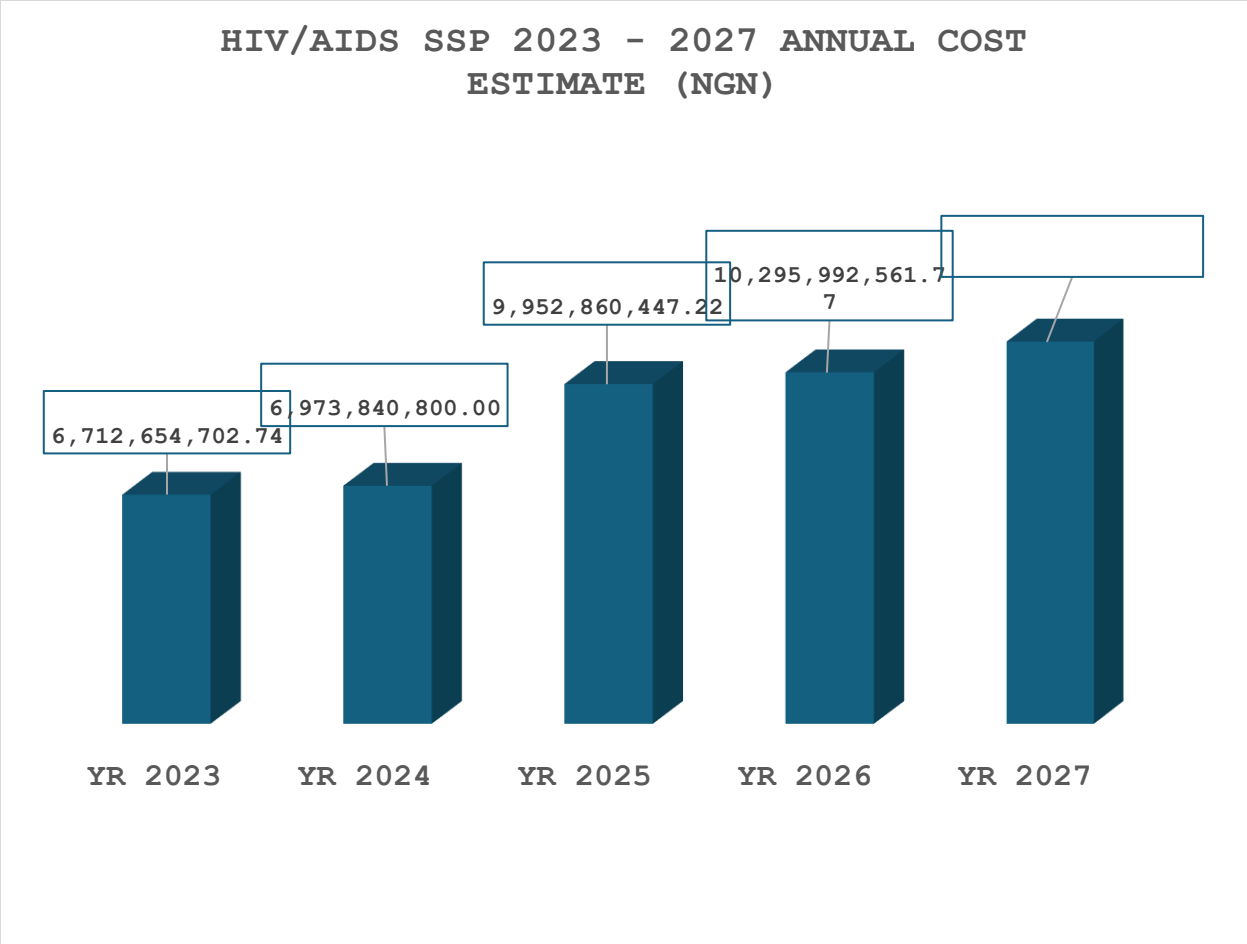


Figure 8: Annual Total Cost for SSP 2025-2027 (Naira)

