



FEDERAL REPUBLIC OF NIGERIA
National Agency for the Control of AIDS (NACA)

NATIONAL HIV PREVENTION PLAN

2026–2030

From Chasing the Epidemic to Outrunning It



FMYD
FEDERAL MINISTRY OF
YOUTH DEVELOPMENT



A paradigm shift from reactive risk-reduction to proactive human development

GENERATION NEGATIVE (GEN-N) STRATEGY

-Self-Respect -Belonging -Curiosity -Critical Thinking -Foresight -Responsibility



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Foreword

When the National Council on AIDS met in August 2025, it endorsed a strategic pivot from chasing the epidemic to outrunning it. This Plan serves as the roadmap for that transition.

For over twenty years, Nigeria has demonstrated strength in pulling people back from the brink: testing, treating, and supporting those at risk. However, the landscape has shifted. Nine out of ten new adult infections now occur among ordinary Nigerians who do not fit traditional "high-risk" categories. Waiting for vulnerability to manifest is no longer epidemiologically sustainable or ethically defensible.

Consequently, we are constructing alternative pathways.

Objective 1 shifts the focus to the classroom, spearheaded by the Federal Ministry of Education. This strategy integrates self-respect, belonging, curiosity, critical thinking, foresight, and responsibility into daily school life. Through the health and wellbeing curriculum and school clubs, students cultivate the essential competencies needed to navigate life's challenges and for a thriving future. Remaining healthy and preventing HIV infection become natural outcomes of character development rather than fear-based messaging. The goal is for learners to leave secondary education empowered to thrive, with HIV prevention inherent to their future success.

Objective 2, under the Federal Ministry of Health, maintains essential HIV prevention services. We continue to mitigate immediate risk for infants, key populations, and those needing protection while building long-term resilience.

Success requires a whole-of-society approach; no entity can construct these pathways alone. Every sector is challenged to contribute to developing an "internal compass" in adolescents and young people. All stakeholders have a role.

A 90% reduction in new infections by 2030 represents a future where families are empowered to pursue their full potential, and national energy is directed toward enterprise. The dividend is a generation that chooses health based on their own internal values.

I urge all stakeholders to embrace this shift from fixing problems to building people. By mobilizing every sector of society into a comprehensive ecosystem of action, we ensure a sustained end to the HIV epidemic. Walk with us.



Dr. Temitope Ilori

Director-General

National Agency for the Control of AIDS

Acknowledgements

The development of the National HIV Prevention Plan 2026-2030 was a highly collaborative and consultative process, reflecting the "whole-of-society" approach that is central to its implementation. The National Agency for the Control of AIDS (NACA) wishes to express its profound gratitude to the numerous individuals, institutions, and partners who contributed their expertise, time, and resources to the formulation of this strategic document.

We extend our sincere appreciation to the National Council on AIDS (NCA) for their foresight in endorsing the strategic pivot from "chasing the epidemic to outrunning it," providing the political leadership necessary to drive this paradigm shift.

Special recognition is accorded to the Federal Ministry of Education and the Federal Ministry of Health for their leadership in spearheading the plan's core objectives. The Federal Ministry of Education's commitment to integrating internal values into the school curriculum is the cornerstone of our strategy to prevent future risk, while the Federal Ministry of Health's dedication remains vital for mitigating current risks and sustaining essential services.

We acknowledge the invaluable contributions of the Ministries, Departments, and Agencies (MDAs) across the relevant sectors, including Youth, Women Affairs, Information, Science and Technology, Sports, Justice, and Arts and Culture, National Drug Law Enforcement Agency and the National Orientation Agency. Their willingness to collaborate across sectoral lines is the foundation upon which the "Generation Negative" (Gen-N) strategy is built.

NACA is deeply indebted to the Technical Working Group (TWG) for HIV Prevention and the consultants who provided rigorous technical guidance during the drafting process. Their analytical rigour in conducting the situational analysis and developing the theoretical frameworks ensured that this plan is grounded in evidence and best practices.

Our gratitude extends to our development and implementing partners, including the United States Government, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Joint United Nations Programme on HIV/AIDS (UNAIDS). Their continued financial and technical support is indispensable to the national response.

Finally, we thank the community leaders, religious institutions, traditional rulers, parents, teachers, and, most importantly, the adolescents and young people of Nigeria. Your insights, resilience, and active participation are the driving force behind this plan. It is your future we seek to secure, and your ownership of these values will sustain the gains of this effort for generations to come.



Dr. James Anenih

Director, Community Prevention and Care Services
National Agency for the Control of AIDS

Abbreviations

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral (medicine/therapy)
AYP	Adolescents and Young People
BPNS	Basic Psychological Needs Satisfaction
CFC	Consideration of Future Consequences
DHIS2	District Health Information System 2
DHS	Demographic and Health Survey
EMTCT	Elimination of Mother-to-Child Transmission
FCT	Federal Capital Territory
FMACTCE	Federal Ministry of Arts, Culture, Tourism and Creative Economy
FME	Federal Ministry of Education
FMHSW	Federal Ministry of Health and Social Welfare
FMWA	Federal Ministry of Women Affairs
FMYD	Federal Ministry of Youth Development
FSW	Female Sex Workers
GAS	Global AIDS Strategy
GBV	Gender-Based Violence
Gen-N	Generation Negative
GF GC7	Global Fund Grant Cycle 7
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
IBBSS	Integrated Bio-Behavioural Surveillance Survey
ICT	Information and Communication Technology
IDP	Internally Displaced Persons
KP	Key Population(s)
LGA	Local Government Area
LMIS	Logistics Management Information System
M\&E	Monitoring and Evaluation
MDA	Ministries, Departments, and Agencies
MSM	Men who have Sex with Men
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food and Drug Administration and Control

NAIIS	Nigeria HIV/AIDS and Impact Survey
NASA	National AIDS Spending Assessment
NASCP	National AIDS, Viral Hepatitis and STIs Control Programme
NBS	National Bureau of Statistics
NCoS	Nigeria Correctional Service
NCS	Nigeria Customs Service
NDLEA	National Drug Law Enforcement Agency
NEMIS	National Education Management Information System
NHRC	National Human Rights Commission
NIBUCCA	Nigeria Business Coalition Against
AIDSNOA	National Orientation Agency
NSP	Needle and Syringe Programme
NYSC	National Youth Service Corps
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PEPFAR.U.S.	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
PTA	Parent-Teacher Association
PWID	People Who Inject Drugs
SACA	State Agency for the Control of AIDS
SBCC	Social and Behaviour Change Communication
SDT	Self-Determination Theory
STI	Sexually Transmitted Infection
TMA	Total Market Approach
TOT	Training of Trainers
TWG	Technical Working Group
U=U	Undetectable = Untransmittable
WCA	West and Central Africa

Section 1: The Plan

Introduces the strategic shift from reactive risk-reduction to proactive, development-based HIV prevention, outlining why this shift is needed and how it will be accomplished to achieve a 90% reduction in new infections by 2030 and sustain the reduction thereafter.

GENERATION NEGATIVE (GEN-N) STRATEGY

Self-Respect • Belonging • Curiosity • Critical Thinking • Foresight • Responsibility

1.1. Introduction

Nigeria's fight against HIV has reached a critical juncture, demanding a fundamental rethinking of the national prevention strategy. While the 68% reduction in new infections since 2010 is noteworthy, missing the 81% reduction target for 2024 indicates that the current approach is insufficient. New infections are declining too slowly because efforts are misaligned with the reality of the epidemic. The national response has been characterised by a reactive, risk-based model that addresses vulnerability only after it emerges. This paradigm has not only fallen short of its intended targets, but also results in the suboptimal allocation of limited resources, leaving the vast majority of the population inadequately protected. It is a model built on extrinsic motivation, while largely overlooking the more powerful and enduring force of intrinsic motivation.

A critical shortcoming of the current paradigm is the misallocation of focus and funding, a direct consequence of over-reliance on the risk-based framework. A detailed analysis reveals a significant disparity: while 80% of HIV prevention expenditure is directed towards key populations, this group accounts for 11% of new infections in adults. This "wait-for-risk" strategy proves strategically limiting; by focusing narrowly on a specific high-risk group, it constrains the scale of resources that can be deployed for broader prevention, leaving the general population largely unprotected. This approach prioritizes fighting fires as they occur rather than fireproofing the building. It overlooks the reality that sustaining protective behaviours is most effectively secured by an internal compass that guides individuals away from vulnerability, rather than through reactive interventions.

This plan introduces a paradigm shift from a narrow, reactive risk-reduction model to a holistic, proactive development-based approach grounded in the principles of intrinsic motivation. The prevailing model is inadequate because it does not account for Nigeria's complex reality. Common risk assumptions often prove unreliable; data shows that people with lower education and those in poorer households often have lower HIV prevalence, and individuals in polygynous unions can also have lower prevalence than those in monogamous ones. Furthermore, marriage is the primary context for sexual activity, as 89% of never-married adolescent boys and girls have never had sex. This is consistent with adolescent boys and girls having the lowest incidence and prevalence of HIV. These findings demonstrate that Nigeria's diverse sociocultural norms shape behaviour in ways that the current risk categories do not capture adequately. Instead of waiting for vulnerability to emerge, the HIV prevention response must build pathways that lead young people who have little or no current risk away from risk by cultivating the internal assets that make those behaviours unlikely in the first place. These insights call for the promotion of culturally adapted, whole-of-society action that leverages local norms and existing structures, ensuring effective, resource-efficient strategies that reduce risk across diverse populations.

¹ Ryan RM, Deci EL. Self-determination theory and the facilitation of intrinsic motivation, social development, and well being. *American Psychologist*. 2000;55(1):68–78.

Crucially, this paradigm shift does not advocate for the abandonment of strategies for managing current risk. This forward-looking strategy operates in tandem with, not in place of, urgent interventions for those currently at risk. The elimination of vertical transmission remains a priority, as infants born to women living with HIV are at high risk of infection during pregnancy, childbirth, or breastfeeding. Key populations, including female sex workers, men who have sex with men, and people who inject drugs, continue to face a disproportionately high burden of HIV, with prevalence rates far exceeding that of the general population. Therefore, maintaining and scaling up access to testing, treatment, PrEP, condoms, harm reduction, and comprehensive services for these groups remains an ethical and public health imperative. Similarly, for individuals within the general population who engage in high-risk behaviours, targeted biomedical and behavioural interventions remain essential to prevent immediate infections. This dual-track approach, simultaneously managing the current situation while building a resilient, low-risk future, represents the comprehensive and responsible path forward.

This new, long-term approach is grounded in fostering core internal values that address fundamental human psychological needs. Drawing on Self-Determination Theory, nurturing autonomy, competence, and relatedness unlocks a powerful, self-sustaining form of motivation. A young person with a strong sense of self-worth (competence) and a clear vision for their future (autonomy) is intrinsically motivated to navigate life transitions safely. Similarly, cultivating a sense of belonging (relatedness) creates positive community bonds that reinforce healthy norms. These internal values constitute the ultimate form of primary prevention, providing a durable defense not only against HIV but against a wide range of life challenges.

Ultimately, this values-based paradigm represents the most sustainable and effective option for long-term HIV prevention because it creates a positive, self-reinforcing cycle of human flourishing. In contrast, the current model's reliance on extrinsic motivators risks the "undermining effect," where individuals become dependent on external interventions and lose their internal drive for health. The new model empowers individuals to become contributing members of society who, in turn, shape healthier communities. As these young people mature into leaders within their families, work spaces, and communities, they perpetuate these values, creating a societal fabric that is inherently resilient to HIV. This aligns with the vision of the West and Central Africa Commitment: to cultivate healthy, educated, responsible adolescents and young people who are active agents in the development of their families, communities, and countries.

This strategy represents a long-term investment in human capital that will yield dividends far beyond HIV prevention. By building these internal compasses, we foster a generation characterised by psychological well-being, purpose, and the integrity to lead ethically. Thus, the approach achieves more than disease prevention; it cultivates citizens equipped to build a safer, healthier, and more prosperous future for all.

1.2. HIV Prevention Strategy

1.2.1. Goal

To reduce the number of new HIV infections by 90% by 2030 compared to 2010 and sustain the reductions.

1.2.2. Objectives

- 1 To empower adolescents and young people with agency to make choices that promote their holistic well-being, thereby building resilience to prevent HIV infection throughout their lives.
- 2 To mitigate current HIV risk by ensuring balanced access to targeted interventions and values-based social behavioural change across key and general populations.

1.2.3. Theory of change

IF adolescents and young people are empowered with agency through education and whole-of-society action, and **IF** resources are allocated to provide balanced access to targeted interventions and social behavioural change across all populations, **THEN** new HIV infections will be reduced by 90% by 2030 and the reductions will be sustained, **BECAUSE** this proactive, comprehensive prevention action fosters intrinsic motivation and resilience while addressing both future and current risks in Nigeria's diverse context.

1.2.4. Strategies

1.2.4.1. Prevent future risk of HIV infection

This strategy focuses on AYP aged 10–24 years who start with little or no risk of acquiring HIV infection but become exposed to risk as they grow older and become sexually active. It equips today's low-risk adolescents with six internal values and an enabling environment so their future HIV prevalence never climbs toward current mid-life peaks, locking in lasting epidemic control.

Fostering robust internal values in young people represents a paradigm shift from traditional public health approaches that often rely on extrinsic motivation. For AYP, a period marked by profound identity formation and heightened susceptibility to peer influence, cultivating an "internal compass" is more impactful in preventing high-risk behaviours than relying solely on fear-based messaging or reactive behaviour modification. By equipping young individuals with a strong sense of self-respect, belonging, curiosity, critical thinking, foresight, and responsibility, they are empowered to autonomously navigate complex social situations. This proactive strategy focuses on building resilience and character, enabling adolescents to resist external pressures from peers, social media, or other societal influences that might lead them toward unsafe practices.

² Centre for Self Determination Theory. <https://selfdeterminationtheory.org/theory/>

³ Ministers of Education and Health from the 25 countries of West and Central Africa (WCA) met in April 2023 in Brazzaville, Republic of Congo, for a high-level political commitment for educated, healthy and thriving adolescents and young people. <https://www.commit4youngpeople.org/>

Adolescence (ages 10–19) is a developmental stage characterised by significant cognitive, emotional, and social transformations. As individuals solidify their identity and seek autonomy, they become increasingly attuned to peer opinions. This heightened sensitivity to social influence, combined with a still-developing capacity for long-term thinking, can increase vulnerability to health risks. Traditional HIV prevention campaigns have often focused on extrinsic motivators, such as the fear of illness or tangible rewards for safe behaviour. While these approaches can raise awareness or prompt short-term compliance, they often do not engender the deep, internalized commitment necessary for sustained, autonomous healthy decision-making. Fear-based messaging may lead to denial or anxiety, and its power may diminish in the heat of the moment. Furthermore, financial incentives do little to build the underlying character and value system required for consistent, long-term healthy choices.

In contrast, fostering internal values shifts the focus to one where healthy choices become an authentic expression of an individual's identity. When a young person genuinely internalizes a value like self-respect, the desire to protect their physical and emotional well-being becomes a primary driver. This intrinsic drive is more resilient than external pressures; it involves acting in a way that is consistent with who they are and who they aspire to be. This sense of agency and self-determination is crucial for resisting peer pressure. If a young person has a strong internal commitment to their health and future, they are better equipped to assertively say “no” to situations that compromise these values. This approach fosters a proactive stance towards health rather than a reactive one. Intrinsic motivation supports long-term persistence; in the context of HIV prevention, this means consistently making healthy life choices. The development of these internal values provides a stable foundation upon which adolescents can build a repertoire of skills, such as assertive communication, that enable them to effectively manage challenging situations. This strategy of empowering adolescents to remain free of HIV throughout their lives is referred to as the Generation Negative (Gen-N) strategy.

To operationalise this focus on internal values, the Gen-N Strategy will deploy two synergistic domains of action: Communication to Empower and Support AYP and Multi-sectoral Action to Empower and Support AYP. Together, these domains create a whole-of-society ecosystem for resilience. By prioritizing low-risk AYP with this comprehensive approach, the strategy ensures resource-efficient prevention, supporting the vision of an HIV-free Nigeria by 2030 and beyond.

1.2.4.1.1. Communication to Empower and Support AYP

Departing from traditional, fear-based HIV messaging, the Gen-N strategy prevents HIV risk by empowering adolescents and young people (AYP, aged 10-24 years) through positive, values-based communication. This tailored communication targets four key groups: AYP,

guardians (parents/caregivers, teachers, faith leaders), influencers (radio, TV, film, music, and social media personalities), and political leaders (traditional leaders and elected officials).

For AYP, both in school and out-of-school, age-appropriate content will cultivate core internal values (such as self-respect, belonging, curiosity, critical thinking, foresight, and responsibility), develop essential life skills (such as self-discipline, negotiation, and leadership to navigate peer pressure), and provide accurate information on health and HIV prevention, all while respecting Nigeria's diverse cultural norms. Implementation will involve working with parents to strengthen parent-child trust, equipping them to support health decisions for and by their children, and to counter negative peer pressure. Teachers will be supported in delivering the existing civics education and school health and wellbeing curricula that are consistent with the West and Central Africa Commitment for educated, healthy, and thriving adolescents and young people. The strategy also involves partnering with religious leaders to strengthen parent-child relationships and promote values that empower AYP as responsible members of their families and communities.

Engagement with influencers will focus on co-creating and modeling positive behaviours and narratives that promote responsibility and reduce risks associated with HIV transmission. Traditional and political leaders will be engaged to champion norms, policies, and programmes that create the environment AYP need to achieve holistic wellbeing and prevent HIV.

Recognizing that less than 40% of AYP and the wider population access media weekly, and that an even smaller percentage use the internet, this strategy prioritizes face-to-face platforms. These include school assemblies, parent-teacher meetings, religious gatherings, community meetings, and other group interactions, alongside the delivery of content through various traditional and new media platforms. Comprehensive communication toolkits will be developed for all target groups to ensure tailored and effective engagement. These toolkits will contain modules to foster health and HIV literacy and a range of thematic modules, including but not limited to:

- **Foundational Content for AYP:** Modules focused on fostering self-respect, belonging, curiosity, critical thinking, foresight, responsibility, assertive communication, teamwork, leadership, and navigating peer pressure.
- **Guidance for Guardians (Parents/Caregivers, Teachers, Religious Leaders):** Modules on effective communication strategies, supporting adolescent health and development, and creating safe, nurturing, and value-aligned environments at home, school, and in faith communities.
- **Resources for Influencers:** Modules on responsible storytelling and modeling positive behaviours.

- **Resources for Political and Traditional Leaders:** Modules on championing social norms that promote internal values, advocating for youth-friendly policies, and mobilizing community support.

By providing these tailored resources, the strategy ensures that every actor in a young person's life is equipped with the appropriate tools to contribute to a holistic ecosystem of support.

1.2.4.1.2. Multi-sectoral Action to Empower and Support AYP

This domain expands the whole-of-society approach, recognizing that HIV risk is not merely a health issue but a complex societal challenge. It unites education, health, youth, women affairs, information, science, sports, law enforcement, justice, arts, and culture to create a reinforcing ecosystem that equips AYP with the internal values, knowledge, and skills they need to become agents of positive change. By doing so, this collaborative action ensures Nigeria becomes HIV-free and remains so.

This domain provides opportunities for the practical application and reinforcement of the values, attitudes, and behaviours promoted through the communication domain. To achieve this, the education sector will serve as the focal point of this multi-sectoral collaborative action, leveraging its unique, long-term relationship with young people. The primary platform for this action will be school clubs, with a strategic focus on secondary schools. Secondary schools are prioritized because they hold the largest percentage of AYP in one place (14 million students, 29% of adolescents), providing the best opportunity to reach them in a consistent, organized manner for six consecutive years. Furthermore, school clubs are existing, monitored structures that engage students from early adolescence (10-14 years), making them an ideal starting point to lay the foundations of this strategy.

The club-based activities are designed not merely for skill acquisition, but as deliberate platforms to cultivate the core internal values of this strategy. The process of learning and applying club-specific skills will also involve developing self-respect, belonging, curiosity, critical thinking, foresight, and responsibility, ensuring AYP emerge equipped to make choices that promote their overall well-being, health, and freedom from HIV infection.

To operationalise this, school clubs will be supported by both the private entities and public institutions across the relevant sectors. The strategy will mobilise sector-specific expertise: for example, the entertainment sector will support drama clubs to build skills in script writing, acting, and stage management. Similarly, the health sector will support wellness and first-aid clubs; the science and technology sector will mentor innovation clubs; the sports sector will support sports teams; while the youth sector can provide mentorship and support club skill

⁴ Federal Ministry of Education. Nigeria Digest of Education Statistics 2022 and National Bureau of Statistics (2023). Demographic Statistics Bulletin 2022. Available from: https://www.nigerianstat.gov.ng/pdfuploads/DEMOGRAPHIC_BULLETIN_2022_FINAL.pdf

development through the National Youth Service Corps. In each domain, core values are embedded within specific activities.

The various sectors will also be mobilised to support inter-school club competitions. These competitions will foster interest in clubs, contribute to the sustainability of the club system, and improve outcomes for the students. While there is already experience with inter-school debating and sports competitions, this initiative extends the concept to all clubs - an Inter-School Club Olympiad, which may take place at local government, state, and national levels.

1.2.4.2. Mitigate current risk of HIV infections

While the first objective builds a resilient future, this objective addresses the immediate realities of the epidemic. It remains an ethical and public health imperative to mitigate current risk for those who are vulnerable. This strategy focuses on groups at high risk of HIV infection: infants of women living with HIV, key populations (female sex workers, men who have sex with men, people who inject drugs), and individuals in the general population engaging in high-risk sexual behaviour. To do so, this objective will leverage two synergistic domains of action: Strategic Communication for HIV Risk Reduction and HIV Prevention Service Uptake and Total Market Approach for Biomedical HIV Prevention Tools.

1.2.4.2.1. Strategic Communication for HIV Risk Reduction and HIV Prevention Service Uptake

This domain focuses on conducting targeted, strategic communication campaigns that empower individuals to protect their health. Tailored communication toolkits will be developed for each risk group, moving beyond simple awareness to address specific barriers, promote the responsible use of biomedical prevention tools, and foster positive health-seeking behaviours. Messaging on STI prevention, recognition, and prompt treatment is critical given the rising trend in STIs and the high percentage of men and women who do not seek treatment. The three to four-fold increase in the prevalence of STIs means that proper and consistent condom use is more critical than ever. The communication toolkit will include content to promote early treatment initiation and adherence since, “treatment is prevention”. The ultimate goal is to create an enabling environment where individuals are supported and motivated to access and consistently use the services they need.

1.2.4.2.2. Total Market Approach for Biomedical HIV Prevention Tools

To promote sustainable and equitable access to prevention tools, this domain employs a total market approach that strategically integrates public and private sector resources to address the diverse needs of the population. For products such as condoms and PrEP, this strategy draws on commercial, social marketing, and public sector channels to enhance accessibility, choice, and affordability. Concurrently, essential interventions aimed at eliminating vertical transmission—such as antiretrovirals (ARVs) for pregnant and breastfeeding women,

prophylaxis for newborns, early infant diagnosis, and post-exposure prophylaxis (PEP) following occupational exposure or gender-based violence—will continue to be provided free of charge to recipients, thereby safeguarding vulnerable groups. The health sector will play a pivotal role in these efforts, ensuring that services are accessible, key population-, adolescent- and youth-friendly, and delivered in collaboration with parents and guardians to provide appropriate and confidential care for minors.

1.3. HIV Prevention Action Plan

1.3.1. Ensure that evidence to inform action is up to date

1.3.1.1. Conduct studies (surveys and modelling) to update the country context

- Integrated Bio-Behavioural Surveillance Survey
- HIV Stigma Index
- HIV Incidence Pattern Modelling
- National AIDS Spending Assessment
- Cost-effectiveness of HIV prevention tools
- Drug Use Survey
- HIV prevention self assessments
- Documenting sociocultural norms nationwide by LGA and autonomous community
- Conduct AIDS Impact and Indicator Survey

1.3.1.2. Conduct operational research to further characterise and understand needs and barriers

- Develop and implement a research agenda for HIV prevention.
- Explore how different population groups perceive, experience, and prefer aspects of education, health, and development as they relate to adolescents and young people.
- Assess the reliability and validity of current risk assessment tools for adolescent girls and young women by analysing existing data from AGYW programmes over the past five years.
- Examine the consistency of the term hotspots in HIV prevention programming.

1.3.1.3. Conduct evaluations on select components of the HIV prevention response

- HIV self-testing
- Needle and Syringe Programme
- Medication-Assisted Treatment/Opioid Substitution Therapy
- Pre-exposure prophylaxis (PrEP)
- Elimination of vertical transmission programme

1.3.2. Operationalize strategies to prevent future risk and mitigate current risk

1.3.2.1. Prevent future risk of HIV infection

1.3.2.1.1. Communication to Empower and Support AYP

- Develop a comprehensive communication toolkit that takes into consideration the findings from the mapping of sociocultural norms and the findings from the exploration of perceptions, experiences and preferences of the population groups as they relate to education, health and development of AYP. The toolkit will be for AYP, parents/caregivers, teachers, religious leaders, influencers, traditional leaders, and politicians. It will include teaching and learning materials for the civics education and health and wellbeing components of the 12-year school curriculum.
- Make the communication toolkit available for use nationwide
 - Develop modules on NACA e-learning platform as one dissemination platform that also allows certification of knowledge/competence in the themes contained in the modules.
 - Provide orientation/training for members of the four population groups (TOT)
 - Support use of the toolkit across the four population groups

1.3.2.1.2. Multi-sectoral Action to Empower and Support AYP

- Map existing clubs in schools
- Develop harmonized curriculum for each club
- Develop a handbook for each club that is based on the curriculum and presented in a variety of formats that will facilitate their availability and use
- Develop a handbook for school administrators on the oversight, management, monitoring and safeguarding of clubs
- Make the harmonized curriculum available for use nationwide
 - Provide orientation/training for schools on the curriculum
 - Ensure availability of the handbooks in schools
 - Mobilise support for the effective operation of the clubs from relevant public and private sectors, as well as other interested individuals and entities.
 - Promote, coordinate, and support inter-school club competitions at the local government, state, and national levels.

