

TB AND HIV

CONCEPT NOTE

Investing for impact against tuberculosis and HIV

Countries with overlapping high burden of tuberculosis (TB) and HIV must submit a single concept note that presents each specific program in addition to any integrated and joint programming for the two diseases.

In requiring that the funding requests be presented together in a single concept note, the Global Fund aims at maximizing the impact of its investments to make an even greater contribution towards the vision of a world free of the burden of TB and HIV. Enhanced joint HIV and TB programming will allow to better target resources, to scale-up services and to increase their effectiveness and efficiency, quality and sustainability.

All concept notes should articulate an ambitious, strategically focused and technically sound investment, informed by the national health strategy and the national disease strategic plans (NSPs).

The concept note for TB and HIV is divided into the following sections:

Section 1: The description of the country's epidemiological and health systems context including barriers to access, the national response to date, country processes for reviewing and revising the response, and plans for further alignment of the NSPs, policies and interventions for both diseases.

Section 2: Information on the national funding landscape, additionality and sustainability

Section 3: The funding request to the Global Fund, including a programmatic gap analysis, rationale and description of the funding request, as presented in the modular template.

Section 4: Implementation arrangements and risk assessment.

IMPORTANT NOTE: Applicants should refer to the TB and HIV Concept Note Instructions to complete this template.

SUMMARY INFORMATION			
Applicant Information			
Country	NIGERIA		
Funding Request Start Date	01/07/2015	Funding Request End Date	31/12/2017
Principle Recipient(s)	NACA, ARFH, SFH, IHVN		
If the programs are to be managed as separate grants:			
Funding Request Start Date for HIV	01/07/2015	Funding Request End Date for HIV	31/12/2017
Principal Recipient(s) for HIV	NACA, ARFH, SFH		
Funding Request Start Date for TB	01/07/2015	Funding Request End Date for TB	31/12/2017
Principal Recipient(s) for TB	IHVN, ARFH		

FUNDING REQUEST SUMMARY TABLE



A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including descriptions of the TB and HIV disease epidemiology and their overlaps, the health systems and community systems setting, and the human rights situation.

1.1 Country Disease, Health Systems and Community Systems Context

With reference to the latest available epidemiological information for TB and HIV, and in addition to the portfolio analysis provided by the Global Fund, highlight:

- a. The current and evolving epidemiology of the two diseases, including trends and any significant geographic variations in incidence or prevalence of TB and HIV. Include information on the prevalence of HIV among TB patients and TB incidence among people living with HIV/AIDS.
- b. Key populations that may have disproportionately low access to prevention, treatment, care and support services, and the contributing factors to this inequity.
- c. Key human rights barriers and gender inequalities that may impede access to health services.
- d. The health systems and community systems context in the country, including any constraints relevant to effective implementation of the national TB and HIV programs including joint areas of both programs.

A. Evolving Epidemiology of TB and HIV in Nigeria

Introduction

The epidemiological analysis is based on data from detailed epidemiology reviews carried out for both HIV/AIDS and TB prior to the development of this concept note. The epidemiology review for HIV relied on findings from a series of antenatal HIV sero-prevalence sentinel surveys (1991 - 2010); two national HIV/AIDS and reproductive health surveys (NARHS) carried out in 2007 and 2012 and integrated bio-behavioural surveillance survey (IBBSS) 2007 and 2010. Others are the 2013 Midterm Review (MTR) of the National HIV/AIDS Strategic Plan for 2010-2015; routine programme data as well as the latest spectrum estimates. The described epidemiology of tuberculosis relied on TB epi-analysis conducted in 2014; the KAP survey conducted in 2012; routine programme data from the Nigerian National TB and Leprosy Control Programme (NTBLCP), 2012 Midterm Review of the National TB Strategic Plan (2010 – 2015), the revised 2015 - 2010 National TB strategic plan and supplemented by the recently conducted TB prevalence and drug resistance surveys.

The epidemiology of HIV/TB Co-infection

Nigeria has one of the largest burden of both HIV and TB in Africa and is classified as a high TB, HIV, and MDR-TB burden country¹. According to the NARHS, 2012, the current HIV prevalence in the general population is 3.4%. An estimated 3.46 million people were living with HIV in Nigeria in 2013. The first-ever population-based TB prevalence survey conducted in Nigeria in 2012² found a TB prevalence of 322/100,000, which represents a three-fold increase in the WHO estimate for the same year³. Based on

¹ WHO 2013, Global TB report

² Nigeria, TB prevalence survey report, 2013

³ WHO 2013, Global TB report

the prevalence survey projections of an incidence of 338/100,000, an estimated 591,752 incident cases of all forms of TB occurred in 2013. In that same year, however, only 100,401 cases were notified, representing a case notification rate of 57.3/100,000.