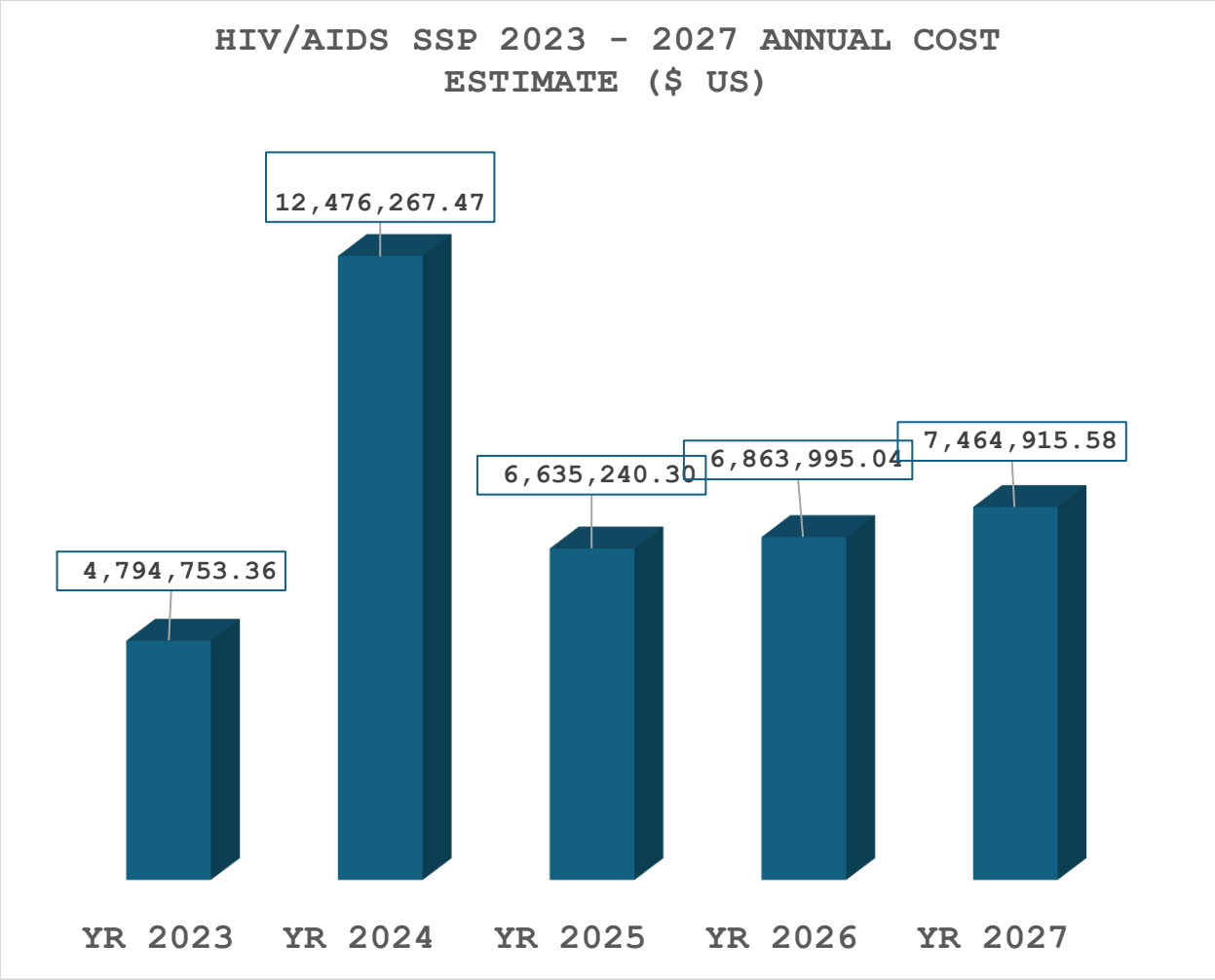


Figure 9: Annual and Total Cost for SSP 2023-2027 (USD)