1.3.2.2. Mitigate current risk of HIV infection

1.3.2.2.1. Communication on Behaviour Change and Availability of Biomedical HIV Prevention Tools

- Develop communication toolkits for populations with current risk of HIV
Develop modules on NACA e-learning platform as one dissemination platform that also allows certification of knowledge/competence in the themes contained in the modules.
Provide orientation/training for members of the relevant population groups (TOT)
Support use of the toolkits

1.3.2.2.2. Total Market Approach for Biomedical HIV Prevention Tools

- Guarantee comprehensive access to all services within the HIV vertical transmission elimination cascade for pregnant and breastfeeding women, with particular attention to those not accessing antenatal care.
 - Develop and implement detailed action plan for engaging communities in 20 states with the lowest antenatal care coverage to negotiate access to antenatal care and services within the HIV vertical transmission elimination cascade for pregnant and breastfeeding women.
- Facilitate a total market approach for condoms and PrEP
- Advocate for and facilitate action towards local manufacturing of condoms and lubricants.
 - Conduct feasibility study for local manufacturing of condoms and lubricants.
 - Develop investment case for local manufacturing of condoms and lubricants.
- Expand access to harm reduction services
- Develop/update protocols for access to PEP following occupational exposure and GBV

1.3.3. Strengthen coordination, sustain capacity and mobilise resources

1.3.3.1. Coordinate and foster multi-sectoral collaboration, oversight and management of the HIV prevention response

- Support operations of HIV prevention technical working groups at national and state levels
- Ensure linkages to other technical working groups such as the EMTCT TWG, harm reduction TWG and the M&E TWG
- Organise biennial national HIV prevention conference

1.3.3.2. Strengthen and maintain capacity for leadership, coordination, oversight, and management of the HIV prevention response

- Develop full curriculum for the NACA Moodle e-learning platform
- Develop content based on the full curriculum and add to the Moodle platform
- Roll out full curriculum and modules nationwide
- Develop a structured mentoring programme for young public health professionals

1.3.3.3. Monitor, evaluate and report performance of HIV prevention programme

- Design and validate assessment instruments to measure changes in key internal values (self-respect, belonging, curiosity, critical thinking, foresight and responsibility) among AYP participating in the programme, in order to directly assess the effectiveness of the paradigm shift.
- Update NACA, NEMIS and NASCP reporting platforms with all indicators in the performance monitoring framework relevant to their platform and provide access to stakeholders to report on their indicators.
- Publish an Annual Report of HIV Prevention Performance
- Conduct an evaluation of the HIV prevention programme

1.3.3.4. Mobilise resources

- Collaborate with MDAs and the private sector to identify and leverage existing structures, frameworks, resources and opportunities for implementation of the HIV prevention plan as it concerns the populations groups they work with and their own employees.
- Develop and maintain a database of funding opportunities
- Develop funding proposals to fill gaps and expand on the plan as needed
- Champion this HIV prevention plan as an investment case

1.3.3.5. Workplan and Budget

- Review and update work plan and track budget performance annually.

1.4. Risks and Risk Mitigation

The successful execution of this Plan requires a fundamental transformation in how HIV prevention is conceptualized and delivered across Nigeria. As the national response pivots from a reactive, risk-reduction model to a proactive, whole-of-society approach, it faces inherent structural and operational challenges. These include the complexities of inter-sectoral coordination, the need for specialized capacity to foster internal values, and the methodological difficulties associated with measuring abstract psychological concepts. To ensure the resilience of this strategy and the achievement of the 2030 targets, potential risks have been identified and proactively assessed. Table 1.1 below outlines these critical risks, evaluates their likelihood and potential impact, and defines the specific countermeasures and responsible parties designated to mitigate them.

No	Risk Category	Description	Likelihood	Impact	Countermeasures	Responsible Party
1	Operational	Multi-Sectoral Coordination Failure: The plan relies heavily on a “whole-of-society” approach involving Ministries of Education, Youth, Information, Sports, Justice, etc. Historical precedent suggests these sectors often operate in silos and may not prioritize HIV prevention, leading to weak implementation of school clubs and curricula and other aspects of the Plan	High	High	Leverage the National Council on AIDS (NCA) to provide continuous high-level political backing; Integrate specific HIV prevention activities and deliverables of each MDA into their annual strategic plans and reporting platforms; Establish formal linkages between national and state prevention TWGs and other existing sectoral TWGs (e.g., Basic Education, Youth Development) to ensure joint planning and resource mapping; Convene regular MDA forum for peer review.	NACA
2	Monitoring Evaluation (M&E)	Inability to Measure “Internal Values”: Quantifying abstract concepts like “foresight,” “belonging,” or “self-respect” is methodologically difficult. If the plan cannot prove these values are being adopted, it cannot demonstrate success or justify continued funding.	High	Medium	Use internationally recognised and validated assessment instruments as the basis for the Nigeria adaptation and validation; use a mix of qualitative (focus groups) and quantitative tools; include proxy indicators (e.g., club participation rates, school attendance) alongside value metrics; start with existing internationally recognised assessment tools	NACA SI Unit, M&E Technical Working Group

No	Risk Category	Description	Likelihood	Impact	Countermeasures	Responsible Party
3	Human Resource	Capacity Gap for Teachers/Mentors: Teachers and club mentors may lack the specific skills or motivation to facilitate value-based discussions and manage school clubs effectively, leading to “token” implementation rather than the intended deep engagement.	High	Medium	Implement robust “Training of Trainers” (TOT) programs; develop simple, user-friendly handbooks; introduce certification or recognition incentives for effective club management; utilize NYSC members for mentorship support.	FME, FMYD, NYSC, Federal Ministry of Women Affairs, NOA, NACA
4	Societal	High Community Stigma Undermining Agency: Even with increased agency (internal values), the high levels of community stigma (59-67%) against PLHIV may prevent AYP from accessing testing or treatment if they do engage in risky behavior, fearing judgment.	Medium	Medium	Target communication campaigns specifically at reducing community stigma; engage political and traditional leaders to publicly champion anti-stigma norms; enforce existing anti-discrimination policies in healthcare and community settings.	NACA, Federal Ministry of Information & NOA

No	Risk Category	Description	Likelihood	Impact	Countermeasures	Responsible Party
5	Implementation	<p>Low Media Reach Affecting Communication Strategy: The plan relies on face-to-face interaction due to low media exposure. However, scaling face-to-face engagement is resource-intensive and slow, potentially failing to reach the sheer volume of out-of-school youth.</p>	High	Medium	Prioritize and peer-to-peer networks to multiply reach; leverage religious gatherings and community meetings which have high attendance; explore low-tech ICT solutions (e.g., radio drama in local languages) to supplement face-to-face efforts.	NACA, All stakeholders

Section 2: The Evidence

Presents the data and analysis revealing why current strategies are insufficient, highlighting gaps in prevention investment, population coverage, and the misalignment between expenditure and epidemiological trends.

GENERATION NEGATIVE (GEN-N) STRATEGY

Self-Respect • Belonging • Curiosity • Critical Thinking • Foresight • Responsibility

2.1. Situational analysis

1. New HIV infections are declining too slowly and the decline appears strongly related to an increase in HIV treatment coverage.

- Between 2010 and 2024, Nigeria achieved a remarkable 68% reduction in new HIV infections. This decline closely aligns with an increase in HIV treatment coverage from 18% to 83%, as indicated by a correlation coefficient of -0.99 (Figures 1 and 2).
- Nevertheless, the goal of an 81% reduction in new HIV infections by 2024 was not met.

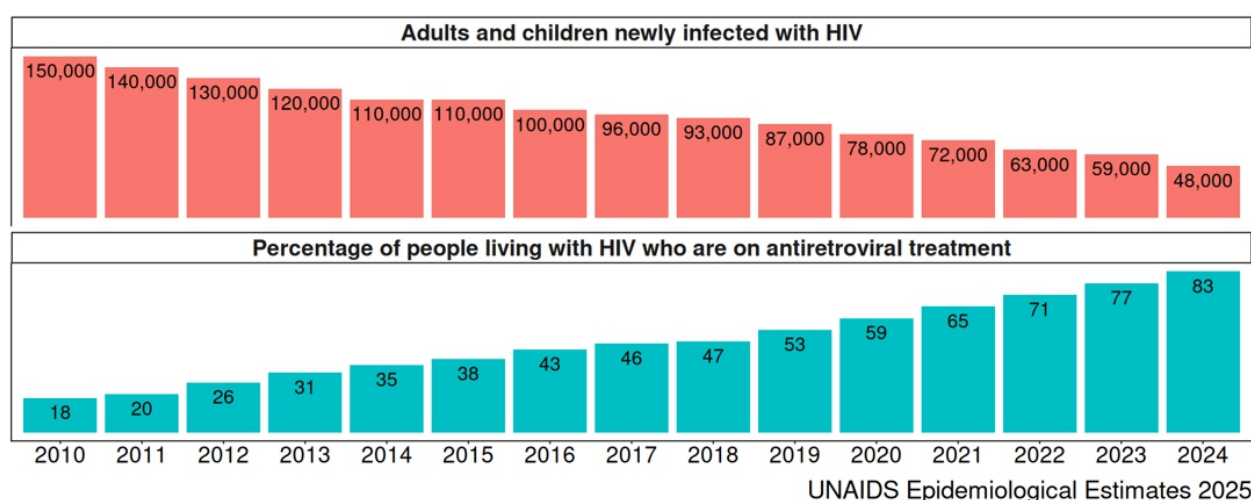


Figure 1: Trends in new HIV infections and HIV treatment coverage from 2010 to 2024

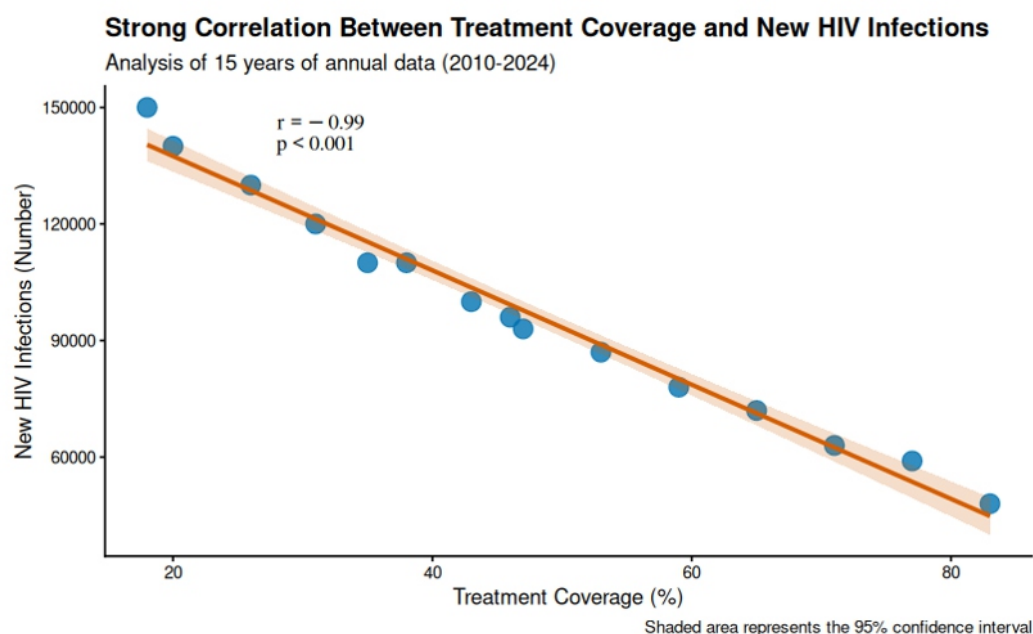


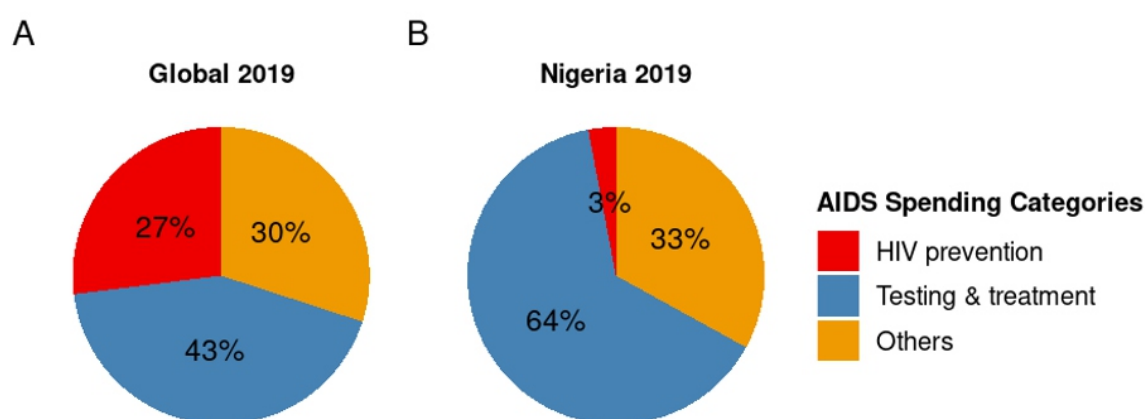
Figure 2: Correlation between HIV treatment coverage and new HIV infections from 2010 to 2024

⁵ This situational analysis expands and updates the analysis presented in the HIV Prevention Strategy for Adolescents and Young People (2024).
⁶ This is based on an extrapolation from the targets set at the 2016 UN General Assembly to reduce new HIV infections by 75% by 2020 and 90% by 2030 compared to the number of new HIV infections in 2010.

2. Underinvestment in primary prevention is a major challenge and is likely to have contributed to the slow decline in new HIV infections.

- From 2019 to 2021, expenditure on primary HIV prevention constituted only 2-9% of total HIV-related spending, whereas 64-76% was allocated to HIV testing and treatment (National AIDS Spending Assessment 2024).
- This level of investment in prevention is comparatively low by global standards. For example, Figure 3 indicates that in Nigeria, just 3% of AIDS expenditure in 2019 was directed toward HIV prevention- including the prevention of vertical transmission - while globally, 27% of AIDS funding was allocated to prevention efforts, excluding vertical transmission prevention.

The Global AIDS Strategy (GAS) 2021-2026 recognizes the challenge posed by underinvestment in the primary prevention of HIV pointing out that “A massive increase in spending on HIV prevention will enable urgent, transformational scale-up of HIV prevention services.”



Prevention of vertical transmission is under 'HIV prevention' in Nigeria data and under 'Others' in global data.
Sources: A) Global AIDS Strategy 2021-2026; B) National AIDS Spending Assessment in Nigeria 2019-2021

Figure 3: Comparison of AIDS Spending on HIV prevention globally and in Nigeria in 2019.

3. Most of the HIV prevention expenditure is on key populations but the vast majority of new HIV infections occur in the general population.

- HIV prevention services at scale prioritise key populations which is consistent with the risk-based approach to HIV prevention outlined in the GAS.
- The significant increase in HIV prevention expenditure, from 2% to 9% of total HIV spending, was primarily driven by expanded access to pre-exposure prophylaxis (PrEP). In 2021, PrEP represented 60% of HIV prevention spending compared to 0.5% in 2019. The DHS 2024 shows that 18% of women and 24% of men have heard of PrEP while

71% of women and 83% of men who have heard of PrEP approve of people who take PrEP to prevent getting HIV.

- The NASA 2019-2021 confirms the implementation of this risk-based approach as it shows that 80% of HIV prevention expenditure was on key populations compared to 16% spent on the general population and 4% on preventing vertical transmission of HIV in 2021 (Figure 4A), which is the most recent year assessed.
- However, 69% of new HIV infections occurred in the general population, 23% in children and only 8% among key populations (Figure 4B).
- In 2021, only 1.2% of HIV prevention spending was allocated condoms for the general population and just 0.2% to social and behavioural change communication (SBCC) for the general population. These figures account for 0.1% and 0.02%, respectively, of total HIV expenditure.
- Consequently, condom provision remains a substantial gap, with an estimated shortfall of about 750 million condoms annually⁷. Of condoms distributed in 2021, 58% were provided by the commercial sector while social marketing and the public sector (free) provided 28% and 14% of condoms, respectively.⁸

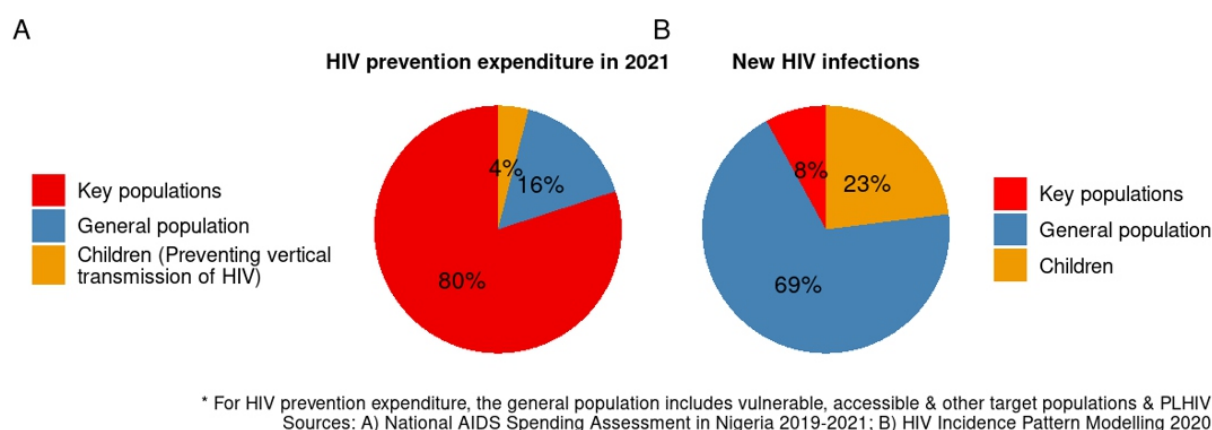


Figure 4: Distribution of expenditure on HIV prevention and new HIV infections by population group

Resources mobilised through the Global Fund Grant Cycle 7 (GF GC7) and PEPFAR have been allocated to address the unacceptably high contribution of new infections in children. HIV testing coverage among pregnant women increased from 16% in 2008 to 33% in 2022-2023 (DHS 2008, 2024). However, with implementation of the GF GC7 grant, the number of pregnant women reported to have been tested for HIV increased from 2.8 million in 2023 to 5.2 million in 2024 suggesting that testing coverage has almost doubled and that new infections in children can be expected to decline significantly as newly diagnosed pregnant women living with HIV are put on anti-retroviral drugs. The programme to eliminate the vertical transmission of HIV focuses on women who receive formal or informal antenatal care. This leaves a gap among pregnant women who do not receive antenatal care who make up 26% of pregnant women.

⁷ FMH and NACA. National Condom Strategy Operational Plan 2021-2025.

⁸ Ogundipe A, Ndukwe D, Essomeonu K, Oyedeji S. Total Market Approach for Condoms– Nigerian Experience. 2023 Aug 10; <https://www.hivinterchange.com/events/condom-link-learn-total-market-approach-hosted-by-nigeria>

Excluding children shows that the continuing unaddressed challenge with new HIV infections is among adults in the general population.

- Among adults, 89% of new HIV infections were in the general population while 11% were in the key populations (Figure 5).
- While it is vital to ensure that HIV prevention services are available to key populations at scale, there is a big gap in the general population that calls for urgent action.
- The central issue concerns whether HIV prevention efforts should target the entire general population or focus on specific sub-groups within that population.

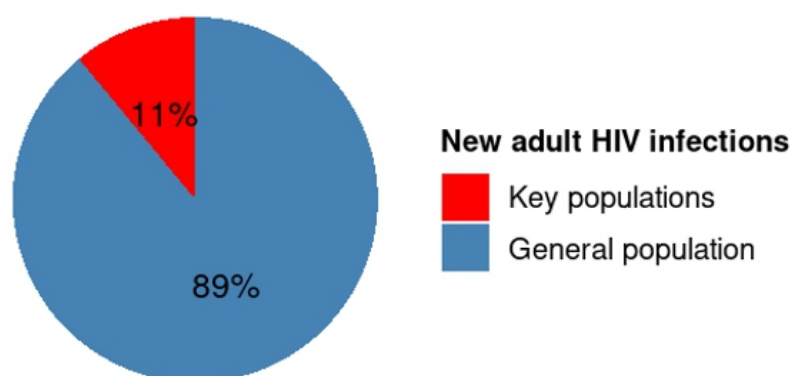


Figure 5: Contribution to new HIV infections among adults by population group (HIV Incidence Pattern Modelling 2020)

4. Adolescents and young people have the lowest incidence and prevalence of HIV in the general population.

- Women who were 25-34 years old had the highest incidence and it was four times that of 15-24 year-old women (Figure 6A).
- HIV prevalence rises with age to peak in the 35-39 year age group for women and in the 50-54 year age group for men. When compared to the HIV prevalence among 15-19 year-olds, the peak prevalence represents a 10-fold increase for women and a 20-fold increase for men (Figure 6B).
- In programme data, HIV test positivity rates for adolescent girls and young women selected through high-risk location targeting and individual risk profiling at those locations, are below 0.3%.

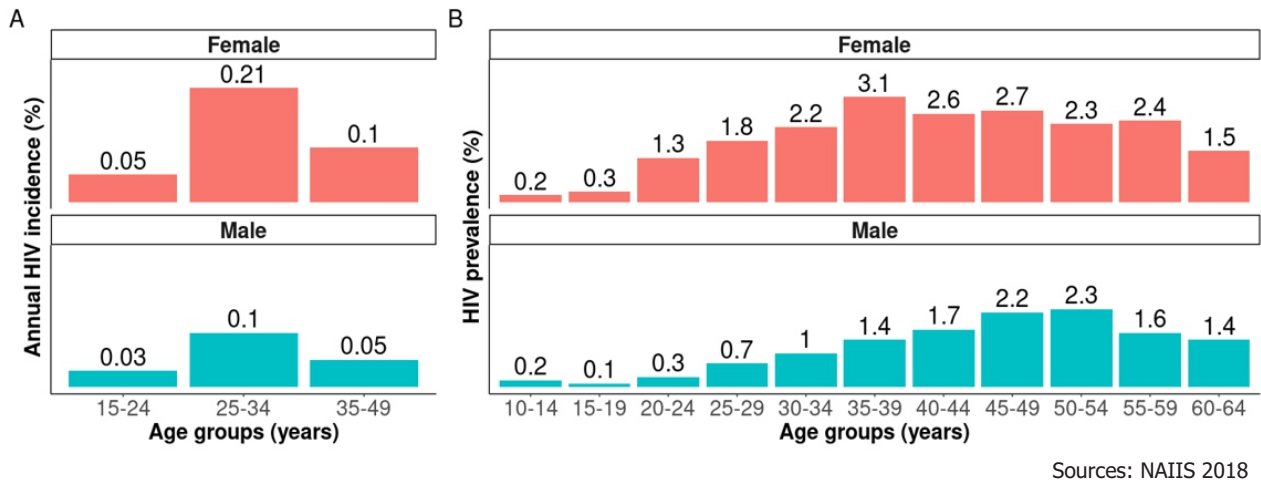


Figure 6: Percentage annual incidence of HIV and prevalence of HIV by age and sex

- While HIV prevention programming engages with adolescent girls and young women based on vulnerability to HIV, the data suggests that vulnerability and risk rise with age for both women and men. Despite higher incidence and prevalence of HIV in older women and men, they are not the beneficiaries of any focused HIV prevention programme.

5. Low levels of comprehensive knowledge of HIV are a concern and may be related to low coverage of health and well-being education in schools

- The comprehensive knowledge about HIV was low in 2018 but declined further in 2024 among adolescents and young people (Figure 7). This trend is attributed to the reduced emphasis on primary prevention within the general population, which has resulted in diminished focus on HIV-related education in schools.