Table 9: Intervention Summary Cost for SSP 2025 to 2027

Intervention Summary Cost for SSP 2025 to 2027						
SSP Priority Area	2024	2025	2026	2027	Total (in Naira)	Total (in USD)
HIV Prevention		₦ 1,801,334,911.80	₦ 2,201,771,662.70	₦ 2,691,225,503.32	₦ 6,694,332,077.82	$ 4,462,888.05
HIV testing, treatment, care, viral suppression and integration		₦ 4,323,203,788.33	₦ 5,284,251,990.47	₦ 6,458,941,207.96	₦ 16,066,396,986.76	$ 10,710,931.32
Vertical HIV transmission, paediatric AIDS		₦ 1,080,800,947.08	₦ 1,321,062,997.62	₦ 1,614,735,301.99	₦ 4,016,599,246.69	$ 2,677,732.83
Total Care and Treatment	₦ -	₦ 7,205,339,647.22	₦ 8,807,086,650.79	₦ 10,764,902,013.26	₦ 26,777,328,311.27	$ 17,851,552.21
Cost in USD		$ 4,803,559.76	$ 5,871,391.10	$ 7,176,601.34	₦ 17,851,552.21	$ 11,901.03
Strategic Priority 1: Equitable and equal access to HIV services for all		₦ 2,546,294,800.00	₦ 2,633,703,805.34	₦ 3,649,791,759.80	₦ 8,829,790,365.13	$ 5,886,526.91
Strategic Priority 2: BREAK DOWN BARRIERS TO ACHIEVING HIV		₦ 11,570,000.00	₦ 20,387,964.00	₦ 31,882,328.97	₦ 63,840,292.97	$ 42,560.20
Startegic Priority 3: FULLY RESOURCE AND SUSTAIN EFFICIENT HIV RESPONSES AND INTEGRATE THEM INTO SYSTEMS FOR HEALTH, SOCIAL PROTECTION, HUMANITARIAN SETTINGS AND PANDEMIC RESPONSES		₦ 70,850,000.00	₦ 88,616,750.00	₦ 113,918,818.36	₦ 273,385,568.36	$ 182,257.05
Enabler: Cross Cutting Issue		₦ 118,806,000.00	₦ 145,216,573.80	₦ 177,498,218.16	₦ 441,520,791.96	$ 294,347.19
Total Programme Management		₦ 2,747,520,800.00	₦ 2,887,925,093.14	₦ 3,973,091,125.29	₦ 9,608,537,018.42	$ 519,164.44
Cost in USD		$ 1,831,680.53	$ 1,925,283.40	$ 2,648,727.42		$ 6,405,691.35
Grand Total for SSP		₦ 9,952,860,447.22	₦ 11,695,011,743.93	₦ 14,737,993,138.55	₦ 36,385,865,329.69	$ 24,257,243.55
Grand Total Cost in USD		$ 6,635,240.30	$ 7,796,674.50	$ 9,825,328.76		$ 24,257,243.55

Table 7: Implementation Cost for the SSP (in Naira) by Programme Area and Year *HIV/AIDS SSP 2025 - 2027*

Intervention Cost - New HIV NSP 2023 – 2027	HIV/AIDS SSP 2025 - 2027 Total Summary Cost						
	2023	2024	2025	2026	2027	Total Cost in Naira	Grand Total (in USD)
Treatment and Care	976,176,300.00	986,479,300.00	7,205,339,647.22	79,332,951,131.77	8,538,268.36	**88,509,484,647.35**	**59,006,323.10**
Prevention Services (KPs)	732816000	98,408,000	408,930,000	41665003	4190000	**1,286,009,003.00**	**857,339.34**
Other Preventive Services	89,064,860.00	95,736,225.00	218,473,300.00	222,139,950.00	226,166,600.00	**851,580,935.00**	**567,720.62**
Cross-cutting Interventions	NA	NA	11,880,600.00	11,880,600.00	11,880,600.00	**35,641,800.00**	**23,761.20**
Monitoring Research & Development	37,204,000	28,924,000	170,785,000.00	170,785,000.00	170,785,000.00	**578,483,000.00**	**385,655.33**
Total	**1,835,261,160.00**	**1,209,547,525.00**	**8,015,408,547.22**	**79,779,421,684.77**	**421,560,468.36**	**91,261,199,385.35**	**60,840,799.59**