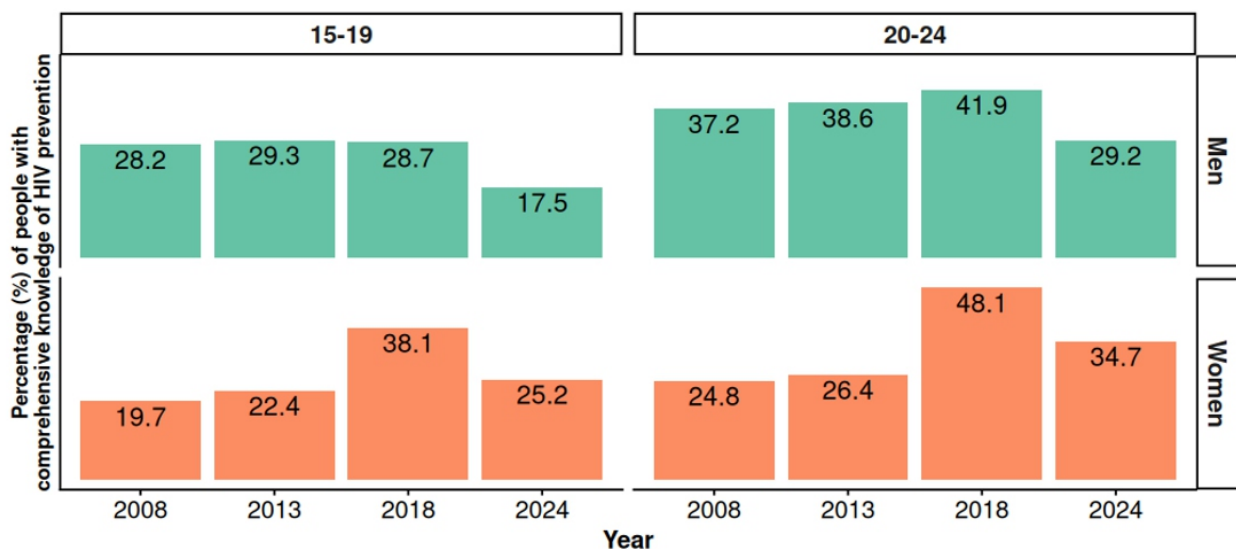


Figure 7: Trends in comprehensive knowledge of HIV prevention by age and sex from 2008 to 2024

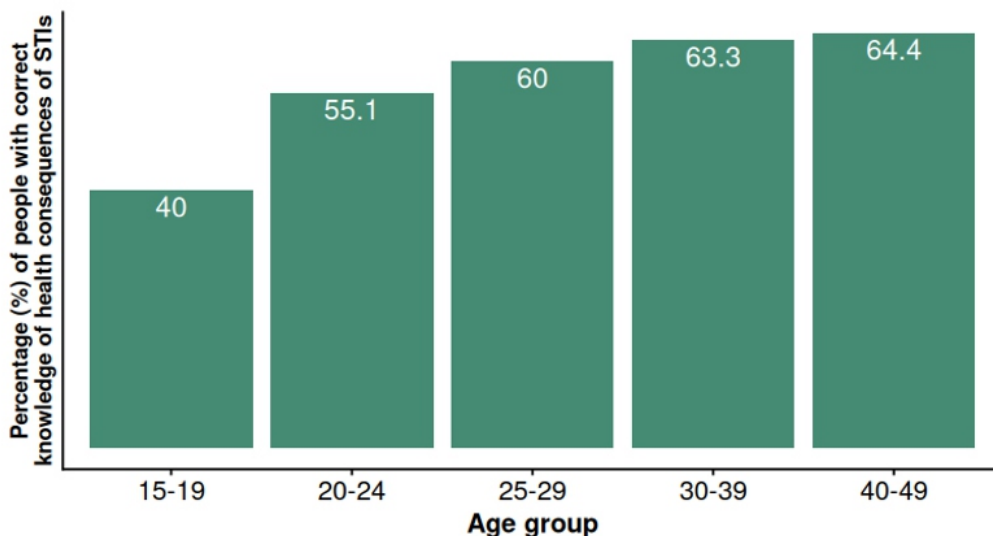
- Core indicators for monitoring and evaluation of the delivery of the health and well-being education in schools show low coverage in 2021 and 2022 (Table 1).

Table 1: Core indicators for the monitoring and evaluation of the delivery of health and well-being education (NEMIS)

Core Indicators	2021 (%)	2022 (%)
Percentage of schools that provided life skills-based HIV and sexuality education in the previous academic year	33.5	Not available
Percentage of schools that provided an orientation process for parents or guardians of students regarding life skills-based HIV and sexuality education programmes in schools in the previous academic year	25.0	30.8
Percentage of schools with teachers who received training, and also taught lessons, in life skills -based HIV and sexuality education in the previous academic year	29.8	23.5

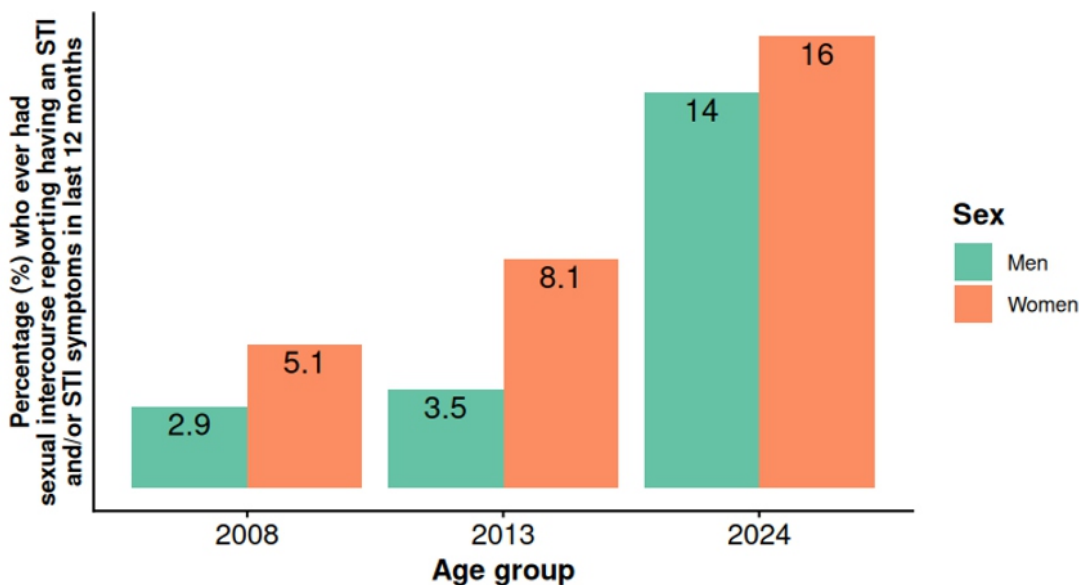
6. A majority of people have correct knowledge of the health consequences of sexually transmitted infections are above average. However, there has been a three-fold increase in the percentage of sexually active individuals reporting having an STI and/or symptoms of an STI. A large percentage of these individuals do not seek treatment.

- The DHS 2024 introduced the assessment of the correct knowledge of the health consequences of sexually transmitted infections (STI) defined as preventing women from getting pregnant and men from fathering children in the future.
- The percentage of women with correct knowledge increased from 40% among 15-19 year old women to 64% among 40-49 year old women (Figure 8).
- Reported STI increased markedly from 2008 to 2024 for men (4-fold) and women (3-fold). Women were more likely to report STI than men, however, the wide disparity seen in 2008 and 2013 was no longer present in 2024 (Figure 9).
- An unacceptably high percentage of men (23%) and women (40%) who had an STI and/or symptoms of an STI did not seek advice or treatment (Figure 10).
- There were higher rates of reported STI among key populations in 2020 ranging from 30% among MSM to 56% among FSW.



Sources: DHS 2024

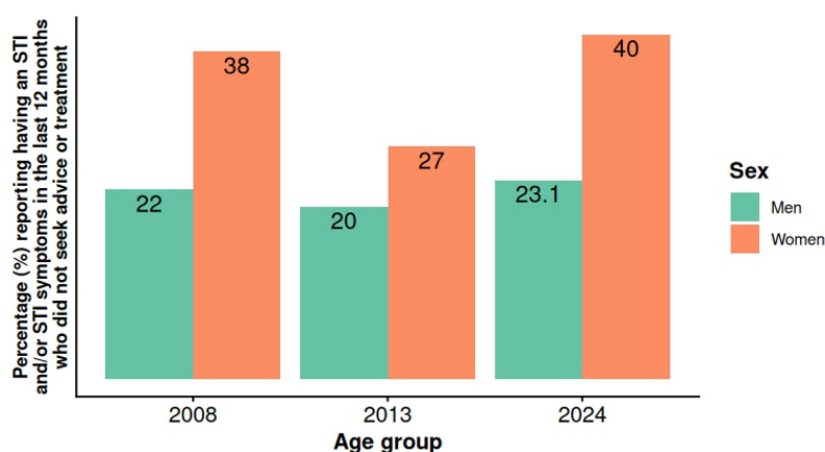
Figure 8: Correct knowledge of health consequences of STIs (prevent women from getting pregnant and men from fathering children in the future) among women 15-49 years of age



Sources: DHS 2008, 2013 & 2024

Figure 9: Men and women who ever had sexual intercourse reporting having an STI and/or symptoms of an STI in the last 12 months

Sources: DHS 2008, 2013 & 2024

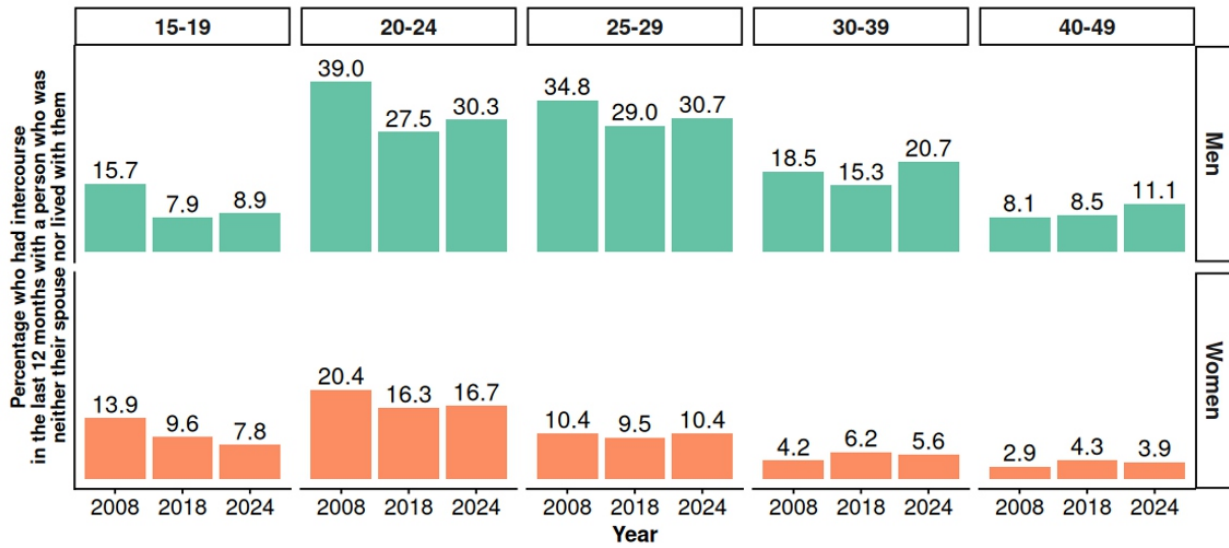


Sources: DHS 2008, 2013 & 2024

Figure 10: Men and women reporting having an STI and/or symptoms of an STI in the last 12 months who did not seek advice or treatment

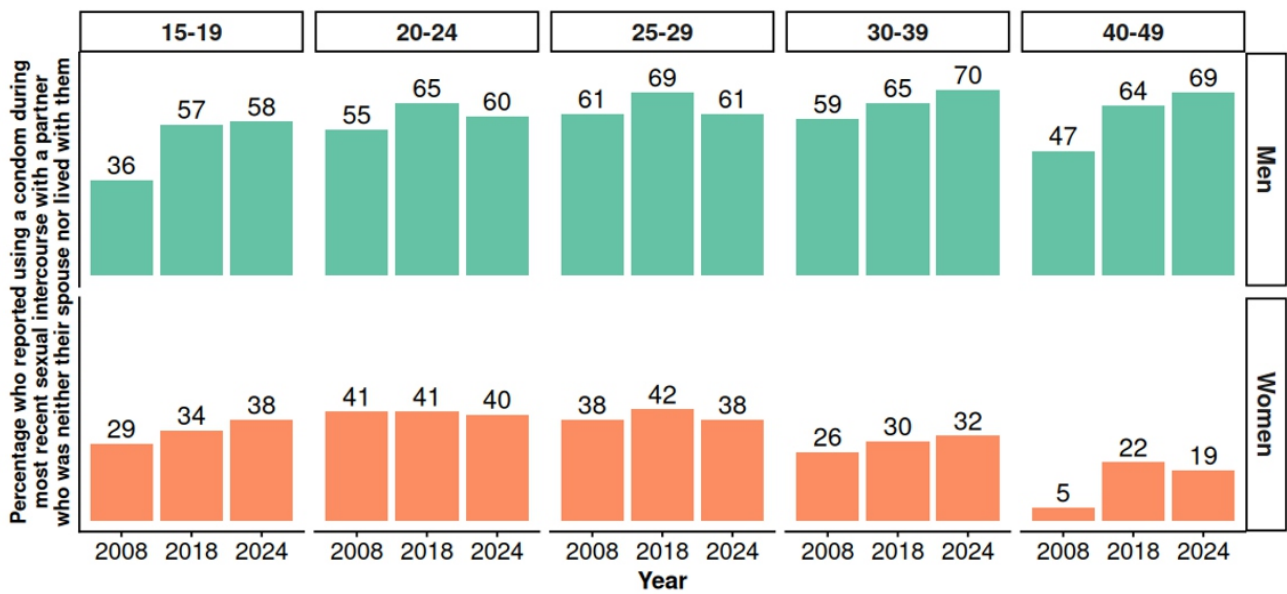
7. Among key populations, consistent condom use is too low while in the general population, there has been very little change over time in the pattern of sexual behaviour associated with risk of HIV transmission.

- Key populations had higher rates of condom use than the general population. Condom use at last sexual intercourse with casual partners or clients ranged from 77% among PWID to 91% among FSW. However, consistent condom use in the last 6 months which is particularly important for key populations was much lower, with the lowest rates occurring among PWID (27%) and MSM (43%).
- In the general population, men are more likely than women to have had sexual intercourse with a person who was neither their spouse nor lived with them (Figure 11), a trend that has remained relatively stable over time.
- Men were also more likely to report using a condom the last time they had sexual intercourse with a person who was neither their spouse nor lived with them (Figure 12).



Sources: DHS 2008, 2018 & 2024

Figure 11: Men and women who had intercourse in the last 12 months with a person who was neither their spouse nor lived with them

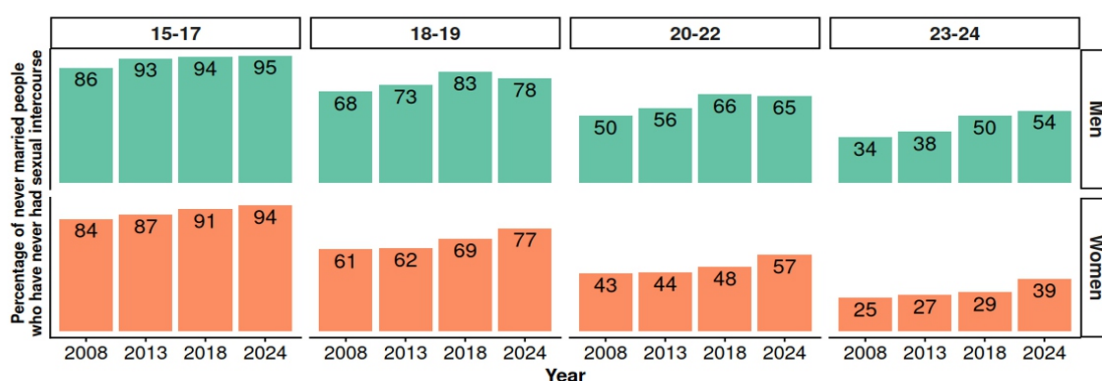


Sources: DHS 2008, 2018 & 2024

Figure 12: Men and women who used a condom the last time they had intercourse with a person who was neither their spouse nor lived with them.

8. Sex before 15 years has declined by more than 50%. Abstinence plays a much larger role in protecting adolescents and young people from HIV than is generally appreciated and has risen progressively since 2008.

- The proportion of 15-24 year olds who had sex before 15 years declined from 15.7% in 2008 to 7.5% in 2024 for women and from 5.7% in 2008 to 2.6% in 2024 for men. Among 18-24 year women, the proportion who had sex before 18 years increased from 49% in 2008 to 53% in 2018 before declining to 42% in 2024. For 18-24 year old men, the proportion that had sex before 18 years declined progressively from 26% in 2008 to 16% in 2024.
- The percentage of never married women and men who have never had sex increased progressively from 2008 to 2024 (Figure 13) with gender parity among adolescents.
- Among adolescents, only 6% of 15-17 year old girls and 5% of 15-17 year olds boys who are not married have ever had sex increasing to 23% and 22% among 18-19 year women and men, respectively (Figure 13).
- These high rates of abstinence help explain the observation that adolescents have the lowest incidence and prevalence of HIV.



Sources: DHS 2008, 2013, 2018 & 2024

Figure 13: Never married men and women who have never had sex by age group

9. HIV testing coverage has doubled since 2008 but remains below a third of the population.

- The percentage of people aged 15-49 years who were ever tested for HIV and received the results of the most recent test increased from 15% in 2008 to 32% in 2024 among women and from 14% in 2008 to 30% in 2024 among men.
- For people aged 15-49 years who were tested for HIV in the past 12 months and received the most recent test result, the percentage of women increased from 7% in 2008 to 11% in 2024 and the percentage of men increased from 7% in 2008 to 9% in 2024.
- HIV testing coverage appears to be very low among adolescents (Figure 14A). However, this is because the vast majority of them are not sexually active. When testing coverage is considered among sexually active adolescents, the wide disparity disappears (Figure 14B).
- About 11% of women and 21% of men had heard of the HIV self-test kit. Overall, 2% of women and 3% of men had used the HIV self-test kit.

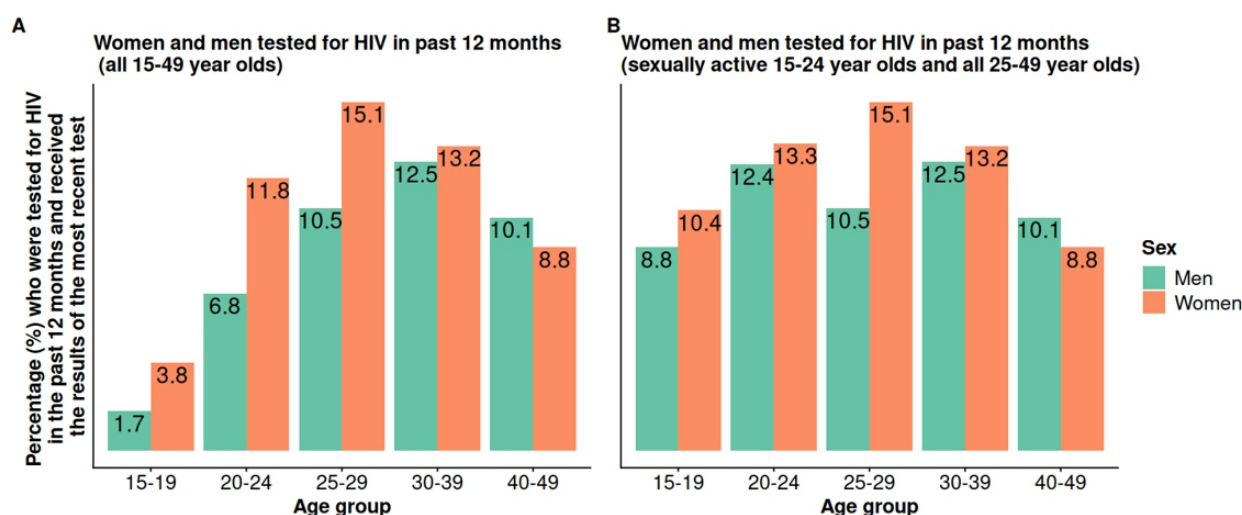


Figure 14: Women and men tested for HIV in the past 12 months

10. Assumptions about risk factors for HIV need to be revisited as some of them may not be universally applicable in Nigeria. Designing and implementing interventions to address factors that are not true risk factors will likely have little or no impact on the achievement of objectives at great cost.

- The NAIIS 2018 survey revealed that:
 - Women and men with no education had the lowest prevalence of HIV (Figure 15).
 - The women and men in the poorest households had lower HIV prevalence than women and men in richer households (Figure 16).
 - Women with co-wives had lower HIV prevalence than women in non-polygynous unions and single women (Figure 17). Similarly, men with more than one wife had a lower prevalence than men with one wife. However, single men had the lowest prevalence of HIV.
- The data suggests that social and cultural norms and practices and other factors may be influencing behaviour and risk of new HIV infections in different ways in different parts of the country. This is not surprising since Nigeria is one of the most ethnically and linguistically diverse countries in the world with over 350 tribes and even more languages.
- Another explanation for these findings is that education and economic empowerment may provide agency for choices that increase risk with the magnitude of their impact being different for women and men.
- Only 0.2% of HIV prevention spending in 2021 went to social and behavioural change communication (SBCC), which may be the missing link needed to help education and economic empowerment reduce risk and to shift social and cultural norms towards safer choices.

9 <https://www.vanguardngr.com/2017/05/full-list-of-all-371-tribes-in-nigeria-states-where-they-originate/>

10 <https://www.ethnologue.com/country/NG/>

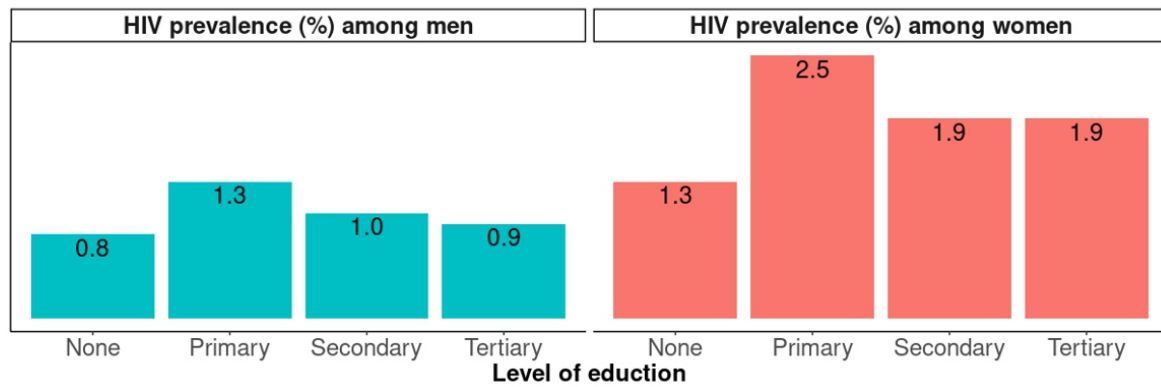


Figure 15: HIV prevalence by education among 15-64 year old men and women (NAIIS 2018)

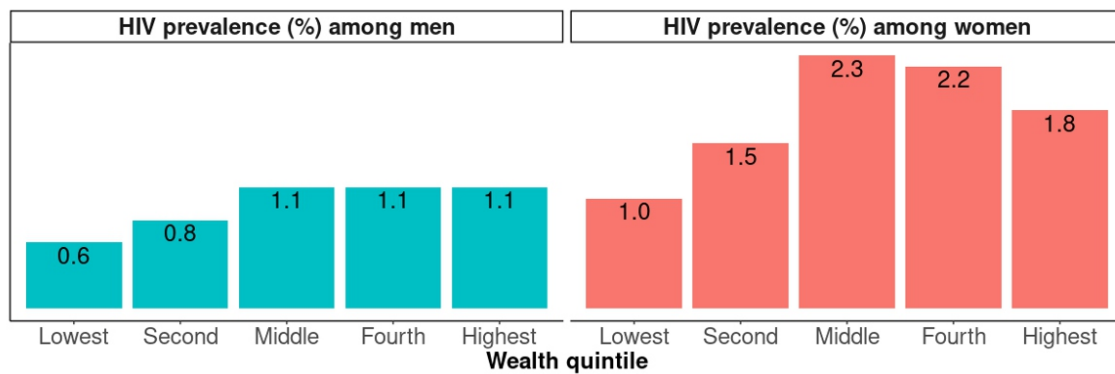


Figure 16: HIV prevalence by household wealth quintile among 15-64 year old men and women (NAIIS 2018)

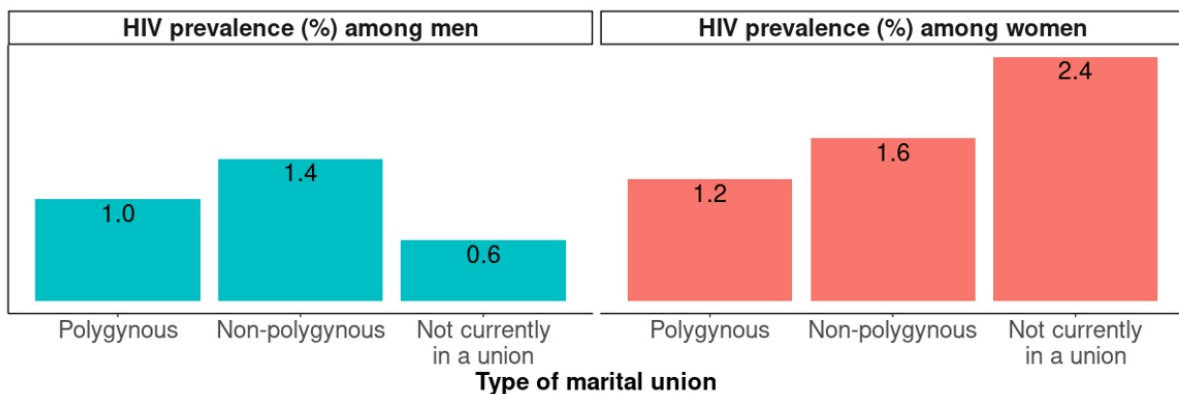


Figure 17: HIV prevalence by type of marital union among 15-64 year old men and women (NAIIS 2018)

11. Stigma and discrimination remain significant challenges, especially in community settings. In health care settings, stigma and discrimination are well below the 10% target in the Global AIDS Strategy.

- When asked about children living with HIV attending schools with children who are HIV negative and about buying fresh vegetables from a shop keeper who has HIV, 59% of men and 67% of women had discriminatory attitudes towards people living with HIV.
- In the 12 months prior to the DHS 2024 survey, 33% of women living with HIV experienced stigma in a community setting while health care workers talked badly about 5% of them and 4% were yelled at, scolded, called names, or verbally abused in another way in a health care setting because of their HIV status.

12. Mass media alone will be insufficient to adequately provide information, especially for AYP who had the least exposure. Internet access is far less readily available despite the perception that most young people get their information from the internet.

- Exposure to television was commoner than radio among 15-24 year old males and females while radio was commoner among individuals who were more than 24 years old.
- Less than 40% of AYP were exposed to any of the mass media at least once a week. Media exposure increased with age for males but not so much for females.
- The use of mobile phones and the internet increased with age but use of the internet was very low across all age groups.
- The low internet usage and even lower use of computers indicates that a lot of work is required to ensure AYP are prepared for, and actively involved in, the digital economy.

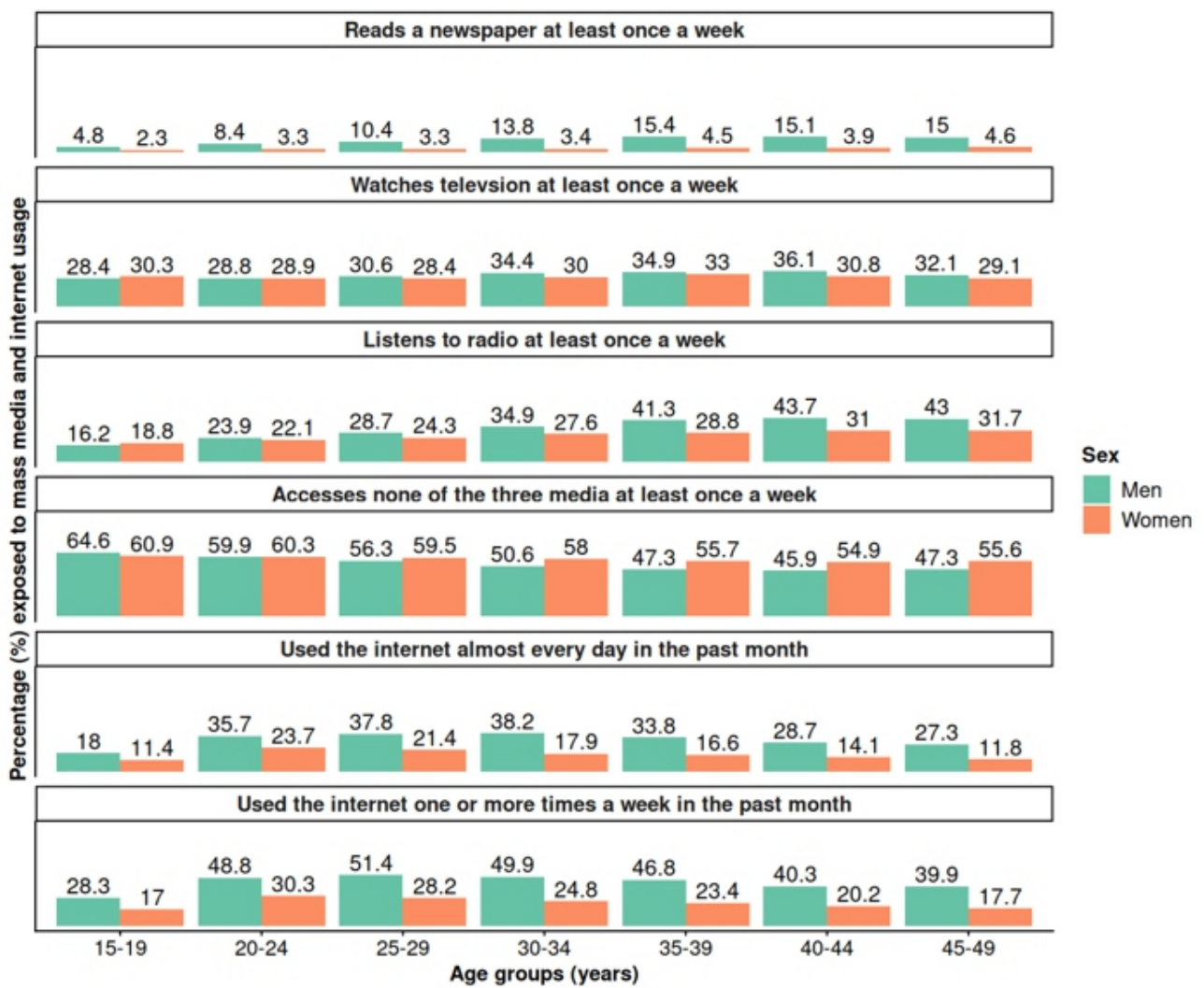
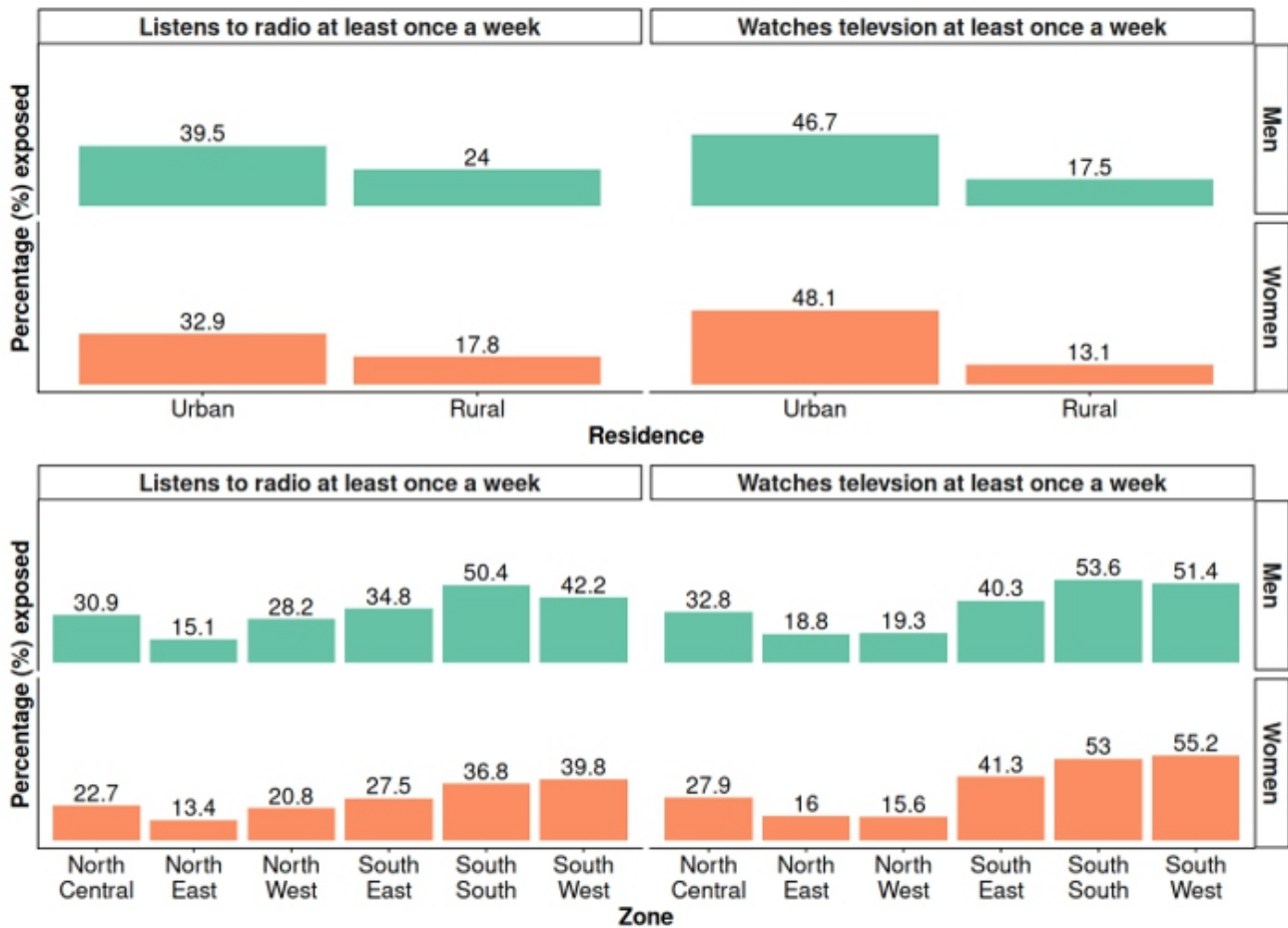
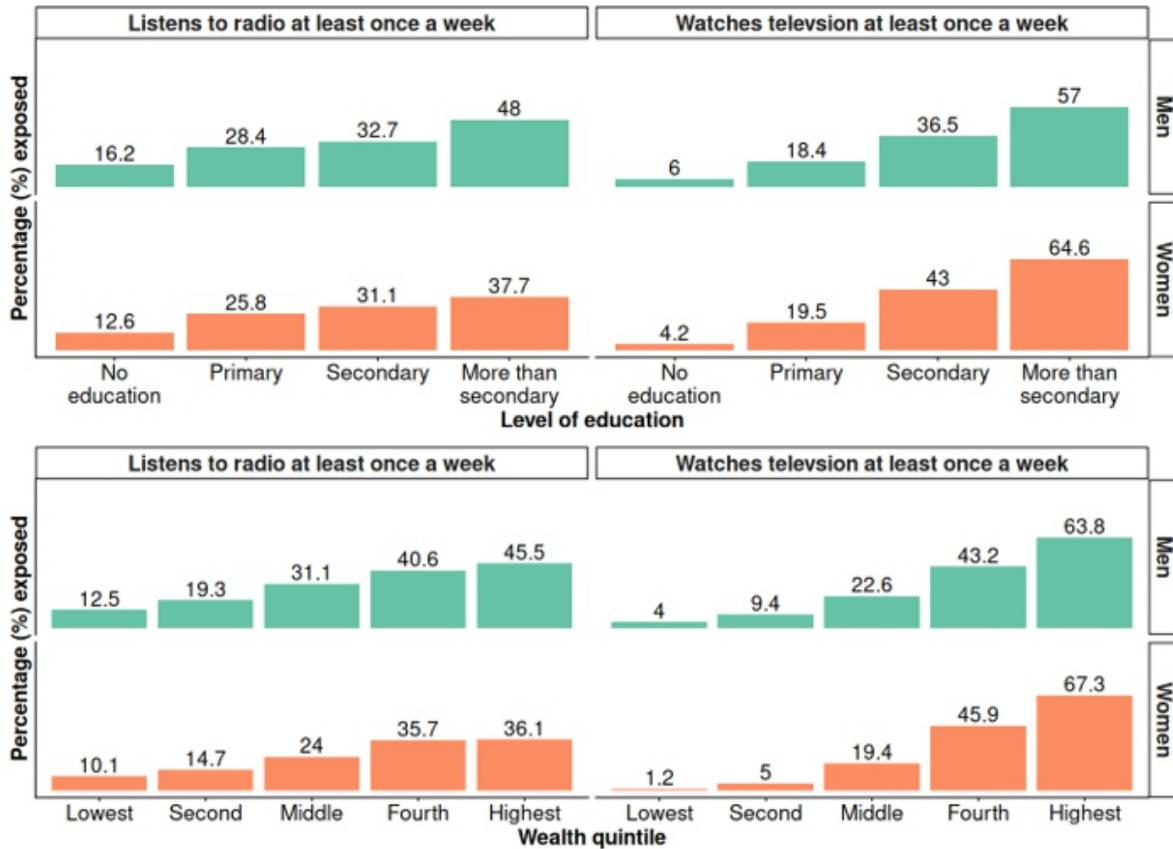


Figure 18: Media exposure and use of ICT disaggregated by age and sex



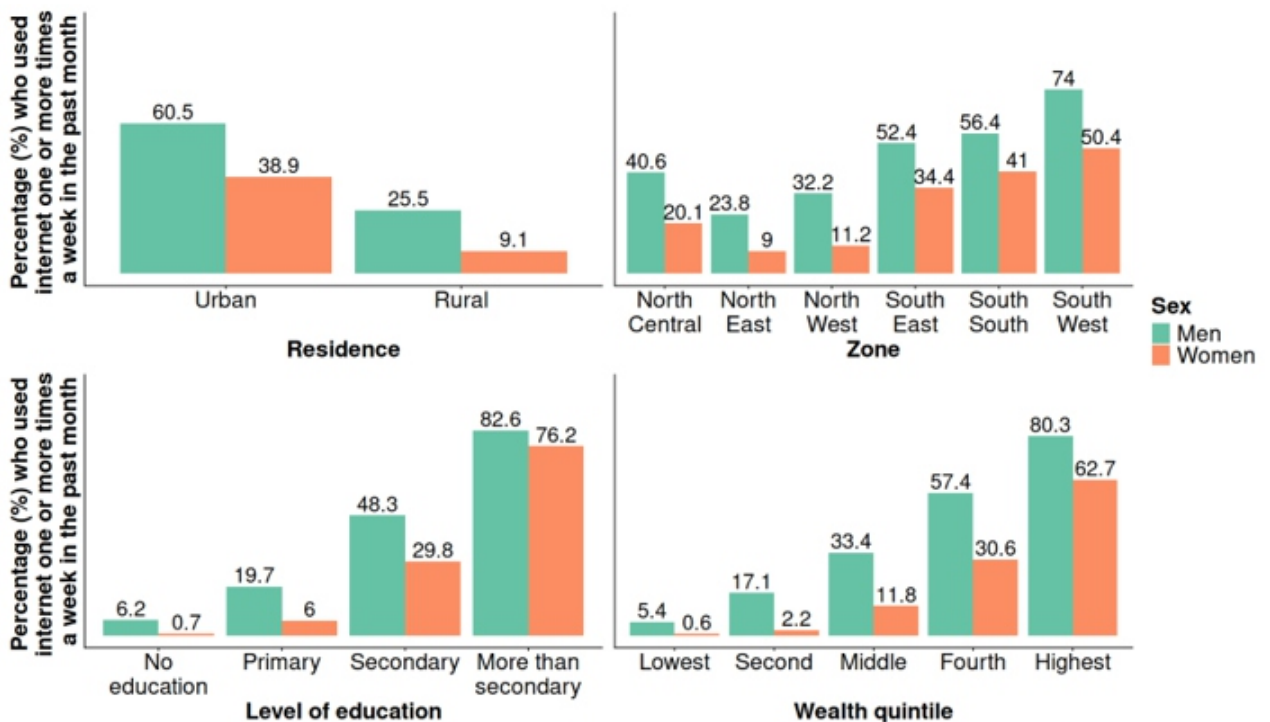
Source: DHS 2024

Figure 19: Exposure of men and women to radio and television by residence and zone



Source: DHS 2024

Figure 20: Exposure of men and women to radio and television by education and wealth



Source: DHS 2024

Figure 21: Use of the internet one or more times a week by men and women disaggregated by residence, zone, education and wealth

2.2. Conclusion

In conclusion, the current-risk approach to HIV prevention is insufficient for Nigeria to sustainably achieve a 90% reduction in new HIV infections

- The key populations who clearly have high risk contribute a small minority of new HIV infections. Therefore, an exclusive focus on this group is unlikely to lead to significant reduction in new HIV infections in Nigeria.
- Furthermore, key populations account for less than 2% of the adult population. Therefore, the almost exclusive focus on key populations contributes to the very low levels of expenditure on HIV prevention since the size of the population to be served is relatively small.
- The general population which has far lower HIV prevalence rates but contributes the vast majority of new HIV infections has been left out. It is now recognised that HIV prevention action in the general population helps reduce new HIV infections in key populations.
- In the general population, adolescent girls and young women (AGYW) are the only beneficiaries of focused HIV prevention action. Here too, the approach is to find the relatively small proportion and number who are currently at high risk of HIV infection and provide them with biomedical interventions.
- The focus of the current-risk approach is on perceived low hanging fruits and short-term solutions.
- In practice, the current-risk approach means “waiting” for people to get into high-risk groups before intervening as depicted in Figure 22 in which individuals are about to walk off a cliff and only at the cliff edge is the single option of a parachute being offered. There are no alternative routes leading away from the cliff edge. People who are not at risk today need interventions to help them remain risk-free or to be prepared to mitigate future risk exposure as illustrated in Figure 23.
- It is in light of the foregoing scenario that the slow decline in new HIV infections persists.



Figure 22: Providing individuals with HIV prevention options that are limited to dealing with a current risk of HIV infection

11 NACA. HIV Incidence Pattern Modelling 2020.

12 NACA. Key Population Programme Review 2024.

13 Korenromp EL et al. New HIV Infections Among Key Populations and Their Partners in 2010 and 2022, by World Region: A Multisources Estimation. (J Acquir Immune Defic Syndr 2024;95:S34 – S45).



Figure 23: Providing adolescents and young people with alternatives while they still have no risk or low risk of HIV infection

Section 3: Theoretical Frameworks, Concepts, and Terms

Explains the paradigms underpinning the plan, contrasting the old Health Belief Model with Self-Determination Theory, and defines key concepts like intrinsic motivation, whole-of-society action, and the holistic proactive development-based approach, amongst others

GENERATION NEGATIVE (GEN-N) STRATEGY

Self-Respect • Belonging • Curiosity • Critical Thinking • Foresight • Responsibility

3.1. Understanding the Paradigm Shift

The National HIV Prevention Plan 2025-2030 represents a fundamental shift in how Nigeria approaches HIV prevention, moving from a reactive risk-based model to a proactive, development-based approach. This transformation is grounded in two distinct theoretical frameworks that guide different aspects of the strategy.

3.1.1. The Health Belief Model: Foundation of the Current Paradigm

The Health Belief Model (HBM) has historically shaped HIV prevention efforts, particularly through fear-based messaging and incentive-driven approaches. This model operates on the premise that individuals will take preventive health actions when they:

1. Perceive themselves as susceptible to a serious health threat
2. Believe the threat has severe consequences
3. Believe the benefits of taking action outweigh the barriers
4. Feel confident they can successfully perform the recommended action
5. Are exposed to internal (e.g. noticing symptoms of an illness) or external cues (exposed to a health campaign) to act

In practice, this translated to campaigns emphasizing the dangers of HIV, the consequences of infection, and offering tangible incentives or fear appeals to encourage behaviour change. While effective for short-term compliance, this approach often failed to create lasting change because it relied on external motivators rather than internal commitment.

3.1.2. Self-Determination Theory: The New Paradigm

Self-Determination Theory (SDT) offers a fundamentally different approach by focusing on intrinsic motivation. It is about understanding what truly motivates people to make healthy choices and live better lives. It is the difference between doing something because one has to and doing it because one wants to. It is driven by three core psychological needs:

- 1. Autonomy:** The need to feel in control of one's own life and choices
- 2. Competence:** The need to feel effective and capable
- 3. Relatedness:** The need for meaningful connections with others

According to SDT, when these needs are satisfied, individuals develop “intrinsic motivation”, a powerful, self-sustaining drive that comes from within rather than being imposed externally. This creates lasting behaviour change because people act in alignment with their values and identity, not just to avoid punishment or gain rewards.

In the context of HIV prevention, SDT suggests that young people who develop strong self-worth, future orientation, and positive relationships are naturally motivated to make healthy choices, rather than being forced into them through fear or incentives.

3.1.3. How the Two Objectives of this HIV Prevention Plan Reflect These Frameworks

The prevention plan's dual objectives represent this theoretical evolution:

Objective 1 fully embodies the SDT approach by focusing on empowering adolescents and young people to develop internal values and resilience. This objective builds the “internal compass” that guides lifelong healthy decision-making, addressing the root causes of risk behaviour rather than just the behaviours themselves.

Autonomy means helping young people develop their own reasons for making healthy choices. It is the difference between being told what to do and deciding for oneself what is best. Instead of just telling young people “don't have unprotected sex,” they will be supported to explore their own values and goals. A young person with strong autonomy will think, “I want to protect my future and my health because that's important to me,” rather than “I need to avoid HIV because someone told me to.”

Competence means helping young people develop the skills and confidence they need to navigate complex situations. This isn't just about knowing fact, it's about feeling capable of saying no to pressure, using protection correctly, and making healthy decisions even when friends are doing otherwise. When someone feels competent, they're more likely to act on their knowledge because they believe they can succeed and to take on new tasks and persist when things get difficult.

The relatedness component of SDT means creating supportive environments where healthy behaviours are the norm. When young people feel connected to positive peers, family members, and community leaders who value their health, they are more likely to make choices that align with those values. This is why the prevention plan emphasizes working with parents, teachers, religious leaders, and influencers, because when the people who matter most model and support healthy behaviours, young people are more likely to follow suit.

Objective 2 acknowledges the continued relevance of addressing current risks but incorporates SDT principles through values-based social and behavioural change communication (SBCC). While it maintains elements of the HBM approach by targeting those currently at risk, it complements this with intrinsic motivation strategies that foster internal values, creating a bridge between the old and new paradigms.

This dual approach ensures that immediate public health needs are addressed while simultaneously building the sustainable, values-driven prevention system that the paradigm shift envisions.

14 Alyafei A, Easton-Carr R (2025). The Health Belief Model of Behavior Change. I. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK606120/>

15 Deci E, Ryan R. Self-Determination Theory: A Macrotheory of Human Motivation, Development, and Health. *Canadian Psychology / Psychologie canadienne*. 2008 Aug 1;49:182–5.

3.2. Concepts and Terms

3.2.1. Wait-for-risk strategy

A prevention approach that delays intervention until individuals are already engaging in high-risk behaviors or have reached situations of significant vulnerability. This strategy identifies and targets only those who are currently at high risk of HIV infection, typically focusing on key populations or individuals already demonstrating risky behaviors. The approach essentially "waits" for people to become vulnerable before offering prevention interventions, rather than building resilience beforehand. As illustrated in the document, this is akin to waiting at the cliff edge to offer a parachute only when someone is about to fall, rather than building alternative safe pathways earlier.

3.2.2. Reactive risk-reduction model

A traditional HIV prevention paradigm that responds to existing risk rather than preventing risk from developing. This model focuses on reducing harm among populations already engaged in high-risk behaviors through targeted interventions such as condom distribution, PrEP provision, and testing services. It operates on the principle of managing current epidemiological risk through biomedical and behavioral interventions, typically employing fear-based messaging or transactional incentives to prompt behavior change. The model is "reactive" because it responds to established risk patterns rather than proactively building protective factors.

3.2.3. Transactional incentives

External rewards or punishments used to influence behavior change through immediate, conditional exchanges. In HIV prevention, these include cash payments for clinic attendance, material goods for test completion, or fear-based messaging that threatens negative consequences for risky behaviors. This approach treats health behaviors as transactions where individuals comply primarily to gain rewards or avoid punishments, rather than developing internal motivation. The model assumes behavior change will persist after incentives are removed, but research shows it often creates dependency on external motivators and can undermine intrinsic motivation through the "overjustification effect"—where individuals attribute their actions to the incentive rather than personal values, reducing long-term commitment to healthy behaviors.

3.2.4. Balanced access

Balanced access means allocating prevention resources in direct proportion to where new infections are occurring, while still safeguarding the rights and needs of every segment of the population.

3.2.5. Internal values

Internal values function as the silent scorecard individuals carry into every aspect of their lives. Beneath moods, opinions and daily goals resides a handful of “why-does-this-matter?” beliefs that are chosen, not inherited and stable, not seasonal. Their violation produces hollowness even without witnesses while honouring them generates a quiet sense of fulfilment without applause.

These values differ from goals (they serve as compass, not destination), from morals (they are personal rules, not society's) and from needs (they are the individual's fingerprints, not universal). Temperament, early attachments, peak moments and adolescent meaning-making weld them into place; trauma may add “protect,” inspiration may add “create.”

They are linked to autonomous motivation: Self-Determination Theory demonstrates that action aligned with intrinsic values yields higher vitality, persistence and well-being, while betrayal creates stress and persistent negative feelings until realignment occurs.

This National HIV Prevention Plan spotlights six internal values, namely, self-respect, belonging, curiosity, critical thinking, foresight and responsibility, because they form the smallest set whose combined practice equips a young person to navigate peer pressure, set life goals and delay risky behaviour before HIV exposure occurs. These six act as “master keys”: cultivate self-respect and honesty or discipline emerge naturally; exercise curiosity and fairness or empathy follow; strengthen foresight and self-discipline is rewarded. Perfecting this compact cluster triggers a cascade of related internal values, keeping the prevention programme focused and measurable while still nurturing the broader moral fabric essential for holistic well-being.

3.2.6. Delayed gratification

Delayed gratification is the conscious choice to forgo an immediate, smaller reward in order to obtain a larger, more valuable benefit in the future. In the context of this HIV prevention plan, it translates into decisions such as abstaining from unprotected sex until a condom is available, completing school before starting a family, or saving money for long-term goals rather than spending it on fleeting pleasures. By practising this skill, young people strengthen foresight and self-control - two internal compass values that make high-risk behaviours less likely and healthier, goal-oriented lifestyles more automatic.

3.2.7. Gen-N strategy

Gen-N (Generation Negative) is the flagship upstream arm of the National HIV Prevention Plan 2026-30. It targets the over 68 million adolescents and young people aged 10-24 who currently have little or no HIV risk and, through whole-of-society action, equips them with six

core internal values - self-respect, belonging, curiosity/interest, critical thinking, foresight and responsibility. The goal is not merely to delay sexual debut or increase condom use, but to create a cohort that never acquires HIV and carries those protective norms into adulthood, shrinking the future pipeline of new infections and sustaining the 90 % reduction target beyond 2030.

In practice, success means the cohort of 15-19-year-old women who today show an HIV prevalence of only 0.3 % and their male peers at 0.1 % will experience little or no rise when they reach today's peak age groups (women 35-39 years, 3.1 %; men 50-54 years, 2.3 %), flattening the national age-prevalence curve and sustaining the 90 % infection-reduction target well beyond 2030.

3.2.8. Whole-of-society action

Whole-of-society action is the deliberate coordination of every sector's ordinary business so that, together, they continuously grow young people's internal compass while keeping HIV prevention services within arm's reach. It moves beyond "health-sector outreach" to treat classrooms, markets, worship centres, sports fields, virtual platforms, factory floors and village meeting places as co-equal learning spaces for autonomy, competence and relatedness. The approach, therefore, turns every sector's core mandate into a HIV prevention platform, creating a mesh of reinforcing messages and opportunities that no single entity could replicate alone.