Table 10: Annual funding gap analysis (in Naira) HIV/AIDS SSP 2025 - 2027

Resource Plan on HIV/AIDS SSP 2025 to 2027					
Funding Source	2025	2026	2027	Total (in Naira)	Total (in USD)
Government of Nigeria				₦ -	$ -
Government of Nigeria (State Budget)	₦ 27,600,000.00	₦ 28,980,000.00	₦ 30,429,000.00	₦ 87,009,000.00	$ 58,006.00
AHF	₦ 25,109,410.00			₦ 25,109,410.00	$ 3,144.67
CIHP				₦ -	$ -
GF	₦ 4,717,000.00			₦ 4,717,000.00	$ -
USAID				₦ -	$ -
HIV Trust Fund				₦ -	$ -
UNAID				₦ -	$ -
WHO				₦ -	$ -
Private Sector				₦ -	$ -
Faith Based				₦ -	$ -
Health Insurance				₦ -	$ -
Total Available	₦ 57,426,410.00	₦ 28,980,000.00	₦ 30,429,000.00	₦ 116,835,410.00	$ 77,890.27
HIV/AIDS State Strategic Plan 2025 to 2027 (Cost in Naira)	₦ 9,952,860,447.22	₦ 11,695,011,743.93	₦ 14,737,993,138.55	₦ 36,385,865,329.69	$ 24,257,243.55
Funding Gap (in Naira)	₦ (9,895,434,037.22)	₦ (11,666,031,743.93)	₦ (14,707,564,138.55)	₦ (36,269,029,919.69)	$ (24,179,353.28)
Funding Gap Percentage	-99%	-100%	-100%	-100%	

The proposed strategy to meet up with the financial requirement of this SSP is to strengthen advocacy to Kogi State government and all her concerned agencies and parastatals to continue to prioritize and increase HIV funding. Community led organizations will be greatly encouraged to harness enough resources to support this SSP. Though donor support has been dwindling with time, there has always been a good relationship between the State Government and the implementing partners and their commitment is assured.

APPENDIXES

Appendix I: Details of Costing of the SSP

Appendix I-A: Cost of interventions relating to SSP Strategic Priority I, 2025-2027

Strategic Priority/Result Area	**'2025 Cost**	**'2026 Cost**	**'2027 Cost**	**2025-2027 Total Cost (Naira)**	**2025-2027 Total Cost (USD)**
Result Area 1.1: HIV Prevention	₦ 1,801,334,911.80	₦ 2,201,771,662.70	₦ 2,691,225,503.32	₦ 6,694,332,077.82	$ **4,462,888.05**
Result Area 1.2: HIV testing, treatment, care, viral suppression and integration	₦ 4,323,203,788.33	₦ 5,284,251,990.47	₦ 6,458,941,207.96	₦ 16,066,396,986.76	$ **10,710,931.32**
Result Area 1.3: Vertical HIV transmission, paediatric AIDS	₦ 1,080,800,947.08	₦ 1,321,062,997.62	₦ 1,614,735,301.99	₦ 4,016,599,246.69	$ **2,677,732.83**
Total in Naira	₦ 7,205,339,647.22	₦ 8,807,086,650.79	₦ 10,764,902,013.26	₦ 26,777,328,311.27	$ **17,851,552.21**
Total in USD	$ 4,803,559.76	$ 5,871,391.10	$ 7,176,601.34	**$** 17,851,552.21	

Intervention Cost for NSP 2023-2027	**Strategic Priority I: Equitable & equal access to HIV services for all**					**Total (in 'Billion Naira)**	**Total In USD (in Million)**
Priority I: Result Areas	**2023**	**2024**	**2025**	**2026**	**2027**		

4.1.1. HIV Prevention	₦ 26,976,000	₦ 2,065,000	₦ 1,801,334,911.80	₦ 2,008,488,426.66	₦ 2,239,464,595.73	6,076,284,584.19	**$4,050,856.39M**
4.1.2. HIV Testing, Treatment, Care, Viral Suppression and Integration	₦ 8,629,300		₦ 4,323,203,788.33	₦ 4,820,372,223.99	₦ 5,374,715,029.75	₦ 14,526,920,342.06	**$9,684,613.56M**
4.1.3. Vertical HIV Transmission, paediatric AIDS			₦ 1,080,800,947.08	₦ 1,205,093,056.00	₦ 1,343,678,757.44	₦ 3,629,572,760.52	**$2,419,715.17M**
Total for Strategic Priority 1	35,605,300	2,065,000	₦ 7,205,339,647.22	₦ 8,033,953,706.64	₦ 8,957,858,382.91	₦ 24,234,822,036.77	**$24,199,240,473.64**M
Cost in USD	$23,736.87M	$137.66M	$ 4,803,559.76	$ 5,355,969.14	$ 5,971,905.59	$ 16,131,434.49	
Programme Management Cost	435,951,000	432,905,000	2,123,000.00	2,123,000.00	2,123,000.00	₦ 875,225,000	**$583,480.00M**
Grand Total for Strategic Priority 1	471,556,300	434,970,000	13,548,112,600	12,757,545,900	13,333,999,200	46,570,614,800	**$ 18,395,013.00 M**
Grand Total Cost in USD	**$314,370.87M**	**$289,980M**	**$9,032,074.17M**	**$8,505,030.6M**	**$8,889,332.8M**	**$31,047,076.53M**	