3.2.9. Harmonised school club curricula

Harmonised club curricula constitute the strategic backbone of Objective 1: a nationally standardised yet adaptable framework provided for each club genre. Every template embeds uniform minimum benchmarks - clear learning objectives, sequenced termly pathways and explicit integration of the six internal-compass values - while encouraging schools to enrich content with local context and innovation in fun and exciting ways. This balance guarantees nationwide equivalence of core competencies, allows students to move between schools without disadvantage, and safeguards quality without constraining institutional creativity.

The overall premise is that staying HIV-negative is a natural outcome when students enjoy acquiring real skills and feel confident.

3.2.10. Safeguarding

Safeguarding means creating and maintaining an environment where every adolescent and young person (10-24) can grow their internal compass without exposure to abuse, exploitation, harassment, or neglect. Because the plan reaches learners as young as 10, all adults who interact with them (teachers, mentors, faith leaders, private-sector volunteers

and others) must sign a code-of-conduct, and receive periodic refresher training on boundaries, power dynamics, and mandatory reporting. Developing the safeguards will involve the Federal Ministries of Education and Justice and the National Human Rights Commission. By embedding these safeguards, the plan ensures that the journey toward autonomy, competence and relatedness is itself safe and rights-based.

3.2.11. Holistic proactive development-based approach

The new prevention paradigm proposed in this plan that builds intrinsic motivation and resilience in young people before they encounter risk. This approach focuses on cultivating internal values (self-respect, belonging, curiosity, critical thinking, foresight, and responsibility) and life skills that empower adolescents and young people to make healthy choices autonomously. Rather than targeting specific risky behaviors, it develops the whole person through education, multi-sectoral collaboration, and supportive environments. The approach is "**proactive**" because it intervenes during the developmental years (ages 10-24) when young people have little or no current HIV risk, building their capacity to navigate future challenges safely. It is "**holistic**" because it addresses not just HIV prevention but overall wellbeing, recognizing that healthy, empowered young people are naturally more resilient to HIV and other life challenges.

3.2.12. Communication toolkits

To operationalise the shift from risk-reduction to values-based HIV prevention, a comprehensive communication toolkit serves as the primary vehicle for translating intrinsic motivation theory into practice and for providing accurate, age-appropriate health and HIV information. This framework ensures that the core values of self-respect, belonging, curiosity, critical thinking, foresight, and responsibility are effectively internalized by the target audiences and that they receive consistent health and HIV information. Interactive engagements are a particular priority. There are two, one focused on preventing future risk and the other focused on mitigating current risk. The toolkits are designed around four key components:

1. Audience-Specific Content

I. Preventing Future Risk: The content is curated to address the unique roles and psychological needs of the four primary population groups:

- a. Adolescents and Young People (AYP): Modules focused on fostering internal values, developing life skills (negotiation, self-discipline), and providing accurate health information to navigate life transitions.
- b. Guardians (Parents, Teachers, Faith Leaders): Resources on effective communication strategies, understanding adolescent development, and creating supportive, value-

aligned environments at home and in community institutions.

- c. Influencers (Radio, TV, Film, Music, and Social Media Personalities): Guidance on responsible storytelling, modeling positive behaviors, and leveraging their platforms to shift social norms toward health and responsibility.
- d. Political & Traditional Leaders: Briefs and advocacy materials focused on championing youth-friendly policies, mobilizing community support, and reinforcing the cultural relevance of the strategy.

The toolkit will cover relevant health, HIV, stigma, discrimination and related topics.

II. Mitigating Current Risk: The content will include modules on behaviour change, biomedical HIV prevention products, HIV testing, HIV treatment and harm reduction all aimed at reducing high risk behaviour, receiving early diagnosis, initiating treatment promptly and adhering to treatment. The content will be adapted for each of the high-risk groups: pregnant and breastfeeding women living with HIV (whose infants are at high risk of HIV infection); MSM, FSW, PWID, GBV survivors, and people with occupational exposure.

The content will cover STIs, stigma and discrimination, patient rights, and seeking redress.

2. Presentation and Material Formats

To accommodate diverse learning styles and literacy levels, the toolkit utilizes a multi-modal approach to presentation:

- a. Print Materials: Books, booklets, pamphlets, and posters for distribution in schools, health centers, and community spaces.
- b. Visual Aids: Infographics and flipcharts designed for different settings or quick reference during group discussions.
- c. Digital Media: Audio and video content for broadcast on radio/TV and for sharing via social media and e-learning platforms.

3. Delivery Formats: Print and Digital

The toolkit is developed in two primary formats to maximize accessibility:

- a. Print: Physical copies for environments with limited internet access, ensuring that schools, clinics, and religious centers have tangible resources.
- b. Digital: Interactive PDFs, e-learning modules, and multimedia content hosted on national and sub-national platforms (e.g., NACA e-learning, MDA platforms) to reach wider audiences and facilitate remote training.

4. Differentiated Opportunities for Engagement

Engagement with the toolkit content is not one-size-fits-all; it is differentiated to align with the interaction patterns of each stakeholder group:

- a. Adolescents and young people: Peer-to-peer learning, school club activities, and youth-led community dialogues.
- b. Guardians: Parent-teacher association (PTA) meetings, parenting workshops, and religious study groups.
- c. Influencers: Content creation workshops, campaign co-creation sessions, and media advocacy events.
- d. Leaders: Policy roundtables, town hall meetings, and executive briefings.

Operational Examples

The framework is applied differently depending on the sector and the specific stakeholders involved. A brief example using the education sector is presented below:

Secondary School Face-to-Face Engagement

In the education sector, the toolkit facilitates structured face-to-face interactions. For AYP, it is used during school assemblies to introduce high-level concepts and during classroom teaching, followed by deeper application in school clubs, where students engage in role-playing, debates, and project-based learning to practice the values. This creates a consistent ecosystem of support within the school environment.

Teacher Training (In-Service and Pre-Service Curriculum)

For teachers, the toolkit is integrated into both in-service training (continuous professional development) and pre-service curriculum (e.g. Colleges of Education). This ensures that incoming and existing teachers are not merely handed materials, but are trained to internalize and model the values themselves. The curriculum guides teachers on how to facilitate difficult conversations, identify students needing support, and effectively embed the health and wellbeing curriculum into their daily lesson plans.

Parent-Teacher Association Engagement

For parents and guardians, the toolkit transforms Parent-Teacher Association (PTA) meetings into forums for joint exploration. Leveraging the "Guidance for Guardians" modules, these sessions move beyond one-way updates to facilitate collaborative dialogue. Teachers and parents come together to share insights on adolescent development and co-create strategies for reinforcing the internal values curriculum. This partnership ensures a unified approach, where concepts like self-respect and foresight are nurtured consistently both in school and at home, empowering parents to support their children's journey through shared understanding rather than rigid instruction.

Section 4: Institutional Roles and Responsibilities

Describes who does what across government, civil society, private sector, and development partners to operationalise both objectives of the plan, ensuring coordinated, multi-sectoral delivery.

GENERATION NEGATIVE (GEN-N) STRATEGY

Self-Respect • Belonging • Curiosity • Critical Thinking • Foresight • Responsibility

4.1. Roles and Responsibilities

All stakeholders share fundamental responsibilities in Nigeria's HIV prevention response:

1. Aligning programmes with the National HIV Prevention Plan 2025-2030 objectives
2. Integrating HIV prevention into existing mandates and budgets
3. Participating in coordination mechanisms and fostering multi-sectoral collaboration at national and sub-national levels
4. Ensuring balanced access for all populations, including people with disabilities
5. Supporting school clubs
6. Promoting sustainability through resource mobilization and capacity building
7. Contributing to evidence generation through data collection and reporting

Each stakeholder is expected to **champion** values-based approaches that build intrinsic motivation while addressing current risks, **demonstrate** accountability through transparent reporting, and **advocate** for supportive policies within their spheres of influence. Success requires moving beyond siloed interventions to creating a cohesive ecosystem where every sector contributes unique strengths toward the shared goal of a 90% reduction in new HIV infections by 2030.

This section presents key stakeholders, however, the list is not exhaustive. Numerous other entities play vital roles in creating the comprehensive ecosystem needed for sustainable HIV prevention. All organizations and associations, regardless of size or formal recognition, are encouraged to identify how their core mandates can contribute to building youth autonomy, competence, and relatedness while ensuring access to HIV prevention information and services.

Table 4.1: Institutional Roles and Responsibilities

Institution	Role	Responsibilities
4.1.1. Coordination		
1 National Agency for the Control of AIDS (NACA)	To provide strategic leadership, coordination, and overall stewardship of the National HIV Prevention Plan to ensure a unified multi-sectoral response.	<ul style="list-style-type: none"> • Engage with MDAs, legislature, civil society, private sector to ensure shared understanding of, and commitment to the National HIV Prevention Plan. • Coordinate the operations of HIV prevention technical working groups and ensure linkages across all sectors to operationalise the dual-track approach. • Mobilise resources and engage with development partners and private sector, including NIBUCCA, to champion the plan as an investment case in human capital. • Oversee the development of guiding documents such as communication toolkits, school club curricula, and M&E frameworks, ensuring alignment with the internal compass paradigm. • Champion the biennial National HIV Prevention Conference as a “learning market” for sectors to trade successes and challenges in values-based programming and balanced commodity access.
4.1.2. Government Ministries, Departments and Agencies		
2 National AIDS, Viral Hepatitis, and STIs Control Programme, Federal Ministry of Health and Social Welfare	To ensure balanced access to high-impact biomedical interventions and managing the clinical aspects of the HIV response in collaboration with other programmes/units, departments and agencies in the ministry	<ul style="list-style-type: none"> • Maintain uninterrupted, stigma-free availability of the full prevention cascade (condoms, PrEP, PEP, EMTCT, HIV testing, and harm reduction) for key and general populations. • Integrate values-based, non-fear messaging into all patient contacts and provider curricula so clinical encounters reinforce self-respect, foresight, and responsibility. • Implement a total market approach for commodities to ensure balanced access to prevention tools across public and private sectors.
3 Federal Ministry of Education	To serve as the hub of the Generation Negative (Gen-N) strategy, weaving the “internal compass” into the fabric of daily school life to prevent future HIV risk.	<ul style="list-style-type: none"> • Oversee implementation of the civics education and health & well-being components of the curriculum and harmonized club curricula to ensure every school implements them. • Operationalize school clubs as platforms for building character and skills recognising that the number and type of clubs will vary from school to school. • Deploy parent, teacher (pre-service and in-service), and administrator communication toolkits to ensure guardians model the internal values. • Create and supervise safe school environments that support the holistic well-being of learners. • Reach out-of-school AYP through the structures and activities of the National Commission for Mass Literacy, Adult and Non-Formal Education
4 Federal Ministry of Youth Development	To empower adolescents and young people with agency and resilience by harnessing youth-focused structures for mentorship and development.	<ul style="list-style-type: none"> • Integrate the six internal values into all National Youth Service Corps (NYSC), youth centre, and digital youth programmes. • Deploy selected youth corps members as mentors to school clubs to transfer skills and build competence among student as part of their community development service. • Facilitate values-facilitator training for registered youth NGOs and certify organizations that complete the course. • Deploy AYP communication toolkits through youth hubs, online platforms, and holiday camps to reach out-of-school youth.

4.1.2. Government Ministries, Departments and Agencies

5	Federal Ministry of Women Affairs	To ensure gender-responsive interventions that protect girls and women from violence and empower them with the agency to make healthy life choices.	<ul style="list-style-type: none"> • Embed the six internal values into girls' empowerment, economic skills, and GBV prevention programmes, requiring documentation of sessions. • Maintain a confidential, toll-free reporting channel for gender-based violence and fast-track survivors to legal aid, PEP, and psychosocial support. • Advocate for policies that protect the rights of women and girls, ensuring they are not left behind in the Gen-N strategy.
6	Federal Ministry of Information and National Orientation & National Orientation Agency	To shape societal narratives and cultural norms that support the internal compass and counter stigma and discrimination through strategic communication.	<ul style="list-style-type: none"> • Integrate messaging from the communication toolkits into routine orientation campaigns and grassroots dialogues, presenting HIV prevention as responsible citizenship. • Partner with influencers in media and entertainment to model positive behaviors and responsible storytelling. • Collect and share audience feedback to refine messages and ensure they resonate with local sociocultural norms.
7	Federal Ministry of Arts, Culture, Tourism and the Creative Economy	To leverage the creative industries to model positive behaviors and embed the internal compass values in authentic cultural expression.	<ul style="list-style-type: none"> • Encourage artistic productions (film, music, theatre) that explicitly model the internal values. • Support school clubs related to arts and culture, providing expertise in specific skills. • Use cultural festivals and tourism platforms to celebrate and reinforce values that reduce HIV risk.
8	Federal Ministry of Justice and National Human Rights Commission	To protect the human rights of adolescents and key populations, creating a legal environment that reduces stigma and enables access to services.	<ul style="list-style-type: none"> • Ensure enforceable anti-stigma and anti-discrimination protections including access-to-justice mechanisms are operational making "friendly, respectful and compassionate" care a legal norm. • Maintain confidential hotlines for reporting stigma and rights violations • Facilitate access to legal aid for individuals who experience rights violations or barriers to services.
9	Federal Ministry of Power & Federal Ministry of Innovation, Science and Technology	To foster critical thinking, problem-solving, and innovation as components of the internal compass.	<ul style="list-style-type: none"> • Support STEM-related school clubs and club projects coordinating the collaborative efforts of private sector energy providers / electricity distribution companies. • Support students in school clubs to design solutions for community challenges to build both STEM skills and the internal compass.
10	Federal Ministry of Humanitarian Affairs and Poverty Alleviation	To facilitate and coordinate the integration of HIV prevention activities and service delivery within humanitarian responses	<ul style="list-style-type: none"> • In collaboration with the FMOHSW, NACA, the National Emergency Management Agency (NEMA), and the National Commission for Refugees, Migrants, and Internally Displaced Persons, ensure the delivery of a "minimum initial service package" for HIV prevention in emergencies and a more comprehensive HIV prevention program for internally displaced persons (IDPs), refugees, and host communities.
11	National Sports Commission	To promote physical health, discipline, and teamwork as vehicles for building internal values and resilience among young people.	<ul style="list-style-type: none"> • Certify coaches and sports associations that complete values-facilitator training to ensure they reinforce the internal compass. • Facilitate inter-school sports competitions that foster interest in healthy lifestyles and community bonding. • Ensure national sports events include messaging on the six internal values, leveraging athletes as role models.

4.1.2. Government Ministries, Departments and Agencies			
12	National Commission for Persons with Disabilities	To guarantee the inclusion of persons with disabilities by ensuring equitable access to adapted HIV prevention information and services.	<ul style="list-style-type: none"> Adapt the six internal-values communication toolkits into Braille, large print, easy-read, audio, visual, and sign-language formats. Train disability-literate values facilitators and ensure school clubs are inclusive of students with disabilities. Maintain a reporting line for disability-related stigma and fast-track legal redress for denied access to services.
13	National Agency for Food and Drug Administration and Control	To safeguard public health by ensuring the quality, safety, and efficacy of all HIV prevention commodities.	<ul style="list-style-type: none"> Register new HIV prevention commodities and conduct post-market surveillance to prevent the circulation of substandard products. Share adverse-event reports and commodity seizure data with NACA and NBS to enable rapid response.
14	Nigeria Customs Service	To facilitate the efficient importation of genuine HIV prevention commodities while preventing the entry of counterfeit products.	<ul style="list-style-type: none"> Fast-track customs clearance for condoms, PrEP, HIV test kits, and related consumables to prevent stock-outs. Transmit real-time quantity and value data to NACA and NBS for performance tracking and supply chain management. Conduct post-entry inspections to seize fake or expired products, protecting the integrity of the prevention program.
15	National Drug Law Enforcement Agency (NDLEA)	To balance drug control with public health by ensuring harm reduction services are accessible and integrating substance abuse prevention with life-skills education.	<ul style="list-style-type: none"> Integrate internal-values sessions into all NDLEA outreach and rehabilitation programmes, linking drug-free choices to an HIV-free future. Ensure drug-policy enforcement does not create barriers to accessing HIV prevention information, clean needles, or harm reduction services. Support expansion of harm reduction services.
16	Nigeria Police Force & Nigeria Security and Civil Defence Corp	To provide a secure and enabling environment for HIV prevention by protecting the rights of vulnerable populations and upholding the rule of law.	<ul style="list-style-type: none"> Protect adolescents, young people, and key populations from harassment, violence, and arbitrary arrest related to their health-seeking behaviors. Train officers to eliminate stigma and ensure law enforcement activities do not obstruct access to health facilities or youth clubs. Maintain confidential hotlines for reporting stigma and rights violations
17	Nigeria Correctional Services	To promote holistic rehabilitation and public health within custodial settings by integrating character development with access to essential biomedical interventions.	<ul style="list-style-type: none"> Implement the Generation Negative (Gen-N) strategy within correctional facilities to cultivate the internal compass among inmates as part of rehabilitation and reintegration. Ensure access to HIV testing and treatment within correctional centers.
18	Ministry of Defence	To safeguard the health and operational readiness of armed forces personnel through the promotion of internal values and the provision of comprehensive HIV prevention services.	<ul style="list-style-type: none"> Integrate the internal compass curriculum (focusing on self-respect, foresight, and responsibility) into military training establishments. Ensure the consistent availability of Post-Exposure Prophylaxis (PEP) for occupational exposure and other biomedical HIV prevention tools for personnel and families. Support youth mentorship programs to build resilience and discipline in the broader population.
19	National Bureau of Statistics	To provide robust, high-quality data and statistical analysis to monitor progress and inform evidence-based decision-making for the HIV response.	<ul style="list-style-type: none"> Embed selected HIV prevention and internal-compass indicators into routine annual surveys to enable frequent performance tracking. Support mathematics and statistics school clubs to foster analytical competence and data literacy among students.

4.1.2. Government Ministries, Departments and Agencies			
20	National Assembly	To provide the legislative framework, budgetary appropriation, and oversight necessary to institutionalize the paradigm shift and ensure the sustainable implementation of the dual-track HIV prevention strategy.	<ul style="list-style-type: none"> • Enact annual appropriation bills that allocate adequate domestic resources for the Generation Negative (Gen-N) strategy, especially, for MDAs and mitigating current risk of HIV. • Champion the "internal compass" values in public discourse and constituency projects, utilizing legislative influence to mobilise community support for the whole-of-society approach.
21	State Governments, State Assemblies, State Ministries, Departments and Agencies and Local Government Authorities	To adapt and implement the National HIV Prevention Plan at the sub-national level, ensuring that strategies are contextualized to local realities.	<ul style="list-style-type: none"> • Adapt and fund state-specific costed plans that embed the six internal values in state curricula and broadcasting. • Establish functional state multi-sectoral HIV-prevention technical working groups to review workplans and budget performance quarterly. • Transform community spaces into living classrooms for character development while ensuring community-level access to HIV prevention commodities.
4.1.3. Traditional Councils, Civil Society, Faith-Based and Community-Based Organizations			
22	Traditional Councils	To leverage cultural authority and community influence to anchor the "internal compass" values within local norms, fostering a supportive environment for the Generation Negative strategy.	<ul style="list-style-type: none"> • Facilitate the documentation of local sociocultural norms and ensure that community-based interventions are culturally adapted, respectful, and contextually relevant. • Promote sociocultural norms that foster the holistic wellbeing of adolescents and young people. • Mobilise community support for school clubs and youth activities, using traditional platforms (festivals, town halls) to reinforce internal values.
23	Networks / Associations of People Living with HIV	To utilize lived experience to champion the internal compass values and advocate for the rights and needs of people living with HIV.	<ul style="list-style-type: none"> • Train peer-leaders to deliver values-based testimonies in school clubs and youth hubs, modeling resilience and responsibility. • Integrate communication toolkits into peer-outreach sessions to provide accurate information on biomedical prevention tools. • Advocate for the elimination of stigma and discrimination in health care and community settings.
24	Civil Society and Faith-Based Organizations	To bridge the gap between policy and community by delivering grassroots interventions that build resilience and facilitate access to services.	<ul style="list-style-type: none"> • Deliver the six internal-values curriculum in non-school settings (youth hubs, faith venues, online platforms) using certified facilitators. • Integrate communication toolkits into community outreach and provide rapid referral to health services.
4.1.4. Private Sector Partners			
25	Private Sector and Philanthropic Organisations	To drive economic investment in human capital and support the operationalization of the plan.	<ul style="list-style-type: none"> • Adopt and support school clubs through corporate social responsibility initiatives and employee volunteering. • Integrate workplace HIV prevention programs that focus on employee well-being and the internal compass. • Provide technical expertise and funding for inter-school club competitions and community festivals. • Fund operational research and the development of innovative tools for measuring internal values and behavior change. • Co-invest in the local manufacturing of HIV prevention commodities, such as condoms, to ensure sustainable supply.

4.1.5. Academic and Research Institutions			
26	Academic and Research Institutions	To generate critical evidence, validate intervention tools, and train the next generation of experts to support the HIV prevention agenda.	<ul style="list-style-type: none"> • Support the development of modules for communication toolkits and the NACA e-learning platform. • Participate in the research agenda development, conduct studies, and validate measurement instruments for the Gen-N strategy. • Embed internal-compass and HIV-prevention modules into tertiary curricula and supervise student theses on values-based HIV prevention.
4.1.6. Development Partners (Multilateral, Bilateral Agencies & International NGOs)			
27	Development Partners (Multilateral, Bilateral Agencies & International NGOs)	To provide technical assistance and financial resources that align with national priorities and strengthen the capacity of government and civil society.	<ul style="list-style-type: none"> • Provide technical and financial resources that support the paradigm shift from disease-focused to development-based HIV prevention. • Ensure complementary support that strengthens health and education systems for immediate service delivery and long-term resilience building. • Support South-South learning exchanges to share innovations and lessons in values-based HIV prevention.

Section 5: Workplan, Performance Monitoring, and Budget

Details the five-year implementation roadmap, including annual activities, indicator-based monitoring, and budgeted resources required to track and achieve the 2030 targets.

GENERATION NEGATIVE (GEN-N) STRATEGY

Self-Respect • Belonging • Curiosity • Critical Thinking • Foresight • Responsibility

5.1. Workplan

The workplan translates the strategic objectives of the National HIV Prevention Plan into a concrete operational roadmap, detailing the specific activities required to execute the dual-track approach of preventing future risk and mitigating current risk. It provides a comprehensive matrix of actions, timelines, and responsible stakeholders for the Generation Negative strategy, biomedical interventions, and system strengthening efforts. By clearly defining the implementation steps for all relevant sectors—from education to health—this workplan ensures the coordinated accountability and resource allocation necessary to achieve a 90% reduction in new HIV infections by 2030. The plan is based on the activities in Section 1.3 and the institutional roles and responsibilities in Section 4.1. While a lead institution is identified for each activity, all stakeholders are represented in the workplan consistent with the whole-of-society approach

Table 5.1: Workplan

No.	Activity	Description / Scope	2026		2027		2028	2029	2030	Lead Institution(s)
			S1	S2	S1	S2				
1.3.1	Ensure that evidence to inform action is up to date									
1.3.1.1	Conduct studies (surveys and modelling) to update the country context									
1.3.1.1a	Conduct Integrated Bio-Behavioural Surveillance Survey (IBBSS)	Execute the IBBSS to capture up-to-date bio-behavioural data among key populations.	X							NACA
1.3.1.1b	Conduct HIV Stigma Index	Measure and track trends in stigma and discrimination against people living with HIV.	X							NEPWHAN
1.3.1.1c	Conduct HIV Incidence Pattern Modelling	Model incidence patterns to understand where new infections are occurring.					X	X		NACA
1.3.1.1d	Conduct NASA	Assess spending on the HIV response, proportion spent of prevention and sources of funding (domestic versus external) with disaggregation of sources of domestic funding.								NACA
1.3.1.1e	Conduct Cost-effectiveness Analysis	Analyze the cost-effectiveness of various HIV prevention tools and strategies.	X							NACA
1.3.1.1f	Conduct Drug Use Survey	Carry out surveys to understand drug use patterns and implications for HIV risk.	X							FMHSW
1.3.1.1g	Conduct HIV prevention self assessments	Conduct HIV prevention self assessments at national and state levels			X					NACA, SACA
1.3.1.1h	Document sociocultural norms	Document sociocultural norms nationwide by LGA and autonomous community to inform the development of the communication toolkits and other HIV prevention programming	X							NACA, FMACTCE
1.3.1.1i	Embed indicators in existing routine surveys	Incorporate select HIV prevention into routine annual NBS surveys to enable frequent tracking.	X							NBS, NACA
1.3.1.1j	Conduct AIDS Impact and Indicator Survey and Demographic and Health Survey	Survey covers incidence, HIV prevention outcome, including, internal compass, STIs, discrimination`					X	X		NACA

No.	Activity	Description / Scope	2026		2027		2028	2029	2030	Lead Institution(s)
			S1	S2	S1	S2				
1.3.1.2 Conduct operational research to further characterise and understand needs and barriers										
1.3.1.2a	Develop and operationalise research agenda	Develop and operationalise a comprehensive operational research agenda for HIV prevention	X	X	X	X	X	X	X	NACA
1.3.1.2b	Explore perceptions, experiences, and preferences	Explore perceptions, experiences, and preferences of the four population groups as they relate to the education, health, and development of AYP, and HIV		X						NACA
1.3.1.2c	Examine risk assessment tools	Examine the validity and reliability of risk assessment tools applied to adolescent girls and young women for HIV testing	X							NACA
1.3.1.2d	Examine consistency of “Hotspots”	Examine the consistency and validity of the term hotspots in HIV prevention programming	X							NACA
1.3.1.3 Conduct evaluations										
1.3.1.3a	Evaluate HIV Self-Testing	Conduct evaluation of HIV self-testing programs.		X						NASCP
1.3.1.3b	Evaluate Needle and Syringe Programme	Conduct evaluation of the Needle and Syringe Programme (NSP).	X							FMHSW
1.3.1.3c	Evaluate Medication-Assisted Treatment/Opioid Substitution Therapy	Conduct evaluation of the Medication-Assisted Treatment/Opioid Substitution Therapy		X						NACA/FMHSW
1.3.1.3d	Evaluate PrEP	Conduct evaluation of Pre-exposure prophylaxis (PrEP) delivery and uptake.		X						NASCP
1.3.1.3e	Evaluate EMTCT Programme	Conduct evaluation of the Elimination of Mother-to-Child Transmission (EMTCT) programme.	X							NASCP

No.	Activity	Description / Scope	2026		2027		2028	2029	2030	Lead Institution(s)
			S1	S2	S1	S2				
1.3.2	Operationalize strategies to prevent future risk and mitigate current risk									
1.3.2.1	Prevent future risk of HIV infection									
1.3.2.1.1	Communication to Empower and Support AYP									
1.3.2.1.1a	Develop comprehensive communication toolkits	The toolkits are for communication with AYP, parents, teachers, religious leaders, influencers, and politicians.		X						NACA
1.3.2.1.1b	Develop modules on NACA e-learning platform based on the contents of the communication toolkits (general)	The modules cover all four population groups and also tailored for use by different stakeholders (government, civil society, and private sector)		X						NACA
1.3.2.1.1c	Develop modules on NACA e-learning platform based on the contents of the communication toolkits (trainers)	The modules cover all four population groups and also tailored for use by different stakeholders (government, civil society, and private sector) to train their master trainers		X						NACA
1.3.2.1.1d	Develop teacher and student resources for the health and wellbeing curriculum	The resources will draw from the AYP component of the communication toolkits and will articulate teaching and learning materials for each of the grades from 7 to 12		X						FME, NACA
1.3.2.1.1e	Adapt communication toolkits for people with disability	Adapt toolkits into Braille, sign language, easy-read, audio, visual with closed caption and other formats for people with disability			X					NCPWD, NACA
1.3.2.1.1f	Conduct master training for focal points	Master training for focal points across stakeholders on the communication toolkits.		X	X					NACA
1.3.2.1.1g	Conduct master training disability-literate facilitators	Master training for disability-literate facilitators covering multiple disabilities			X					NCPWD, NACA
1.3.2.1.1h	Deploy the communication toolkits for use nationwide	All stakeholders use the toolkits through their existing structures and mechanisms		X	X	X	X	X	X	All stakeholders
1.3.2.1.2	Multi-sectoral Action to Empower and Support AYP									
1.3.2.1.2a	Map existing school clubs	Identify and describe existing clubs in secondary schools nationwide	X							FME
1.3.2.1.2b	Develop harmonised curriculum for each school club	A standard basic curriculum for each school club with club-specific components and harmonized internal compass components	X	X						FME, NACA

No.	Activity	Description / Scope	2026		2027		2028	2029	2030	Lead Institution(s)
			S1	S2	S1	S2				
1.3.2.1.2c	Develop handbooks for each school club	Comprehensive handbooks for each club on how the clubs run, operationalizing the club curriculum	X	X						FME, NACA
1.3.2.1.2d	Develop handbook for school administrators	Handbook describing the oversight, management, monitoring and safeguarding of clubs	X	X						FME, NACA
1.3.2.1.2e	Orientation / training for schools	Orientation / training for school administrators, teachers and parents on the harmonised club curricula		X						FME
1.3.2.1.2f	Mobilise support for clubs (public & private)	Advocacy and engagement with MDAs, civil society and private sector on supporting school clubs		X	X	X	X	X	X	NACA
1.3.2.1.2g	Inter-school club competitions	Organize inter-school club competitions at LGA, state and national levels			X	X	X	X	X	FME
1.3.2.2 Mitigate current risk of HIV infection										
1.3.2.2.1 Communication on Behaviour Change and Availability of Biomedical HIV Prevention Tools										
1.3.2.2.1a	Develop a comprehensive communication toolkits for population with current risk of HIV	The toolkits are for pregnant & breastfeeding women, key populations & individuals in general population at high risk		X						NASCP, NACA
1.3.2.2.1b	Adapt communication toolkits for people with disability	Adapt toolkits into Braille, sign language, easy-read, audio, visual with closed caption and other formats for people with disability			X					NCPWD, NASCP
1.3.2.2.1c	Develop modules on NACA e-learning platform based on the contents of the communication toolkits (general)	Modules are tailored for each of the high-risk groups		X						NASCP, NACA
1.3.2.2.1d	Develop modules on NACA e-learning platform based on the contents of the communication toolkits (trainers)	Modules are for master trainers		X						NASCP, NACA
1.3.2.2.1e	Conduct master training disability-literate facilitators	Master training for disability-literate facilitators covering multiple disabilities			X					NCPWD, NASCP
1.3.2.2.1f	Deploy the risk-group communication toolkits for use nationwide	Service providers use the communication toolkits nationwide		X	X	X	X	X	X	All service providers

No.	Activity	Description / Scope	2026		2027		2028	2029	2030	Lead Institution(s)
			S1	S2	S1	S2				
1.3.2.2.2 Total Market Approach for Biomedical HIV Prevention Tools										
1.3.2.2.2a	Continue provision of full cascade of EMTCT services for women who receive antenatal care	Routine provision of EMTCT services during antenatal care provided by formal and informal providers	X	X	X	X	X	X	X	NASCP, FMHSW
1.3.2.2.2b	Develop and operationalise plan to extend ANC and PMTCT to women who do not receive antenatal care	Develop protocols for engaging communities in states with low ANC coverage leading to provision of ANC and EMTCT services in those communities	X	X	X	X	X	X	X	FMHSW, NASCP, NACA
1.3.2.2.2c	Facilitate total market approach to condoms & PrEP supply	Develop and operationalise a total market approach action plan		X	X	X	X	X	X	NASCP
1.3.2.2.2d	Advocate for local manufacturing of condoms	Advocate and engage with government, PVAC and private sector	X	X	X	X	X	X	X	NACA
1.3.2.2.2e	Conduct feasibility study and develop investment case for local manufacturing of condoms	Detail the feasibility of local manufacturing of condoms and develop detailed investment case		X	X					NACA
1.3.2.2.2f	Scale up harm reduction services	Expand access to harm reduction services beyond current limited availability	X	X	X	X	X	X	X	FMHSW, NDLEA
1.3.2.2.2g	Develop / update PEP protocols (occupational & GBV)	Review and update existing protocols and disseminate to service providers		X						NASCP
1.3.3 Strengthen coordination, sustain capacity and mobilise resources										
1.3.3.1 Coordinate and foster multi-sectoral collaboration, oversight and management of the HIV prevention response										
1.3.3.1a	Support TWG operations (national & state)	National & state prevention TWG meetings quarterly	X	X	X	X	X	X	X	NACA, SACA
1.3.3.1b	Biennial National HIV Prevention Conference	Organize national HIV prevention conference every two years		X			X			NACA
1.3.3.1c	Develop costed state HIV prevention plans	Support states to adapt costed state-specific operational plans aligning with the national strategy.		X						SACA

No.	Activity	Description / Scope	2026		2027		2028	2029	2030	Lead Institution(s)
			S1	S2	S1	S2				
1.3.3.2 Strengthen and maintain capacity for leadership, coordination, oversight, and management of the HIV prevention response										
1.3.3.2a	Develop and deploy full Moodle e-learning curriculum	Curriculum and detailed content cover competencies in the job descriptions of NACA, SACA and other MDA staff at national and state levels. Enrol staff		X	X					NACA
1.3.3.2b	Establish mentoring programme	Develop and run a mentoring programme for young public health professionals.	X	X	X	X	X	X	X	NACA
1.3.3.3 Strengthen HIV prevention programme monitoring and evaluation										
1.3.3.3a	Validate internal value measurement tools	Develop and validate tools to measure changes in internal values (self-respect, belonging, etc.).	X	X						NACA, Academic & Research Institutions
1.3.3.3b	Update NACA, NEMIS & NASCP reporting platforms	Incorporate all indicators in performance monitoring framework into the relevant reporting platforms and provide access to relevant stakeholders to report on their indicators	X							NACA
1.3.3.3c	Publish Annual Report of HIV Prevention Performance	Publish Annual Report of HIV Prevention Performance		X		X	X	X	X	NACA
1.3.3.3d	Evaluate HIV prevention programme	Evaluate HIV prevention programme					X			NACA
1.3.3.4 Mobilise resources										
1.3.3.4a	Organise MDA and private sector forum on HIV prevention	Work with MDAs and the private sector to identify existing structures and resources for implementation.	X	X	X	X	X	X	X	NACA
1.3.3.4b	Organise FBO and CSO forums on HIV prevention	Meeting with FBO and CSO to explore opportunities for implementation within existing mechanisms and activities. Meet with FBO separately given their unique context.	X	X	X	X	X	X	X	NACA
1.3.3.4c	Develop and maintain a database of funding opportunities.	Develop and maintain a database of funding opportunities.	X	X	X	X	X	X	X	NACA
1.3.3.4d	Develop funding proposals to fill gaps and expand on the plan as needed.	Develop funding proposals to fill gaps and expand on the plan as needed.	X	X	X	X	X	X	X	NACA, All stakeholders
1.3.3.4e	Promote HIV plan as an investment case	Engage with NIBUCCA to champion this HIV prevention plan as an investment case	X	X	X	X	X	X	X	NACA, NIBUCAA

No.	Activity	Description / Scope	2026		2027		2028	2029	2030	Lead Institution(s)
			S1	S2	S1	S2				
1.3.3.5	Workplan and budget									
1.3.3.5a	Review progress with work plan implementation & budget performance	Review progress with work plan implementation & budget performance	X	X	X	X	X	X	X	NACA

5.2. Performance Monitoring

The performance monitoring framework establishes a comprehensive system for tracking progress towards the 90% reduction target, ensuring accountability and evidence-based management of the national response. This section outlines key performance indicators, data sources, and reporting frequencies that capture the impact of both the Generation Negative strategy, specifically monitoring shifts in internal values, and the continued mitigation of current risks. By aligning measurement metrics with the activities in the workplan, this framework enables stakeholders to evaluate effectiveness, guide adaptive programming, and ensure that the paradigm shift yields the desired sustainable outcomes. Baselines and targets will be set as part of a national target setting exercise in 2026.

Table 5.2: Performance monitoring framework

No.	Indicator	Disaggregation	Standard Tool / Data Source	Frequency	Reporting institutions	Baseline (Year)	Targets					Notes
							2026	2027	2028	2029	2030	
A	IMPACT											
A1	Goal: 90% reduction in new HIV infections by 2030											
A1.1	Number of new HIV infections	Age: 0-14, 15+ Sex: Male, Female	Spectrum	Annual	NACA							
A1.2	Number of new HIV infections per 1,000 uninfected population (adults and children).	Age: 15-24, 25-34, 35-44, 45+ Sex: Male, Female	NAIIS	Every 10 years	NACA							
A1.3	Percentage reduction in new HIV infections compared to 2010		Spectrum	Annual	NACA							
A1.4	Percentage of infants born to HIV-positive mothers who acquire HIV (Final MTCT rate).	Level: National, State	Spectrum, Programme data, Special survey	Annual	NACA, NASCP							
A1.5	HIV prevalence	Age: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+ Sex: Male, Female Population: General, FSW, MSM, PWID	NAIIS, IBBSS	Every 5-10 years	NACA							
B	OUTCOMES											
B1	Obj 1: Prevent Future Risk											
B1	To empower adolescents and young people with agency to make choices that promote their holistic wellbeing, thereby building resilience to prevent HIV infection throughout their lives											
B1.1	Mean Basic Psychological Needs Satisfaction (BPNS) Score	Age: 10-14, 15-19 Sex: Male, Female Population: Secondary school students	NEMIS, School Survey	Annual	FME							
B1.2	Mean Consideration of Future Consequences (CFC) Score	Age: 10-14, 15-19 Sex: Male, Female Population: Secondary school students	NEMIS, School Survey	Annual	FME							

No.	Indicator	Disaggregation	Standard Tool / Data Source	Frequency	Reporting institutions	Baseline (Year)	Targets					Notes
							2026	2027	2028	2029	2030	
B1.3	Percentage of young women and men 15-24 with comprehensive knowledge of HIV	Age: 15-19, 20-24 Sex: Male, Female Population: General	DHS	Every 5 years	FMHSW, NBS							
B1.4	Percentage of young women and men 15-24 with correct knowledge of health consequences of STIs	Age: 15-19, 20-24 Sex: Male, Female Population: General	DHS	Every 5 years	FMHSW, NBS							
B1.5	Percentage of never-married adolescents and young women and men aged 15–24 who report never having had sexual intercourse	Age: 15-17, 18-19, 20-22, 23-24 Sex: Male, Female Population: General	DHS	Every 5 years	FMHSW, NBS							
B1.6	Median age of sexual debut among adolescents 15-19	Age: 15-19 Sex: Male, Female Population: General	DHS	Every 5 years	FMHSW, NBS							
B2	Obj 2: Mitigate Current Risk To mitigate current HIV risk by ensuring balanced access to targeted interventions and values-based social behavioural change across key and general populations											
B2.1	Percentage of adults (15-49) reporting condom use during last sexual intercourse with a person who was neither their spouse nor lived with them	Age: 15-19, 20-24, 25-29, 30-39, 40-49, 50+ Sex: Male, Female Population: General	DHS	Every 5 years	FMHSW, NBS							
B2.2	Percentage of key populations who reported using a condom every time during sex in the past 6 months	Age: 15-24, 25+ Type of partner: Client, Casual, Regular Population: FSW, MSM, PWID (Male, Female)	IBBSS	Every 5 years	NACA							
B2.3	Percentage of men and women who ever had sexual intercourse reporting having an STI and/or symptoms of an STI in the last 12 months	Age: 15-19, 20-24, 25-29, 30-39, 40-49, 50+ Sex: Male, Female Population: General, FSW, MSM, PWID (Male, Female)	DHS, IBBSS	Every 5 years	FMHSW, NBS, NACA							

No.	Indicator	Disaggregation	Standard Tool / Data Source	Frequency	Reporting institutions	Baseline (Year)	Targets					Notes
							2026	2027	2028	2029	2030	
B2.4	Percentage of men and women who reported having an STI and/or symptoms of an STI in the last 12 months who did not seek treatment	Age: 15-19, 20-24, 25-29, 30-39, 40-49, 50+ Sex: Male, Female Population: General, FSW, MSM, PWID (Male, Female)	DHS, IBBSS	Every 5 years	FMHSW, NBS, NACA							
B2.5	Percentage of PrEP clients retained on PrEP at 12 months	Age: 15-24, 25+ Population: FSW, MSM, PWID (Male, Female), Serodiscordant couples PrEP formulation: Oral, Injection Discontinuation: Planned (stopped because risk ended), Loss to Follow-Up (Missed appointments without documented cessation)	Programme data	Annual	NASCP							
B2.6	Retention on ART at 12 months postpartum among breastfeeding women living with HIV	Level: National, State	Programme data	Annual	NASCP							
B2.7	Testing and treatment cascade	Age: 0-14, 15+. Sex: Male, Female. Population: General, Key Populations (MSM, FSW, PWID), Pregnant/Breastfeeding Women. Administrative Level: National, State.	Spectrum, Programme data	Annual	NACA, NASCP							

No.	Indicator	Disaggregation	Standard Tool / Data Source	Frequency	Reporting institutions	Baseline (Year)	Targets					Notes
							2026	2027	2028	2029	2030	
B3	Stigma and discrimination											
B3.1	Percentage of men and women who had discriminatory attitudes towards people living with HIV	Age: 15-19, 20-24, 25-29, 30-39, 40-49, 50+ Sex: Male, Female Population: General	DHS	Every 5 years	FMHSW, NBS							
B3.2	Percentage of PLHIV who experienced stigma	Age: 15-24, 25+ Sex: Male, Female Setting: Community, Health Care	DHS, Stigma Index Survey	Every 5 years	FMHSW, NBS, NEPWAN							
C	OUTPUTS											
C1	Obj 1: Prevent Future Risk Focus: Creating the tools, platforms, and environments to build the Internal Compass.											
C1.1	Number of standardised communication toolkits (for AYP, Parents, Teachers, Religious Leaders, Influencers, Traditional Leaders, and Politicians) produced and distributed to implementation partners.	Population: AYP, Parents, Teachers, Religious Leaders, Influencers, Traditional Leaders, and Politicians Format: Print, Digital, Audio-Visual	Programme data	Quarterly	NACA							
C1.2	Number of frontline implementers (AYP, Parents, Teachers, Religious Leaders, Influencers, Traditional Leaders, and Politicians) trained in using the Gen-N communication toolkit.	Role: Teacher, Parent, Religious Leader, Influencer, Politician Influencer Platform: Radio/TV, Film, Music, Social Media Administrative Level: 36 States + FCT	Programme data	Quarterly	NACA							
C1.3	Percentage of secondary schools that have rules and guidelines for staff and students related to physical safety, stigma and discrimination, and sexual harassment and abuse that have been communicated to relevant stakeholders	Administrative Level: 36 States + FCT. Location: Urban, Rural Ownership: Public, Private Type of rule/guideline: Physical safety, Stigma and discrimination, Sexual harassment and abuse.	NEMIS	Annual	FME							

No.	Indicator	Disaggregation	Standard Tool / Data Source	Frequency	Reporting institutions	Baseline (Year)	Targets					Notes
							2026	2027	2028	2029	2030	
C1.4	Percentage of secondary schools that delivered the health and well-being curriculum in the previous academic year	Administrative Level: 36 States + FCT. Location: Urban, Rural Ownership: Public, Private	NEMIS	Annual	FME							
C1.5	Percentage of secondary schools that provided an orientation process for parents or guardians of students on the health and well-being curriculum in the previous academic year	Administrative Level: 36 States + FCT. Location: Urban, Rural Ownership: Public, Private	NEMIS	Annual	FME							
C1.6	Percentage of secondary schools with teachers who received training, and also taught lessons based on the health and well-being curriculum in the previous academic year	Administrative Level: 36 States + FCT. Location: Urban, Rural Ownership: Public, Private	NEMIS	Annual	FME							
C1.7	Number of secondary school students who received lessons based on the health and well-being curriculum in the previous academic year.	Administrative Level: 36 States + FCT. Location: Urban, Rural Ownership: Public, Private	NEMIS	Annual	FME							
C1.8	Number of Gen-N curriculum modules uploaded to the NACA Moodle platform and accessible to the public.	Modules: Foundational Content for AYP, Guidance for Guardians, Resources for Influencers, Resources for Political and Traditional Leaders.	Programme data	Quarterly	NACA							
C1.9	Number of distinct harmonized curricula and club handbooks developed for specific club categories (e.g., Drama, Science, Sports, Debate).	Club Type: Drama, Science, Sports, Debate, Innovation etc. Format: Physical Handbook, Digital (pdf, audiovisual).	Programme data	Quarterly	NACA, FME							

No.	Indicator	Disaggregation	Standard Tool / Data Source	Frequency	Reporting institutions	Baseline (Year)	Targets					Notes
							2026	2027	2028	2029	2030	
C1.10	Number of secondary schools with active, functional Gen-N clubs. <i>Stakeholders report on the schools and clubs they support</i>	Administrative Level: 36 States + FCT. Location: Urban, Rural. School Ownership: Public, Private.	NEMIS	Annual	FME							
C1.11	Number of secondary schools with Youth Corpers deployed to support Gen-N clubs in secondary schools	Administrative Level: 36 States + FCT. Location: Urban, Rural. School Ownership: Public, Private. Club Type: Specific Club supported.	NEMIS, NYSC Programme data	Annual	FME, NYSC							
C1.12	Number of secondary schools receiving mentorship for Gen-N clubs	Administrative Level: 36 States + FCT. Location: Urban, Rural. School Ownership: Public, Private. Club Type: Specific Club supported. Mentor: MDA, Civil Society, Private Sector	NEMIS, All stakeholders	Annual	FME, All stakeholders							
C1.13	Number of states organizing inter-school club competitions.	Administrative Level: List of States. Schools: Number of schools involved (Urban, Rural). Club Type: Number and type (Debate, Sports, Drama, Science etc).	Programme data	Annual	NACA, FME, FMYD, National Sports Commission							
C1.14	Number of community events/meetings held to dialogue on the contents of the communication toolkit with members of the four population groups. <i>Stakeholders report on the dialogues they engaged in.</i>	Audience: AYP, Parents, Religious Leaders, Influencers, Traditional Leaders, Politicians. Administrative Level: State, LGA.	Programme data	Quarterly	NACA, FMYD, NOA, Civil Society, Faith-Based Organisations, All stakeholders							

No.	Indicator	Disaggregation	Standard Tool / Data Source	Frequency	Reporting institutions	Baseline (Year)	Targets					Notes
							2026	2027	2028	2029	2030	
C2	Obj 2: Mitigate Current Risk											
	Focus: Delivering biomedical and behavioral services to those currently at risk.											
C2.1	Number of targeted communication campaigns launched for key populations and high-risk general population.	Target Group: FSW, MSM, PWID, High-risk general population. Channel: Radio, TV, Social Media, Outdoor. Administrative Level: State, LGA	Programme data	Quarterly	All relevant stakeholders							
C2.2	Number of public and private health facilities certified as providing adolescent-friendly and KP-friendly HIV prevention services.	Facility Ownership: Public, Private (For profit, NGO, FBO). Level of care: Primary, Secondary, Tertiary. Focus: Adolescent-Friendly, KP-Friendly. Administrative Level: 36 States + FCT.	Programme data	Annual	NACA							
C2.3	Total number of male and female condoms imported	Type: Male, Female. TMA Segment: Commercial, Social Marketing, Public.	Import data	Biannual	NCS, NAFDAC							
C2.4	Number of facilities with established PEP protocols and drug stocks, including for GBV survivors	Facility Ownership: Public, Private (For profit, NGO, FBO). Level of Care: Primary, Secondary, Tertiary. Focus: GBV Centers, General Clinics/Wards.	Programme data	Annual	NASCP							
C2.5	Number of states with operational harm reduction services	Service Type: NSP only, OST only, Both.	Programme data	Biannual	FMHSW							
C2.6	Number of PWID participating in needle and syringe programme	Age: 15-24, 25+. Sex: Male, Female. Administrative Level: 36 States + FCT.	Programme data	Quarterly	FMHSW							

No.	Indicator	Disaggregation	Standard Tool / Data Source	Frequency	Reporting institutions	Baseline (Year)	Targets					Notes
							2026	2027	2028	2029	2030	
C2.7	Number of reports on rights violations and gender-based violence received through hotlines	Subject: Stigma, discrimination, denial of services, GBV Stakeholder platform: National Human Rights Commission, Federal Ministry of Women Affairs, Police, Civil Defence	Programme data	Quarterly	NHRC, FMWA, Police, Civil Defence							
C3	Enabling Environment Focus: Generating evidence, mobilizing resources, and managing the system.											
C3.1	Number of critical surveys and modelling conducted (e.g., IBBSS, Stigma Index, Drug Use Survey, HIV Incidence Modelling).	Survey Type: IBBSS, Stigma Index, Cost-effectiveness, NAIS, etc.	Programme data	Biannual	NACA							
C3.2	Number of operational research studies completed	Topic: AYP Risk Assessment, Sociocultural Norms, Service Access, etc	Programme data	Biannual	NACA							
C3.3	Number of LGAs/Communities with documented sociocultural norms mapped for program adaptation.	Administrative Level: 36 States + FCT. LGA.	Programme data	Biannual	NACA							
C3.4	Number of functional Technical Working Groups (TWGs) at National and State levels meeting quarterly or biannually.	Administrative Level: National, State. Type: Prevention, EMTCT, Harm Reduction.	Programme data	Biannual	NACA, SACA							
C3.5	Number of states with costed HIV prevention workplans	Funding Source: Domestic, Donor, Mixed.	Programme data	Annual	NACA, SACA							
C3.6	Amount of funding (in Naira and USD) mobilised from domestic (state/federal budgets) and private sector partners	Source: Federal Government, State Government, Private Sector, Foundations. Currency: Naira, USD (to enable comparison with external funding).	NASA	Every 3 years	NACA							

5.3. Budget

The budget summarised in Table 5.3 allocates NGN 297.5 billion over five years to operationalise the National HIV Prevention Plan 2026-2030. Excluding commodities, the budget is front-loaded to provide greater resources in the initial two years to establish robust institutional foundations. This early investment finances critical evidence generation activities, the development of comprehensive communication toolkits for all population groups, the creation of harmonised school club curricula and handbooks, and the deployment of the NACA e-learning platform. Efficiency and long-term sustainability are achieved by leveraging the existing systems, structures and human resources of Ministries, Departments and Agencies (MDAs) alongside civil society organisations for implementation, rather than erecting temporary, project-oriented parallel structures that dissipate when external funding concludes.

The major cost items are the AIDS Indicator Impact Survey scheduled for 2029 (18.6%) and commodities for current risk mitigation: condoms (37.2%), test kits for EMTCT (23.2%) and PrEP (14.8%). In keeping with the Total Market Approach, the condom allocation covers the public sector contribution of approximately 30-35% of national condom requirements, to be complemented by commercial and social marketing channels. This represents a substantial increase compared to previous expenditure reported in the NASA and is critical not only for HIV prevention but also for curbing the marked three-to-four-fold rise in sexually transmitted infections (STIs) observed recently in the general population, which ARV-based prevention such as PrEP cannot address. The PrEP budget is calibrated to current targets linked to available and projected resources from international sources, ensuring realistic coverage for key populations.