Appendix I-B: Cost of interventions relating to SSP Strategic Priority II, 2023-2027

Intervention Cost for NSP 2023-2027	**Strategic Priority II: Break down barriers to achieving HIV outcomes**					**Total (in 'Billion Naira)**	**Total In USD (in Million $)**
Priority 2 Result Areas	**2023**	**2024**	**2025**	**2026**	**2027**		

5.1.1. Community led response			11,570,000.00	18,598,200.00	26,530,421.50	56,698,621.50	**$37,799.08 M**
5.1.2 Human rights	-	-	-	-	-	-	-
5.1.3. Gender Equality	-	-	-	-	-	-	-
5.1.4 Young People	-	-	-	-	-	-	-
Grand Total for Result Area II	-	-	₦ 11,570,000.00	₦ 18,598,200.00	₦ 26,530,421.50	₦ 56,698,621.50	**$ 37,799.08**
Cost in USD			**$7,713,33 M**	**$12,398.8 M**	**$17,686.95M**		**$37,799.03M**
Programme Management Cost							
Grand Total for Strategic Priority II			11,190,000.00	16,785,000.00	22,380,000.00	₦ 50,355,000.00 **B**	**$37,799.03M**
Grand Total Cost in USD			**$7,713,33 M**	**$12,398.8 M**	**$17,686.95M**	**$37,799.03M**	

Appendix I-B: Cost of interventions relating to SSP Strategic Priority II, 2025-2027

Strategic Priority/Result Area	**'2025 Cost**	**'2026 Cost**	**'2027 Cost**	**2025-2027 Total Cost**	**2025-2027 Total Cost (USD**
Result Area 2.1: Community-led response	**11,570,000.00**	**20,387,964.00**	**31,882,328.97**	**63,840,292.97**	**$ 42,560.20**
Result Area 2.2: Human Rights	-	-	-	-	-
Result Area 2.3: Gender Equality	-	-	-	-	-

Result Area 2.4: Young People	-	-	-	-	-
Total in Naira	₦ 11,570,000.00	₦ 20,387,964.00	₦ 31,882,328.97	₦ 63,840,292.97	**$ 42,560.20**
Total in USD	7,73.33	13,591.97	23,254.86	42,560.20	

Appendix I-C: Cost of interventions relating to SSP Strategic Priority III, 2023-2027

Strategic Priority/Result Area	**'2025 Cost**	**'2026 Cost**	**'2027 Cost**	**2025-2027 Total Cost**	**2025-2027 Total Cost (USD**
Result Area 3.1: Fully-funded and efficient response	**69,350,000.00**	**85,866,575.00**	**109,436,766.49**	**264,653,341.49**	169,768.90
Result Area 3.2: Integration of HIV into systems for health and social protection	**1,500,000.00**	**2,750,175.00**	**4,482,051.87**	**8,732,226.87**	5,821.48
Result Area 3.3: Humanitarian settings and pandemics	-	-	-	-	313,527.18
Total in Naira	₦ 70,850,000.00	₦ 88,616,750.00	₦ 113,918,818.36	₦ 273,385,568.36	**$ 182,257.05**
Total in USD	47,233.33	57,744.5	75,945.88	182,257.05	