The budget for the elimination of mother-to-child transmission of HIV, syphilis and hepatitis B (EMTCT) services focuses on procuring test kits and facilitating extension of antenatal care services to pregnant women who do not currently receive such care in the twenty states with the lowest antenatal coverage, addressing a critical gap in vertical transmission prevention.

A defining feature of this budget is the provision for rigorous evidence generation through surveys, evaluations, operational research and strengthening reporting systems. A major cost element is the allocation for the AIDS Indicator Impact Survey scheduled for 2029. Beyond standard epidemiological indicators, this survey will specifically explore the reach and measurable effects of the values-based programming under Objective 1 and the biomedical and behavioural interventions under Objective 2, providing the empirical basis for strategic adjustments and long-term sustainability planning.

Overall, this budget diverges from patterns seen in previous National AIDS Spending Assessments (NASA) by amplifying basic prevention and catering for the general population amid funding constraints, positioning Nigeria for sustainable, domestically driven progress toward zero new infections by 2030 through collaborative, cost-effective action.

Table 5.3: Budget Summary

		48,083,347,700	47,615,032,062	48,705,765,099	104,108,745,099	49,023,855,099	297,536,745,058
Total NGN							
Less condoms & PrEP		19,635,070,000	17,278,560,000	16,683,870,000	72,086,850,000	17,001,960,000	142,686,310,000
Less condoms, PrEP & PMTCT tests		5,805,070,000	3,448,560,000	2,853,870,000	58,256,850,000	3,171,960,000	73,536,310,000
Workplan Ref. No.	Workplan Activity Group & Sub -group	2026	2027	2028	2029	2030	Total
1.3.1.	Ensure that evidence to inform action is up to date	2,440,445,000	462,770,000	379,790,000	55,851,920,000	490,430,000	59,625,355,000
1.3.1.1	Conduct studies (surveys & modelling) to update the country context	1,830,015,000	41,490,000	179,790,000	55,430,640,000	179,790,000	57,661,725,000
1.3.1.2	Conduct operational research to further characterise and understand needs and barriers	389,150,000	200,000,000	200,000,000	200,000,000	200,000,000	1,189,150,000
1.3.1.3	Conduct evaluations of components of the HIV prevention programme	221,280,000	221,280,000	0	221,280,000	110,640,000	774,480,000
1.3.2.	Operationalize strategies to prevent future risk and mitigate current risk	44,893,742,700	46,665,872,062	47,922,565,099	47,922,565,099	47,922,565,099	235,327,310,058
1.3.2.1.	Prevent future risk of HIV infection	1,453,745,000	1,448,320,000	1,116,400,000	1,116,400,000	1,116,400,000	6,251,265,000
1.3.2.1.1	Communication to Empower & Support AYP	1,106,400,000	1,037,250,000	968,100,000	968,100,000	968,100,000	5,047,950,000
1.3.2.1.2	Multi-sectoral Action to Empower & Support AYP	347,345,000	411,070,000	148,300,000	148,300,000	148,300,000	1,203,315,000
1.3.2.2	Mitigate current risk of HIV infection	43,439,997,700	45,217,552,062	46,806,165,099	46,806,165,099	46,806,165,099	229,076,045,058
1.3.2.2.1	Communication on Behaviour Change and Availability of Biomedical HIV Prevention Tools	553,200,000	484,050,000	484,050,000	484,050,000	484,050,000	2,489,400,000
1.3.2.2.2	Total Market Approach for Biomedical HIV Prevention Tools	42,886,797,700	44,733,502,062	46,322,115,099	46,322,115,099	46,322,115,099	226,586,645,058
1.3.3	Strengthen coordination, sustain capacity and mobilise resources	749,160,000	486,390,000	403,410,000	334,260,000	610,860,000	2,584,080,000
1.3.3.1	Coordinate and foster multi-sectoral collaboration, oversight and management of the HIV prevention response	276,600,000	69,150,000	138,300,000	69,150,000	138,300,000	691,500,000
1.3.3.2	Strengthen and maintain capacity for leadership, coordination, oversight, and management of the HIV prevention response	138,300,000	138,300,000	69,150,000	69,150,000	69,150,000	484,050,000
1.3.3.3	Strengthen HIV prevention programme monitoring and evaluation	179,790,000	124,470,000	41,490,000	41,490,000	248,940,000	636,180,000
1.3.3.4	Mobilise resources	126,810,000	126,810,000	126,810,000	126,810,000	126,810,000	634,050,000
1.3.3.5	Workplan and budget	27,660,000	27,660,000	27,660,000	27,660,000	27,660,000	138,300,000

Annexes

Annex 1: Hierarchy of Internal Values

This hierarchy arranges the six values in a sequence that mirrors natural human development, illustrating how they relate to one another. By structuring teaching and measurement in this step-by-step order, the values are deeply internalized and interconnected, ensuring genuine understanding rather than simple memorization.

1. Self-Respect: The Foundation

- a) Simple Logic: "I matter." Before a young person can care about others or the future, they must value themselves.
- b) Why it comes first: Without self-worth, young people are vulnerable to peer pressure and risky behaviors just to feel accepted. This builds the inner strength to say "no."

2. Belonging: The Safety Net

- a) Simple Logic: "I am safe and connected." Once they value themselves, they need to feel securely connected to others (family, school, faith).
- b) Why it comes second: A safe environment gives them the confidence to explore, ask questions, and make mistakes without fear of being rejected.

3. Curiosity: The Spark

- a) Simple Logic: "I want to learn." Feeling safe allows their natural desire to explore the world to wake up.
- b) The Guardrail (The 3-Filter Gate): Curiosity is channeled through a safety check before action. Before acting on an impulse, the young person asks: (1) Is it Legal? (2) Is it Reversible? (3) Can I tell my Mentor? If the answer to all three is "Yes," it is a green-light to explore. This teaches them to filter their own impulses using a self-correction algorithm. This satisfies curiosity safely through logic, rather than suppressing it through fear (e.g. Don't do that).
- c) Why it comes third: Curiosity turns a passive student into an active learner. It drives them to seek knowledge because they want to, not because they are told to.

4. Critical-Thinking: The Filter

- a) Simple Logic: "I can think for myself." Curiosity provides the fuel; critical thinking provides the steering wheel.
- b) Why it comes fourth: This equips them to analyze the information they find. It helps them question myths, resist manipulation, and make choices that align with the self-respect they built in Step 1.

5. Foresight: The View

- a) Simple Logic: "I look ahead." Using their critical thinking, they can now see how today's actions affect tomorrow.
- b) Why it comes fifth: This is where the "Internal Compass" really points forward. It allows them to delay gratification (a key skill in HIV prevention) because they can visualize and value their future self.

6. Responsibility: The Action

- a) Simple Logic: "I own my choices." Because they value themselves (1), feel connected to a group (2), and understand the future (5), they can now be held accountable.
- b) Why it comes last: This is the final integration. A responsible young person doesn't just follow rules; they autonomously choose to protect their health and their community because they understand the stakes.

Sequence logic: Start inside (valuing the self), connect to safe others (finding support), add the drive to learn (curiosity), add the tools to judge (critical thinking), extend the view to the future (foresight), and finally take ownership of the impact (responsibility).

Annex 2: Questions and Answers

This Annex presents ten critical questions and answers formulated to provide clarity on the strategic intention and direction of the National HIV Prevention Plan 2026-2030. As the plan outlines a massive paradigm shift, transitioning from a reactive, risk-based model to a proactive, whole-of-society approach, this section anticipates and addresses the most pressing inquiries regarding its implementation. It explores the complexities of the dual-track strategy, the specific roles of various sectors, the inclusion of vulnerable populations, and the mechanisms for sustainability. By rigorously examining these key issues, this annex serves as a vital resource for stakeholders, ensuring a shared understanding of how Nigeria will operationalise this vision to reduce new infections by 90% by 2030.

1. The plan requires continuous, interactive engagement with adolescents and young people (10-24 years) week-to-week over several years, both in and out-of-school. How will the massive human resource requirements for this sustained interaction be met at a national scale?

Answer: Implementation is designed to be embedded in the routine activities of existing stakeholders rather than creating a new parallel workforce. The plan leverages the established roles of teachers in schools, parents and guardians at home, religious leaders in faith settings, youth corps members (NYSC) through mentorship programs, and community youth groups. The National Orientation Agency (NOA) will utilize its extensive grassroots network. These stakeholders will be supported by resource aids—such as communication toolkits, club handbooks, and curriculum modules—delivered through a variety of formats (face-to-face, traditional media, digital assets, and new media). This approach maximizes reach by utilizing existing delivery mechanisms and interpersonal touchpoints that are already part of the daily lives of young people.

2. Does the paradigm shift mean abandoning those currently at risk, such as key populations?

Answer: No, the paradigm shift does not mean abandoning current at-risk groups. As outlined in Section 1.1 and Section 1.2.4.2, the plan represents an expansion of the prevention reach. It moves beyond targeting only those currently considered "at risk" (key populations and infants of pregnant/breastfeeding women living with HIV) to encompass the entire population. The strategy conceptualizes keeping those with no or little risk (adolescents and young people) protected as they grow older, thereby locking in low prevalence. Simultaneously, Objective 2 explicitly maintains and scales up essential interventions such as testing, treatment, PrEP, condoms, and harm reduction, for key populations and others currently at risk, operating as a dual-track approach to address both immediate and future risks.

3. Given that major donors (like PEPFAR and the Global Fund) are historically invested in the "risk-based" and "hotspot" models, how will Nigeria align its request for funding with this new strategic direction?

Answer: Nigeria is positioning this plan as a "sustainability and transition" blueprint. While acknowledging the continued need for donor support in managing current risk (Objective 2), the country is advocating for domestic and international investment in human capital development (Objective 1) as a long-term cost-saving measure. The "investment case" argument presented in the plan is designed to show donors that investing in the Gen-N strategy reduces the future burden of treatment, which donors ultimately fund. The plan advocates for a re-alignment of existing grant cycles to include "structural and values-based interventions" as allowable interventions, moving beyond purely biomedical outputs.

4. The plan challenges the reliance on "risk profiling." Given that data shows common risk assumptions (e.g., regarding education, wealth, or marital status) often fail to predict infection, does this approach effectively address the complexities of the general population where the majority of infections occur?

Answer: The plan argues that traditional risk profiling is insufficient because sociocultural norms shape behavior in ways that standard risk categories do not capture. For instance, evidence indicates that people with lower education or in polygynous unions can sometimes have lower HIV prevalence than expected based on prevailing assumptions about risk. The new approach shifts focus from targeting isolated "high-risk" subgroups to addressing the general population, where 89% of new adult infections occur (Section 2.1). By fostering internal values across the whole population, the plan addresses the diffuse nature of the epidemic and builds resilience in a way that reactive, risk-based models could not.

5. Who defines the content of the "six internal values," and what mechanisms are in place to ensure this curriculum does not become a vehicle for moralistic or religious conservatism that contradicts public health science?

Answer: While the plan respects cultural and religious diversity, the teaching approach is strictly rooted in Self-Determination Theory (SDT), a validated psychological framework, rather than religious or moral dogma. The development of the health and wellbeing curriculum and club toolkits (Action 1.3.2.1) will be led by technical experts in education and psychology, in collaboration with the Federal Ministry of Education and NACA. The curriculum will include accurate biological and health information (e.g., how HIV is transmitted, how PrEP works) alongside the values modules, ensuring that students are empowered with facts.

6. Is the Education sector now the "lead" for HIV prevention, and does this focus exclude out-of-school youth?

Answer: There is no single "lead" sector for the HIV prevention response; rather, it is a whole-of-society effort where every sector contributes based on its mandate and comparative

advantage. As detailed in Section 4 (Institutional Roles and Responsibilities) and operationalised in the Workplan (Section 5), the plan involves all sectors of government and society.

The plan includes out-of-school youth who are reached through a variety of face-to-face, media, and digital platforms. Furthermore, it is not limited to adolescents and young people (AYP), specifically extending to guardians, influencers, and traditional and political leaders as key audiences. These stakeholders are required to make changes in their own conduct and speech to create an enabling environment. By modeling these values, they provide the necessary support for AYP to exercise their agency towards achieving holistic well-being.

While the multisectoral action component of Objective 1 utilizes schools to reach in-school youth, the communication component ensures that these messages extend to everyone in the society through existing face-to-face opportunities such as small and large group meetings, religious gatherings, and both offline and online media platforms. Objective 2 reaches every one currently at-risk.

7. The communication strategy prioritizes face-to-face interaction due to current low media reach. However, Nigeria's digital penetration is growing rapidly. Is the plan adaptable to a future where the internet is the primary channel for youth?

Answer: Yes. The strategy prioritizes face-to-face interaction based on current data showing less than 40% media access weekly. However, the plan explicitly states that face-to-face interactions will occur “alongside the delivery of content through various traditional and new media platforms” (Section 1.2.4.1.1). Furthermore, the communication toolkits provide for content in digital formats and disseminated through digital platforms on the internet.

8. How is the success of the paradigm shift defined, and what happens if the intended changes are not realized?

Answer: It is important to note that the paradigm shift does not exclude the current-risk model; rather, it integrates it as part of a comprehensive dual-track strategy. Therefore, “failure” is not defined by a choice between two models, but by the overall impact on new infections and value adoption. The plan has a 5-year cycle (2026-2030). Success will be measured through specific indicators tracking both outputs (e.g., club participation, PWID participating in needle and syringe programmes), outcomes (e.g., internalization of values, increase in condom use and reduction in adverse outcomes such as sexually transmitted infections) and impact (reduction in new HIV infections). A full review of impact, outcomes, and outputs is scheduled for 2030. At that time, decisions regarding the future direction of the HIV prevention response will be taken based on the evidence gathered, allowing for flexible and informed next steps rather than a predetermined pathway.

9. How will the plan address potential resistance from state governments or local communities regarding the introduction of health and well-being education, particularly concerning sensitive topics?

Answer: The plan anticipates this by ensuring that content is framed within the context of character development and the "internal compass" (self-respect, belonging, curiosity, critical thinking, foresight, responsibility) rather than as isolated "sexuality education." Discussions regarding sex are introduced in an age-appropriate manner and at the right time within the broader health and well-being curriculum. To ensure cultural alignment, the plan mandates the documentation of sociocultural norms nationwide by Local Government Area and autonomous community (Action 1.3.1.1). This data will inform the development of communication toolkits that respect local values. Additionally, the strategy prioritizes early engagement with "Guardians" (parents, teachers, religious leaders), and traditional leaders to secure community ownership and support before implementation reaches scale.

10. Given the shrinking landscape of international donor funding, how does this plan ensure the financial sustainability of the HIV response?

Answer: The plan ensures financial sustainability by shifting HIV prevention from a "vertical health programme" dependent on external aid to a "horizontal development priority" funded through domestic budgets. By framing the "internal compass" values (self-respect, belonging, curiosity, critical thinking, foresight, responsibility) as essential life skills for national development, the plan aligns with the core mandates of other ministries, departments and agencies. This allows it to access and leverage existing federal and state budgets for Education (curriculum and clubs), Youth (mentorship and development), and Information (public enlightenment) and others rather than relying solely on the health budget. Furthermore, by integrating these activities into routine government functions, such as school systems and the NYSC scheme, the plan reduces the need for expensive, parallel implementation structures, ensuring the response continues regardless of international donor trends.

Annex 3: Indicator Dictionary

This Indicator Dictionary serves as the definitive technical reference for the monitoring and evaluation of the National HIV Prevention Plan 2025-2030. It provides standardised definitions, calculation methodologies, and data sources for every indicator listed in Section 5.2 (Performance Monitoring), ensuring consistent and comparable data collection across all states and implementing partners.

Designed to capture the full scope of the plan's paradigm shift, the dictionary details indicators not only for traditional epidemiological outcomes but also for the novel metrics required to track the Generation Negative (Gen-N) strategy, such as internal values and psychological well-being. By clarifying numerators, denominators, and disaggregation requirements for Impact, Outcome, and Output levels, this dictionary equips stakeholders at the national, state, and LGA levels with the precise tools needed to accurately measure progress toward the goal of a 90% reduction in new HIV infections by 2030.

Group A: IMPACT**Component Description****Indicator Name A1.1 Number of new HIV infections**

Definition	The estimated number of individuals newly infected with HIV during the reporting year.
Numerator	Estimated number of new HIV infections.
Denominator	Not Applicable.
Data Source	Spectrum Age: 0-14, 15+.
Disaggregation	Sex: Male, Female. Population: General. Ultimate Goal: This is the primary measure of the plan’s success. The goal is a 90% reduction by 2030 (Section 1.2.1).
Rationale	Plan Alignment: Aligns with the strategic shift from “chasing the epidemic” to “outrunning it” by measuring the actual decline in infections.

Indicator Name A1.2 Number of new HIV infections per 1,000 uninfected population (adults and children)

Definition	The HIV incidence rate, calculated as the number of new HIV infections per 1,000 uninfected population in a year.
Numerator	Estimated number of new HIV infections.
Denominator	Estimated number of uninfected population (Total population minus People Living with HIV).
Data Source	National Population-based Surveys (NAIIS)
Disaggregation	Age: 15-24, 25-34, 35-44, 45+. Sex: Male, Female. Population: General. Standardization: Allows for comparison over time regardless of population size changes. It highlights the intensity of the epidemic transmission.
Rationale	Plan Alignment: Helps measure the impact of the prevention strategies (Gen-N and Biomedical) across different demographic groups.

Indicator Name A1.3 Percentage reduction in new HIV infections compared to 2010

Definition	The percentage decrease in the estimated number of new HIV infections in the current year relative to the baseline year of 2010.
Numerator	(Number of new HIV infections in 2010 – Number of new HIV infections in current year).
Denominator	Number of new HIV infections in 2010.
Data Source	Calculation based on Spectrum Estimates of new HIV infections in 2010 and current year
Disaggregation	Sex: Male, Female.

Component	Description
Rationale	<p>Population: Adults, Children.</p> <p>Target Measurement: Directly tracks the specific goal of the plan: “90% reduction... by 2030” (Section 1.2.1). It serves as the headline metric for national progress.</p> <p>Plan Alignment: The plan notes that a 68% reduction has already occurred but the 81% target for 2024 was missed; this indicator keeps the focus on the ambitious 2030 target.</p>
Indicator Name	A1.4 Percentage of infants born to HIV-positive mothers who acquire HIV (Final MTCT rate)
Definition	The estimated percentage of infants born to women living with HIV who acquire HIV during pregnancy, delivery, or breastfeeding (up to 18 months post-partum).
Numerator	Estimated number of infants born to HIV -positive mothers who acquire HIV.
Denominator	Estimated number of infants born to HIV -positive mothers.
Data Source	Spectrum / Programme data / Special survey
Disaggregation	<p>Administrative Level: National, State</p> <p>Ethical Imperative: Elimination of vertical transmission is a priority (Section 1.2.4.2).</p>
Rationale	Plan Alignment: Tracks the outcome of Action 1.3.2.2.2 regarding access to EMTCT services.
Indicator Name	A1.5 HIV prevalence
Definition	The percentage of people living with HIV (PLHIV) among the total population.
Numerator	Estimated number of people living with HIV.
Denominator	Total estimated population.
Data Source	National Population-based Surveys (NAIS)
Disaggregation	<p>Age: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50+.</p> <p>Sex: Male, Female.</p> <p>Administrative Level : National, State.</p> <p>Population : General, FSW, MSM, PWID.</p> <p>Epidemic Burden: While incidence measures new infections, prevalence measures the total burden of disease requiring treatment (as prevention) and care.</p>
Rationale	Plan Alignment: It measures long term success of the paradigm shift in the plan. Adolescents and young people with no risk (HIV-free) or little risk (very low prevalence) maintain this status as they grow older (Gen -N) such that the current rising prevalence with age no longer occurs.

Group B: OUTCOMES**B1 - Objective 1: Prevent Future Risk****Component Description**

Indicator Name	B1.1 Mean Basic Psychological Needs Satisfaction (BPNS) Score
Definition	The average score of adolescents and young people (10-24) on a validated scale measuring Autonomy, Competence, and Relatedness (Self Determination Theory).
Numerator	Sum of BPNS scores of survey respondents (AYP).
Denominator	Total number of AYP respondents.
Data Source	School survey using tool developed in Work Plan Action 1.3.3.3
Disaggregation	Age: 10-14, 15-19. Sex: Male, Female. Population: Secondary school students. Paradigm Shift: This is the core metric for the “Internal Compass” strategy (Section 1.2.4.1). It measures the intrinsic motivation required for the Generation Negative approach. Specific internal values covered are Self-Respect, Belonging and Curiosity.
Rationale	Plan Alignment: Directly responds to Action 1.3.3.3 which requires tools to measure changes in these specific internal values.

Indicator Name	B1.2 Mean Consideration of Future Consequences (CFC) Score
Definition	The average score of adolescents and young people (10-24) on a validated scale measuring the extent to which they consider the potential future outcomes of their current behaviours (involves Foresight, Responsibility, Critical Thinking).
Numerator	Sum of CFC scores of survey respondents.
Denominator	Total number of AYP respondents.
Data Source	School survey using tool developed in Work Plan Action 1.3.3.3
Disaggregation	Age: 10-14, 15-19. Sex: Male, Female. Population: Secondary school students. Paradigm shift: This indicator measures the ability of AYP to project into the future, a critical skill for avoiding HIV risk by taking paths away from the cliff.
Rationale	Plan Alignment: Directly responds to Action 1.3.3.3 which requires tools to measure changes in these specific internal values.

Indicator Name	B1.3 Percentage of young women and men 15-24 with comprehensive knowledge of HIV
Definition	The percentage of young people who correctly identify the two major

Component	Description
	ways of preventing the sexual transmission of HIV and reject three common misconceptions about HIV transmission.
Numerator	Number of young women/men 15-24 with comprehensive HIV knowledge.
Denominator	Number of young women/men 15-24 surveyed.
Data Source	National Population-based Surveys (DHS / NAHS)
Disaggregation	Age: 15-19, 20-24. Sex: Male, Female. Population: General. Foundation of Action: While the plan moves beyond “information only,” knowledge remains the foundation. The text notes a decline in knowledge (Figure 7) which needs to be reversed.
Rationale	Plan Alignment: Measures the outcome of the Communication Strategy (Section 1.2.4.1.1) and the Health and Wellbeing curriculum.
Indicator Name	B1.4 Percentage of young women and men 15 -24 with correct knowledge of health consequences of STIs
Definition	The percentage of young people who know that untreated STIs can have serious health consequences, such as infertility.
Numerator	Number of young women/men 15-24 with correct STI knowledge.
Denominator	Number of young women/men 15-24 surveyed.
Data Source	National Population-based Survey (DHS)
Disaggregation	Age: 15-19, 20-24. Sex: Male, Female. Holistic Wellbeing: The plan emphasizes holistic wellbeing (Section 1.2.4.1). Understanding STIs prevents co-factors that increase HIV transmission risk.
Rationale	Plan Alignment: Supports the communication strategy regarding STI awareness and treatment seeking behavior.
Indicator Name	B1.5 Percentage of never -married adolescents and young women and men aged 15 –24 who report never having had sexual intercourse
Definition	The percentage of never-married adolescents and young people who have never had sexual intercourse (Pre-marital abstinence).
Numerator	Number of never-married AYP 15-24 who report never having sex.
Denominator	Number of never-married AYP 15-24 surveyed.
Data Source	National Population-based Survey (DHS)
Disaggregation	Age: 15-17, 18-19, 20-22, 23-24. Sex: Male, Female. Protective Factor: The situational analysis highlights that abstinence plays a much larger role in protecting AYP than generally appreciated (Section 2.1). Gen-N aims to sustain this resilience.

Component	Description
Rationale	Plan Alignment: Measures the success of the valuesbased approach in delaying sexual debut until youth are equipped with the “internal compass” to navigate safely.
Indicator Name	B1.6 Median age of sexual debut among adolescents 15-19
Definition	The age at which half of the adolescents aged 15-19 have had sexual intercourse for the first time.
Numerator	N/A (Demographic calculation).
Denominator	N/A (Demographic calculation).
Data Source	National Population-based Survey (DHS)
Disaggregation	Sex: Male, Female. Population: General. Timing of Risk: A higher median age indicates delayed sexual activity. This is a proxy for the success of the strategy to keep young people “away from the cliff” while they develop resilience.
Rationale	Plan Alignment: Correlates with the findings that adolescents have the lowest incidence (Section 2.1). Keeping the age high supports the Gen-N goal.

B2 - Objective 2: Mitigate Current Risk

Component	Description
Indicator Name	B2.1 Percentage of adults (15-49) reporting condom use during last sexual intercourse with a person who was neither their spouse nor lived with them
Definition	The percentage of respondents who reported using a condom the last time they had sex with a non-cohabiting, non-marital partner.
Numerator	Number of respondents who used a condom at last sex with a non-spouse, non-cohabiting partner.
Denominator	Number of respondents who had sex with a non-spouse, non-cohabiting partner in the last 12 months.
Data Source	National Population-based Survey (DHS)
Disaggregation	Age: 15-19, 20-24, 25-29, 30-39, 40-49, 50+ Sex: Male, Female. Population: General. Blocking the Bridge: Individuals in the general population who have sexual partners outside of marriage or cohabitation act as a potential “bridge” for HIV transmission. This indicator measures whether they are using condoms to block that transmission path during bridging encounters.
Rationale	Plan Alignment: Measures the outcome of the “Total Market Approach”

Component	Description
	for condoms (Section 1.2.4.2.2), ensuring protection is used during high - risk encounters within the general population.
Indicator Name	B2.2 Percentage of key populations who reported using a condom every time during sex in the past 6 months
Definition	The percentage of Key Population (KP) members who report consistent condom use (100% of sexual acts) in the last 6 months.
Numerator	Number of KP members reporting consistent condom use in the last 6 months.
Denominator	Total number of KP members surveyed.
Data Source	Integrated Bio-Behavioural Surveillance Survey (IBBSS).
Disaggregation	Age: 15-24, 25+. Population: FSW, MSM, PWID (Male, Female). Type of partner: Client, Casual, Regular. High-Risk Reduction: Consistent use is critical for KPs who have high prevalence compared to the general population. The text notes inconsistent use (e.g., 27% for PWID) is a challenge.
Rationale	Plan Alignment: Tracks the effectiveness of biomedical and behavioral interventions for KPs (Section 1.2.4.2).
Indicator Name	B2.3 Percentage of men and women who ever had sexual intercourse reporting having an STI and/or symptoms of an STI in the last 12 months
Definition	The percentage of sexually active respondents reporting an STI diagnosis or symptoms in the last year.
Numerator	Number of respondents reporting STI diagnosis/symptoms in last 12 months.
Denominator	Number of respondents who ever had sexual intercourse.
Data Source	National Population-based Survey (DHS)
Disaggregation	Age: 15-19, 20-24, 25-29, 30-39, 40-49, 50+. Sex: Male, Female. Population: General. Risk Behavior Proxy: STIs are a biological marker of unprotected sex and HIV transmission risk. The plan notes a 3-4 fold increase in reported STIs.
Rationale	Plan Alignment: Indicates the need for the Communication strategy (1.3.2.2.1) on STI prevention and treatment.
Indicator Name	B2.4 Percentage of men and women who reported having an STI and/or symptoms of an STI in the last 12 months who did not seek treatment
Definition	The percentage of respondents with an STI/symptoms who did not seek advice or treatment from a medical professional.

Component	Description
Numerator	Number of respondents with STI/symptoms who did not seek treatment.
Denominator	Number of respondents reporting STI/symptoms in last 12 months.
Data Source	National Population-based Survey (DHS)
Disaggregation	Age: 15-19, 20-24, 25-29, 30-39, 40-49, 50+. Sex: Male, Female. Population: General. Health Seeking Behavior: High percentages of untreated STIs (23% men, 40% women) indicate gaps in service uptake.
Rationale	Plan Alignment: Indicates the need for the Communication strategy (1.3.2.2.1) on STI prevention and treatment.
Indicator Name	B2.5 Percentage of PrEP clients retained on PrEP at 12 months
Definition	The percentage of clients who initiated Pre-Exposure Prophylaxis (PrEP) in a defined cohort who are still documented as active (receiving refills/injections) 12 months after initiation.
Numerator	Number of clients who initiated PrEP 12 months ago and have had at least one documented refill/injection within the last defined dosing period of the 12-month mark.
Denominator	Total number of clients who initiated PrEP 12 months ago.
Data Source	Programme data
Disaggregation	Age: 15-24, 25+. Population : FSW, MSM, PWID (Male, Female), Serodiscordant couples. PrEP formulation: Oral, Injection. Discontinuation: Planned (stopped because risk ended), Loss to Follow-Up (Missed appointments without documented cessation). Similarity to ART: Just as viral suppression is impossible without ART adherence, HIV prevention via PrEP is impossible without retention.
Rationale	Plan Alignment: The plan emphasizes a “Total Market Approach” for PrEP (Section 2.4.2.2). Tracking retention helps differentiate between clients who truly discontinue because they are no longer at risk (valid discontinuation) versus those who drop out of care for any reason while still at risk (invalid loss).
Indicator Name	B2.6 Retention on ART at 12 months postpartum among breastfeeding women living with HIV
Definition	The percentage of breastfeeding women living with HIV who initiated ART during pregnancy or childbirth and are still on ART 12 months after delivery.
Numerator	Number of women on ART 12 months postpartum.
Denominator	Number of women who initiated ART 12 months prior.
Data Source	Programme data

Component	Description
Disaggregation	Administrative Level: National, State Preventing Transmission: Retention ensures viral suppression, preventing transmission to the infant and partners. It supports the health of the mother.
Rationale	Plan Alignment: Part of the “Mitigate Current Risk” objective, specifically for maternal health and EMTCT.
Indicator Name	B2.7 Testing and treatment cascade
Definition	The percentage of people living with HIV (PLHIV) who: <ol style="list-style-type: none"> 1. Know their HIV status 2. Are receiving antiretroviral therapy (ART) 3. Have suppressed viral loads
Numerator	<ol style="list-style-type: none"> 1. Number of PLHIV who know their HIV status 2. Number of PLHIV who are receiving ART 3. Number of PLHIV who have suppressed viral loads
Denominator	Number of PLHIV
Data Source	Spectrum, Programme data
Disaggregation	Age: 0-14, 15+. Sex: Male, Female. Population: General, Key Populations (MSM, FSW, PWID), Pregnant/Breastfeeding Women. Administrative Level: National, State. Ultimate Goal: Viral suppression eliminates the risk of sexual transmission (Undetectable = Untransmittable). Achieving these targets is a critical driver for the 90% reduction in new infections by 2030, ensuring that those currently living with HIV do not transmit the virus to others.
Rationale	Plan Alignment: Supports Objective 2 of this Plan to mitigate current risk for infants, key populations, and the general population, while contributing to the overall reduction of new infections.

B3 - Stigma and discrimination

Component	Description
Indicator Name	B3.1 Percentage of men and women who had discriminatory attitudes towards people living with HIV
Definition	The percentage of respondents who report having discriminatory attitudes (e.g., would not buy vegetables from a PLHIV, would not allow children to attend school with a PLHIV).
Numerator	Number of respondents expressing at least one discriminatory attitude.
Denominator	Total number of respondents.
Data Source	National Population-based Survey (DHS), Stigma Index
Disaggregation	Age: 15-19, 20-24, 25-29, 30-39, 40-49, 50+ Sex: Male, Female

Component	Description
	<p>Population: General</p> <p>Social Enabler: Stigma is a barrier to testing and treatment. The Foreword highlights buying dignity, not just drugs. High stigma (59-67%) currently exists.</p>
Rationale	Plan Alignment: The plan uses communication (Section 1.3.2.1) to change norms; this indicator tracks that shift.
Indicator Name	B3.2 Percentage of PLHIV who experienced stigma
Definition	The percentage of people living with HIV who report experiencing specific forms of stigma (e.g., verbal abuse, gossip, denied healthcare) in the last 12 months.
Numerator	Number of PLHIV reporting at least one stigma experience.
Denominator	Total number of PLHIV surveyed.
Data Source	National Population-based Survey (DHS), Stigma Index
Disaggregation	<p>Age: 15-24, 25+</p> <p>Sex: Male, Female</p> <p>Setting: Community, Health Care</p> <p>Lived Experience: Complements B3.1. It measures the actual environment PLHIV navigate, affecting their mental health and adherence.</p>
Rationale	Plan Alignment: Validates the plan’s commitment to “buying dignity”..

Group C: OUTPUTS

C1 - Objective 1: Prevent Future Risk (Gen-N)

Component	Description
Indicator Name	C1.1 Number of standardised communication toolkits (for AYP, Parents, Teachers, Religious Leaders, Influencers, Traditional Leaders, and Politicians) produced and distributed to implementation partners.
Definition	The count of distinct, standardised Gen-N communication toolkits (for AYP, Parents, Teachers, Religious Leaders, Influencers, Traditional Leaders, and Politicians) produced and disseminated to implementing partners.
Numerator	Number of toolkits produced and distributed.
Denominator	Not Applicable.
Data Source	Programme data.
Disaggregation	<p>Traditional Leaders, and Politicians.</p> <p>Format: Print, Digital, Audio-Visual.</p> <p>Foundation of Communication: Action 1.3.2.1.1 mandates the development of these toolkits. Without them, the standardised message of the “Internal Compass” cannot be disseminated.</p>
Rationale	Plan Alignment: Directly measures the output of the communication strategy.

Component	Description
Indicator Name	C1.2 Number of frontline implementers trained in using the Gen-N communication toolkit
Definition	The number of individuals (teachers, parents, religious leaders, influencers) trained via Training of Trainers (TOT) to deliver the Gen-N content.
Numerator	Number of individuals trained.
Denominator	Not Applicable.
Data Source	Programme data
Disaggregation	Role: Teacher, Parent, Religious Leader, Influencer. Politician Influencer Platform: Radio/TV, Film, Music, Social Media Administrative Level: 36 States + FCT. Capacity Building: A toolkit is useless without trained personnel. This measures the scaling of the human resource capacity to “empower AYP.”
Rationale	Plan Alignment: Measures the output of Action 1.3.2.1.1 (Orientation/training).
Indicator Name	C1.3 Percentage of secondary schools that have rules and guidelines for staff and students related to physical safety, stigma and discrimination, and sexual harassment and abuse that have been communicated to relevant stakeholders
Definition	The percentage of secondary schools that have established written rules and guidelines regarding physical safety, stigma and discrimination, and sexual harassment and abuse, and have actively communicated these rules to students, staff, and relevant stakeholders.
Numerator	Number of secondary schools that have established and communicated rules/guidelines regarding physical safety, stigma/discrimination, and sexual harassment/abuse.
Denominator	Total number of secondary schools.
Data Source	NEMIS
Disaggregation	Administrative Level: 36 States + FCT. Location: Urban, Rural. Ownership: Public, Private. Type of rule/guideline: Physical safety, Stigma and discrimination, Sexual harassment and abuse. Safe Learning Environment: A safe and non-discriminatory environment is a prerequisite for Adolescents and Young People (AYP) to engage with the health and wellbeing curriculum. Rules against stigma and harassment protect the psychological safety needed for AYP to internalize the strategy's core values.
Rationale	Plan Alignment: Aligns with Section 1.2.4.1.1 (Communication to Empower and Support AYP), which emphasizes creating "safe, nurturing, and value-aligned environments at home, school, and in faith communities."

Component	Description
Indicator Name	C1.4 Percentage of secondary schools that delivered the health and well-being curriculum in the previous academic year
Definition	The percentage of secondary schools that reported implementing the health and wellbeing curriculum (incorporating internal values and HIV prevention) during the previous academic year.
Numerator	Number of secondary schools that delivered the health and well-being curriculum.
Denominator	Total number of secondary schools.
Data Source	NEMIS Administrative Level: 36 States + FCT.
Disaggregation	Location: Urban, Rural. Ownership: Public, Private. Curriculum Implementation: This measures the core delivery of the "Generation Negative" strategy. Without curriculum delivery, the cultivation of internal values (self-respect, belonging, etc.) cannot occur.
Rationale	Plan Alignment: Directly supports Section 1.3.2.1.1, which lists "Operationalize the communication toolkit nationwide" and "Make the harmonized curriculum available for use nationwide" as key actions.
Indicator Name	C1.5 Percentage of secondary schools that provided an orientation process for parents or guardians of students on the health and well-being curriculum in the previous academic year
Definition	The percentage of secondary schools that organized specific orientation sessions, meetings, or workshops for parents or guardians to explain the content and objectives of the health and wellbeing curriculum during the previous academic year.
Numerator	Number of secondary schools that provided orientation for parents or guardians on the curriculum.
Denominator	Total number of secondary schools.
Data Source	NEMIS Administrative Level: 36 States + FCT.
Disaggregation	Location: Urban, Rural. Ownership: Public, Private. Parental Engagement: Orienting parents ensures that the values taught in school (self-respect, etc) are reinforced at home, creating a consistent ecosystem of support for the AYP.
Rationale	Plan Alignment: Aligns with Section 1.2.4.1.1 and Section 1.3.2.1.1, which mandate working with parents to "strengthen parent-child trust" and "Support use of the toolkit across the four population groups."

Component	Description
Indicator Name	C1.6 Percentage of secondary schools with teachers who received training, and also taught lessons based on the health and well-being curriculum in the previous academic year
Definition	The percentage of secondary schools where teachers responsible for the health and wellbeing curriculum received specific training on the curriculum and subsequently taught lessons from it during the previous academic year.
Numerator	Number of secondary schools where trained teachers taught the curriculum.
Denominator	Total number of secondary schools.
Data Source	NEMIS Administrative Level: 36 States + FCT.
Disaggregation	Location: Urban, Rural. Ownership: Public, Private. Teacher Competence: This indicator links capacity building (training) to actual performance (teaching), ensuring that investment in teacher preparation translates into classroom instruction for students.
Rationale	Plan Alignment: Supports Section 1.3.2.1.1, which specifically outlines the action to "Provide orientation/training for members of the four population groups," including teachers.
Indicator Name	C1.7 Number of secondary school students who received lessons based on the health and well-being curriculum in the previous academic year.
Definition	The total number of individual secondary school students who received at least one lesson or session from the health and wellbeing curriculum during the previous academic year.
Numerator	Total count of secondary school students who received curriculum lessons.
Denominator	Not Applicable.
Data Source	NEMIS Administrative Level: 36 States + FCT.
Disaggregation	Location: Urban, Rural. Ownership: Public, Private. Student Reach: This provides the absolute scale of reach, quantifying how many AYP are being exposed to the internal values interventions necessary to build resilience against HIV.
Rationale	Plan Alignment: Aligns with Section 1.2.4.1 (Prevent future risk), which targets AYP aged 10-24 years, and Section 1.3.2.1.2, which focuses on ensuring availability of handbooks and curricula in schools.

Component	Description
Indicator Name	C1.8 Number of Gen-N curriculum modules uploaded to the NACA Moodle platform
Definition	The count of distinct e-learning modules (Foundational Content for AYP, Guidance for Guardians, Resources for Influencers, Resources for Political and Traditional Leaders) successfully uploaded and made accessible on the NACA platform.
Numerator	Number of modules uploaded.
Denominator	Not Applicable.
Data Source	Programme data
Disaggregation	Modules: Foundational Content for AYP, Guidance for Guardians, Resources for Influencers, Resources for Political and Traditional Leaders. Digital Reach: Action 1.3.2.1.1 prioritize e-learning for certification and wider reach.
Rationale	Plan Alignment: Tracks the expansion of digital learning infrastructure.
Indicator Name	C1.9 Number of distinct harmonized curricula and club handbooks developed for specific club categories
Definition	The number of finalised curricula and handbooks for clubs (Drama, Science, Sports, Debate) that integrate Gen-N values.
Numerator	Number of curricula/handbooks developed.
Denominator	Not Applicable.
Data Source	Programme data
Disaggregation	Club Type: Drama, Science, Sports, Debate, Innovation etc. Format: Physical Handbook, Digital (pdf, audiovisual). Club Content: Clubs are vehicles for values, not just hobbies. Harmonized curricula ensure that every club builds the “internal compass.”
Rationale	Plan Alignment: Measures progress of Action 1.3.2.1.2 (harmonized curriculum development).
Indicator Name	C1.10 Number of secondary schools with active Gen-N clubs
Definition	The count of secondary schools where at least one Gen-N club (club that integrates the six internal values) is meeting regularly with documented activities.
Numerator	Number of schools with active Gen-N clubs.
Denominator	Not Applicable.
Data Source	School Reports / State Ministry of Education Monitoring Administrative Level: 36 States + FCT.
Disaggregation	Location: Urban, Rural. School Ownership: Public, Private. Operational Hub: The “hub” of the strategy (Section 1.2.4.1.2). This is the physical manifestation of the plan in schools.
Rationale	Plan Alignment: Tracks the expansion of the network of clubs nationwide.

Indicator Name	C1.11 Number of schools with Youth Corpers deployed to support Gen-N clubs in secondary schools
Definition	The number of secondary schools that have been assigned National Youth Service Corps (NYSC) members to mentor Gen-N clubs.
Numerator	Number of schools with deployed Youth Corpers.
Denominator	Not Applicable.
Data Source	NEMIS, NYSC Programme data Administrative Level: 36 States + FCT.
Disaggregation	Location: Urban, Rural. School Ownership: Public, Private. Club Type: Specific Club supported. Mentorship: Youth Corpers are identified as a key resource for mentorship (Section 1.2.4.1.2). This measures the mobilization of this workforce.
Rationale	Plan Alignment: Tracks the implementation of the mentorship strategy in Section 1.3.2.1.2.
Indicator Name	C1.12 Number of schools receiving mentorship for Gen -N clubs
Definition	The number of schools where Gen-N clubs are receiving active mentorship from private sector or civil society mentors.
Numerator	Number of schools receiving mentorship.
Denominator	Not Applicable.
Data Source	NACA / Partner Reports Administrative Level: 36 States + FCT. Location: Urban, Rural.
Disaggregation	School Ownership: Public, Private. Club Type: Specific Club supported. Mentor: MDA, Civil Society, Private Sector Whole -of-Society: The plan mobilises sectors to support clubs. This measures the success of that multi-sectoral mobilization.
Rationale	Plan Alignment: Tracks the “mobilise support” component of Action 1.3.2.1.2.
Indicator Name	C1.13 Number of states organizing inter -school club competitions
Definition	The number of states that have conducted inter -school competitions (e.g., Olympiad) for Gen-N clubs.
Numerator	Number of states organizing competitions.
Denominator	Total number of states (37).
Data Source	Programme data (NACA, FME, FMYD, National Sports Commission)
Disaggregation	Administrative Level: List of States. Schools: Number of schools involved (Urban, Rural). Club Type: Number and type (Debate, Sports, Drama, Science etc). Sustainability & Interest: Competitions foster interest and reward the application of skills/values (Foreword). They create buzz around Gen-N.
Rationale	Plan Alignment : Measures the success of Action 1.3.2.1.2 (advocate for and facilitate competitions).

Indicator Name	C1.14 Number of community events/meetings held to dialogue on the contents of the communication toolkit with members of the four population groups
Definition	The number of face-to-face community dialogues held with AYP, parents, religious leaders, influencers, traditional leaders and politicians to discuss Gen-N toolkit contents.
Numerator	Number of documented events held.
Denominator	Not Applicable.
Data Source	Programme data from all stakeholders
Disaggregation	Audience: AYP, Parents, Religious Leaders, Influencers, Traditional Leaders, Politicians. Administrative Level: State, LGA. Community Engagement: The plan prioritizes face-to-face engagement Dialogues ensure ownership and support for AYP at home and in the community
Rationale	Plan Alignment: Tracks the operationalization of the communication toolkit beyond schools.

C2 - Objective 2: Mitigate Current Risk

Component Description

Indicator Name	C2.1 Number of targeted communication campaigns launched for key populations and high-risk general population
Definition	The count of distinct communication campaigns (media, outreach) specifically focused on behavior change and service uptake for current risks.
Numerator	Number of campaigns launched.
Denominator	Not Applicable.
Data Source	Programme data
Disaggregation	Target Group: FSW, MSM, PWID, High-risk general population. Channel: Radio, TV, Social Media, Outdoor. Awareness: While Obj 1 focuses on values, Obj 2 requires urgent risk communication. This tracks the visibility of services.
Rationale	Plan Alignment: Measures the output of Action 1.3.2.2.1 (toolkits for current risk).

Component	Description
Indicator Name	C2.2 Number of public and private health facilities certified as providing adolescent-friendly and KP-friendly HIV prevention services
Definition	The number of facilities that have met national standards for “adolescent -friendly” or “KP-friendly” service provision and have been certified.
Numerator	Number of certified facilities.
Denominator	Not Applicable.
Data Source	Programme data
Disaggregation	Facility Ownership: Public, Private (For profit, NGO, FBO). Level of Care : Primary, Secondary, Tertiary. Focus: Adolescent -Friendly, KP-Friendly. Administrative Level: 36 States + FCT. Service Quality: Certification ensures facilities are safe and welcoming, reducing stigma (B3.1/B3.2) and increasing uptake.
Rationale	Plan Alignment: Supports the delivery of AYP -friendly services mentioned in Section 1.2.4.2.2.
Indicator Name	C2.3 Total number of male and female condoms imported
Definition	The total quantity of male and female condoms imported into the country.
Numerator	Total quantity of condoms imported.
Denominator	Not Applicable.
Data Source	Customs and NAFDAC data. Type: Male, Female.
Disaggregation	TMA Segment: Commercial, Social Marketing, Public. Supply Side: The text highlights a massive shortfall (564 -750 million). Monitoring imports is critical for the Total Market Approach to bridge the gap.
Rationale	Plan Alignment: Tracks the progress of Action 1.3.2.2.2 (condom access and local manufacturing).
Indicator Name	C2.4 Number of facilities with established PEP protocols and drug stocks, including for GBV survivors
Definition	The number of health facilities that have approved PEP guidelines (protocols) and currently have PEP drugs in stock.
Numerator	Number of facilities with protocols and stock.
Denominator	Not Applicable.
Data Source	DHIS2 / Logistics Management Information System (LMIS) Facility Ownership: Public, Private (For profit, NGO, FBO).
Disaggregation	Level of Care : Primary, Secondary, Tertiary. Focus: GBV Centers, General Clinics/Wards. Emergency Response: PEP is essential for GBV survivors and occupational exposure. Stockouts represent a critical failure in risk mitigation.
Rationale	Plan Alignment: Measures the implementation of Action 1.3.2.2.2 (PEP protocols).

Component Description

Indicator Name	C2.5 Number of states with operational harm reduction services
Definition	The number of states that have at least one active site providing Needle and Syringe Programs (NSP) and Opioid Substitution Therapy (OST).
Numerator	Number of states with operational sites.
Denominator	Total number of states (37).
Data Source	NACA / State Agencies Reports
Disaggregation	Service Type: NSP only, OST only, Both. PWID Support: Harm reduction is the standard of care for PWID. This indicator measures the geographic reach of these essential services.
Rationale	Plan Alignment: Tracks the expansion of harm reduction services in Action 1.3.2.2.2.

Indicator Name	C2.6 Number of PWID participating in needle and syringe programme
Definition	The total number of unique People Who Inject Drugs registered and receiving sterile needles/syringes from harm reduction sites.
Numerator	Number of unique PWID participants.
Denominator	Not Applicable.
Data Source	Programme Data Age: 15-24, 25+.
Disaggregation	Sex: Male, Female. Administrative Level : 36 States + FCT. Coverage: The number of sites matters, but the number of clients reached matters more. This measures the scale of the intervention for this key population.
Rationale	Plan Alignment: Monitors the uptake of services for the “Mitigate Current Risk” objective.

C3 - Enabling Environment
Component Description

Indicator Name	C3.1 Number of critical surveys conducted
Definition	The count of priority surveys (IBBSS, Stigma Index, Drug Use, etc.) completed in the reporting period.
Numerator	Number of surveys completed.
Denominator	Not Applicable.
Data Source	NACA / Technical Working Group Reports
Disaggregation	Survey Type: IBBSS, Stigma Index, DHS, AISS. Evidence Base: Section 1.3.1.1 mandates updating the country context. Without surveys, the plan operates in the dark.
Rationale	Plan Alignment: Measures progress with ensuring up-to-date data is available to inform programme design and implementation.

Component	Description
Indicator Name	C3.2 Number of operational research studies completed
Definition	The number of specific operational research studies (e.g., on risk assessment tools, AYP preferences) completed.
Numerator	Number of studies completed.
Denominator	Not Applicable.
Data Source	Programme data
Disaggregation	Topic: AYP Risk Assessment, Sociocultural Norms, Service Access, etc Problem Solving: Operational research answers “what” and “how” questions to improve implementation (Action 1.3.1.2).
Rationale	Plan Alignment: Ensures the plan is adaptable based on specific findings (e.g., validity of hotspots).
Indicator Name	C3.3 Number of LGAs/Communities with documented sociocultural norms mapped for program adaptation
Definition	The number of LGAs or autonomous communities where sociocultural norms related to internal values, AYP development, education, work, health and HIV have been documented.
Numerator	Number of LGAs/Communities mapped.
Denominator	Total number of LGAs (774).
Data Source	Programme data
Disaggregation	Administrative Level: 36 States + FCT. LGA. Localization: The plan emphasizes that Nigeria is diverse and “one size fits all” doesn’t work (Section 1.1). Mapping norms enables tailored adaptation.
Rationale	Plan Alignment: Directly measures Action 1.3.1.1 (Documenting sociocultural norms).
Indicator Name	C3.4 Number of functional Technical Working Groups (TWGs) at National and State levels meeting quarterly
Definition	The number of HIV Prevention Technical Working Groups that hold at least one meeting per quarter or semester and record minutes.
Numerator	Number of TWGs meeting quarterly or biannually.
Denominator	Not Applicable.
Data Source	Programme data
Disaggregation	Administrative Level: National, State. Type: Prevention, EMTCT, Harm Reduction. Coordination: Section 1.3.3.1 emphasizes multi-sectoral collaboration. Regular TWG meetings are the mechanism for this coordination.
Rationale	Plan Alignment: Measures the functionality of the governance structure.

Component	Description
Indicator Name	C3.5 Number of states with costed HIV prevention workplans
Definition	The number of states that have developed and endorsed a comprehensive HIV prevention workplan with an attached budget/costing.
Numerator	Number of states with costed workplans.
Denominator	Total number of states (37).
Data Source	Programme data.
Disaggregation	Funding Source: Domestic, Donor, Mixed. Ownership & Readiness: A costed workplan is a prerequisite for resource mobilization. It shows a state is ready to implement.
Rationale	Plan Alignment: Supports Action 1.3.3.4 (Mobilise resources).
Indicator Name	C3.6 Amount of funding (in Naira and USD) mobilised from domestic (state/federal budgets) and private sector partners
Definition	The total financial value of resources mobilised for HIV prevention from government and private sources.
Numerator	Total value of funding mobilised.
Denominator	Not Applicable.
Data Source	NASA
Disaggregation	Source: Federal Government, State Government, Private Sector, Foundations. Currency: Naira, USD (to enable comparison with external funding). Sustainability: The plan calls for moving away from donor dependency. Mobilizing domestic/private resources is critical for longevity.
Rationale	Plan Alignment: Directly measures the outcome of Action 1.3.3.4 (Resource mobilization).

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