Appendix I-D: Cost of interventions relating to Cross cutting Interventions

Strategic Priority/Result Area	**'2025 Cost**	**'2026 Cost**	**'2027 Cost**	**2025-2027 Total Cost**	**2025-2027 Total Cost (USD**
Result Area 4.1: Leadership, Country Ownership, Governance, and Advocacy	**118,806,000.00**	**145,216,573.80**	**177,498,218.16**	**441,520,791.96**	294,347.19
Result Area 4.2: Partnerships, Multi-sectorality, and Collaboration	-	-	-	-	
Result Area 4.3: Data for Impact, Science, Research, and Innovation	-	-	-	-	
Total in Naira	₦ 118,806,000.00	₦ 145,216,573.80	₦ 177,498,218.16	₦ 441,520,791.96	**$ 294,347.19**
Total in USD	63,527.33	72,675.27	83,140.51	294,347.19	

Intervention Summary Cost for SSP 2025 to 2027						
SSP Priority Area	###	2025	2026	2027	Total (in Naira)	Total (in USD)
HIV Prevention		₦ 1,801,334,911.80	₦ 2,008,488,426.66	₦ 2,239,464,595.73	₦ 6,049,287,934.19	$ 4,032,858.62
HIV testing, treatment, care, viral suppression and integration		₦ 4,323,203,788.33	₦ 4,820,372,223.99	₦ 5,374,715,029.75	₦ 14,518,291,042.06	$ 9,678,860.69
Vertical HIV transmission, paediatric AIDS		₦ 1,080,800,947.08	₦ 1,205,093,056.00	₦ 1,343,678,757.44	₦ 3,629,572,760.52	$ 2,419,715.17
Total Care and Treatment	##	₦ 7,205,339,647.22	₦ 8,033,953,706.64	₦ 8,957,858,382.91	₦ 24,197,151,736.77	$ 16,131,434.49
Cost in USD		$ 4,803,559.76	$ 5,355,969.14	$ 5,971,905.59	₦ 16,131,434.49	$ 10,754.29
Strategic Priority 1: Equitable and equal access to HIV services for all		₦ 2,546,294,800.00	₦ 2,402,503,266.75	₦ 3,037,121,719.37	₦ 7,985,919,786.12	$ 5,323,946.52
Strategic Priority 2: BREAK DOWN BARRIERS TO ACHIEVING HIV		₦ 11,570,000.00	₦ 18,598,200.00	₦ 26,530,421.50	₦ 56,698,621.50	$ 37,799.08
Startegic Priority 3: FULLY RESOURCE AND SUSTAIN EFFICIENT HIV RESPONSES AND INTEGRATE THEM INTO SYSTEMS FOR HEALTH, SOCIAL PROTECTION, HUMANITARIAN SETTINGS AND PANDEMIC RESPONSES		₦ 70,850,000.00	₦ 80,837,500.00	₦ 94,795,906.25	₦ 246,483,406.25	$ 164,322.27
Enabler: Cross Cutting Issue		₦ 118,806,000.00	₦ 132,468,690.00	₦ 147,702,589.35	₦ 398,977,279.35	$ 265,984.85
Total Programme Management		₦ 2,747,520,800.00	₦ 2,634,407,656.75	₦ 3,306,150,636.47	₦ 8,688,079,093.22	$ 468,106.20
Cost in USD		$ 1,831,680.53	$ 1,756,271.77	$ 2,204,100.42		$ 5,792,052.73
Grand Total for SSP		₦ 9,952,860,447.22	₦ 10,668,361,363.39	₦ 12,264,009,019.38	₦ 32,885,230,829.99	$ 21,923,487.22
Grand Total Cost in USD		$ 6,635,240.30	$ 7,112,240.91	$ 8,176,006.01		$ 21,923,487.22

Appendix I-H: Annual intervention cost (by Target) for the SSP costing (2025-2027)

Budget sub-item	'2025 Cost	'2026 Cost	'2027 Cost	2025-2027 Total Cost	% of NSP Cost
01. Training - Capacity building- - Govt, CSO, IP(s) & HF(s)	267,969,500.00	333,461,163.35	417,367,923.13	1,018,798,586	**2.8%**
02. Human Resources (HSS & Programme Specific)	756,100,000.00	598,346,407.50	1,135,976,046.45	2,490,422,454	**6.8%**
03. Logistics (Medicines, Commodities & Supplies including distribution Cost)	7,871,589,647.22	9,467,006,420.79	11,594,679,216.13	28,933,275,284	**79.5%**
04. Supervision and Coordination of implementing entities - Govt, CSO, IP(s) & HF(s) (meetings & Visits)	116,622,000.00	141,495,892.60	173,099,831.25	431,217,724	**1.2%**
05. Infrastructure, Equipment, Transport (Facilities & Programme)- Construction, Renovations & Maintenance; Equipment & Vehicle Purchase,Operation & Repairs)	5,860,000.00	7,162,678.00	8,754,941.32	21,777,619	**0.1%**
06. Surveys, Studies, Research, M&E, Surveillance	171,065,000.00	209,263,871.50	255,992,392.56	636,321,264	**1.7%**
07. Media, Communication (Planning & Implementation)	12,760,000.00	15,706,555.00	19,332,583.73	47,799,139	**0.1%**
08. Advocacy (Planning & Implementation)	13,678,000.00	16,871,406.90	20,808,672.82	51,358,080	**0.1%**
09. Community mobilization & Social Outreaches	52,930,000.00	66,517,566.00	82,858,198.90	202,305,765	**0.6%**
10. Policies, Laws, Strategies, Guidelines,SOP (Development/Review)	18,320,000.00	23,602,613.00	30,328,550.99	72,251,164	**0.2%**
11. General Programme Administration and Operational/Running cost	2,423,000.00	3,144,977.90	4,068,209.08	9,636,187	**0.0%**
12. Other HIV Program Costs	663,543,300.00	812,432,191.39	994,726,572.20	2,470,702,064	**6.8%**
Grand Total in Local Currency	**9,952,860,447.22**	**11,695,011,743.93**	**14,737,993,138.55**	**36,385,865,329.69**	
Grand Total in $US	**$ 6,635,240.30**	**$ 7,796,674.50**	**$ 9,825,328.76**	**$ 24,257,243.55**	

Appendix I-E: Strategic Plan Summary by Target Population

Strategic Priority/Result Area	'2025 Cost	'2026 Cost	'2027 Cost	2025-2027 Total Cost
Gen Population	₦ 3,296,401,211.80	₦ 3,702,289,082.98	₦ 4,949,312,518.16	₦ 11,948,002,812.95
HIV+ Infant	₦ 3,100,000.00	₦ 3,789,130.00	₦ 4,631,453.60	₦ 11,520,583.60
HIV+ve 5-14yrs	₦ -	₦ -	₦ -	₦ -
Pregnant Women	₦ 1,080,800,947.08	₦ 1,321,062,997.62	₦ 1,614,735,301.99	₦ 4,016,599,246.69
Adolescent & young People	₦ -	₦ -	₦ -	₦ -
OVC	₦ -	₦ -	₦ -	₦ -
PLHIV	₦ 4,334,103,788.33	₦ 5,301,486,420.47	₦ 6,487,028,733.01	₦ 16,122,618,941.81
Adults 15-49	₦ -	₦ -	₦ -	₦ -
HIV+ Adult	₦ -	₦ -	₦ -	₦ -
High Risk Group	₦ 800,000.00	₦ 977,840.00	₦ 1,195,213.83	₦ 2,973,053.83
Key Population	₦ 408,930,000.00	₦ 501,955,829.50	₦ 622,855,808.20	₦ 1,533,741,637.70
HIV+ve/-ve persons with TB	₦ -	₦ -	₦ -	₦ -
Health Worker/facilities in (Public & Private)	₦ 453,640,000.00	₦ 405,290,234.00	₦ 498,224,885.87	₦ 1,357,155,119.87
Policy Makers	₦ 18,373,000.00	₦ 22,457,317.90	₦ 27,449,579.67	₦ 68,279,897.57
Community Gatekeepers	₦ 7,500,000.00	₦ 9,167,250.00	₦ 11,205,129.68	₦ 27,872,379.68
SACA/LACA	₦ 349,211,500.00	₦ 426,535,641.45	₦ 521,354,514.54	₦ 1,297,101,655.99
Grand Total in Local Currency	**9,952,860,447.22**	**11,695,011,743.93**	**14,737,993,138.55**	**36,385,865,329.69**
Grand Total in $US	**$ 6,635,240.30**	**$ 7,796,674.50**	**$ 9,825,328.76**	**$ 24,257,243.55**

Appendix I-F: Sstrategic Plan Summary by Level of Implementation

Strategic Priority/Result Area	'2025 Cost	'2026 Cost	'2027 Cost	2025-2027 Total Cost
State level	₦ 8,400,550,447.22	₦ 10,129,019,318.43	₦ 12,397,301,310.13	₦ 30,926,871,075.77
Local Government level	₦ 473,050,000.00	₦ 578,209,015.00	₦ 706,744,879.03	₦ 1,758,003,894.03
Public & Private Workplace (formal & Informal)	₦ 664,500,000.00	₦ 477,247,035.00	₦ 999,497,567.01	₦ 2,141,244,602.01
Community level	₦ 414,760,000.00	₦ 510,536,375.50	₦ 634,449,382.37	₦ 1,559,745,757.87
Ward level	₦ -	₦ -	₦ -	₦ -
Grand Total in Local Currency	9,952,860,447.22	11,695,011,743.93	14,737,993,138.55	36,385,865,329.69
Grand Total in $US	$ 6,635,240.30	$ 7,796,674.50	$ 9,825,328.76	$ 24,257,243.55

Figure 8: Aggregate Planned Resource by Target Population

Appendix II: List of NSP 2023-2027 Development Consultants

LIST OF NSP 2023-2027 DEVELOPMENT CONSULTANTS		
S/N	**NAME**	**CONSULTANT**
1	Dr Mary Ojonema Onoja-Alexander	Kogi State Consultant
2	Engr. Barr, Cyril Omoikhoje Ojeonu	National Lead Consultant
3	Dr. Patrick Ikani	Co-Lead Consultant
4	Mr David Adebowale	Lead Costing Consultant

Appendix III: List of Participants in the NSP Development Process

S/N	NAME	ORGANIZATION
1.	Ibrahim Anate	Ag. ES KOSACA
2.	Dr Francis Akpa	Director Public Health SMoH
3.	Okai Mohammed	KP LEAD
4.	Mrs Ime Makolu	NACA
5.	Mr Mosesrock Anikene	NACA
6.	Musa Romatu I.	KOSACA

7.	Etudaiye O. El-hadi	NHRC
8.	Abah Percy	NEPWHAN
9.	David O. Onile	C.A. N
10	Ibrahim Mohammed	KOSACA
11	Sarah Dogwo	KOSACA
12	Dr Joseph Afangideh	SASCP / NCMP
13	Bayere Richard	KGSHIA
14	Dr Hadiza Ismail Ahmed	KSPHCDA
15	Pharm. Musa Habib Idris	STBLCP
16	Ojochide Gladys Ibrahim	MIN. HUMANITARIAN AFFAIRS
17	Alh. Alsu S.O	JNI
18	David O. Onile Jp	C.AN
19	Dr Samuel Babatunde	KSSH
20	Dr. Onyeyili Ikemefuna	AHF
21	Pharm. Bako Aisha	KSDMSMA
22	Dr Esther O. Ajiboye	SMOH
23	Raphel Okolobia	CRHP
24	Achimugu Oniche	SACP/SMOH
25	Siyaka Musa Sule	SCIENCES
26	Mohammed Abduraman	SMOH
27	Dorathy L. Onoja	SMOH
28	Mebanidu O. Ambose	Min. of Health
29	Mrs. Bosede T. Micah	CISHAN
30	Abubarkar N. Abdullahi	MYSD
31	Okwori Grace Unekwu	ASHWAN
32	Salifu Eneojo	KP
33	Olorunrayetan T. Lizzy	MWASD
34	Dr. Kenkwo Emmanuel	CIHP
35	Pharm. Idowu Temitope Orogbemii	AHF
36	Jimoh Audu	NEPWHAN
37	Kayode Adejumoh Emmanuel	KOSACA
38	Okwoh Grace Unekwu	ASWHAN
39	Ayo Paul	KPS OSS
40	Dr. Olayemi	HMB
41	Pharm. Eric Akojie	SASCP
42	Usman Rashidat Blessing	SMDNS
43	Ayeh Godwin Ojochegbe	CIHP
44	Agada Christopher Samuel	HSS