HIV in TB cases: In 2013, the Nigerian National TB and Leprosy Control Program (NTBLCP) reported that 88% of people diagnosed with TB received an HIV test⁴. Also, 19,423 of the 88,317 TB cases tested were found to be HIV positive. This represents a TB/HIV co-infection rate of about 22%.

TB in HIV cases: On the other hand, TB screening among people living with HIV (PLHIV) was reported at 68% in 2013⁵. Anecdotal data on TB infection in HIV patients suggest that an estimated 10.5% of HIV patients are co-infected with TB⁶

Evidence suggests that the high HIV prevalence in Nigeria is a major driver of the high TB burden. A recent modeling of the population-attributable-fraction (PAF) of different risk for TB quantified the relative contributions of determinants of TB disease burden in Nigeria⁷. This showed that the top PAF for TB was HIV, accounting for 25% of all TB disease; i.e. This implies that Nigeria could reduce TB by 25% just by controlling HIV. This is a missed opportunity in Nigeria as currently, only one-third of the estimated 1.5 million Nigerians who need ART are receiving it -an identified national priority requiring funding support and is prioritized for Global Fund investment in this application.

These two scenarios illustrate the double challenge facing Nigeria. Continuing HIV transmission in the context of poor ART coverage and the poor case detection of TB presents the country with a self – propagating epidemiological cycle where the inadequate response to one disease has significant negative consequences on the burden of the other and vice versa. Low TB case detection allows for ongoing transmission while poor ART coverage continues adding fuel to the epidemic. Without a coordinated and intensive effort to scale up prevention, detection and treatment of both diseases, Nigeria is unlikely to control either disease. South Africa, on the other hand, has seen a sustained reduction of the burden of TB following the scale-up of its ART program, despite increased case detection following the introduction of molecular based diagnosis⁸.

The inter-related epidemiological patterns of HIV and TB in Nigeria also present opportunities for joint programming and response.

TB and HIV rates in Children

A significant proportion of HIV exposed infants do not get Early Infant Diagnosis (EID) services and ARV prophylaxis. In 2012, only 42.1% of HIV exposed infants received ARV prophylaxis out of the total deliveries among HIV positive women.

As the TB prevalence survey did not include children, data are lacking on which to base assumptions about the burden of TB in this vulnerable population. At present, children under the age of 15 years comprise approximately only six percent of the TB cases notified in Nigeria every year while globally, children under the age of 15 are estimated to contribute approximately 11% of TB cases (all forms).⁹ In Nigeria, with more than 40% of the population under the age of 15, the burden of TB in children is likely to represent more than 10% of total cases.¹⁰ Given the fact that the highest burden of TB occurs in adults in the childbearing ages, childhood exposure is likely to be high. It can be assumed that there is a significant burden of undetected paediatric TB. Efforts will be made to generate more information about TB in children from the national program.

⁴ Annual TB report, 2013

⁵ NACA, 2013

⁶ Ilyasu Z et al, 2009: Prevalence and Predictors of Tuberculosis Coinfection among HIV Seropositive Patients Attending the Aminu Kano Teaching Hospital, Northern Nigeria; J Epidemiol 2009;19(2):81-87

⁷ Lönnroth K, Castro KG, Chakaya JM, Chauhan LS, Floyd K, Glaziou P, et al. Tuberculosis control and elimination 2010-50: cure, care, and social development. Lancet. 2010;375(9728):1814–29

⁸ Unpublished data from National Institute for Communicable Diseases, Johannesburg, South Africa

⁹ Nelson LJ, Wells CD. Global epidemiology of childhood tuberculosis. Int J Tuberc Lung Dis 2004;8:636-47.

¹⁰ Perez-Velez CM, Marais B. Tuberculosis in children. N Engl J Med 2012;367:348-61.

Geographical overlap in the burden of TB and HIV:

The North Central zone which has the highest HIV prevalence in the country also has the highest TB case notification rate per 100,000-population (2013 NTBLCP report) as well as the highest TB rate per 100,000-population, based on the prevalence survey. The zone with the second highest burden is the South-South, again for both HIV and TB. The co-infection rates for the North Central zone and the South-South zone stood at 32.3% and 28.3% respectively in 2013, the highest rates in the country.

Analysis at state level indicates that 8 + 1 states (Kaduna, Akwa Ibom, Lagos, Oyo, Sokoto, Imo and FCT) out of the 12 + 1 states (Kaduna, Akwa Ibom, Lagos, Kano, Oyo, Benue, Rivers, Sokoto, FCT, Taraba, Nasarawa, Imo and Cross River) which account for about 60% of HIV burden are also high TB burden states. The prevalence of both HIV and TB are higher among urban than rural dwellers.

TB and HIV rates by age-group and sex

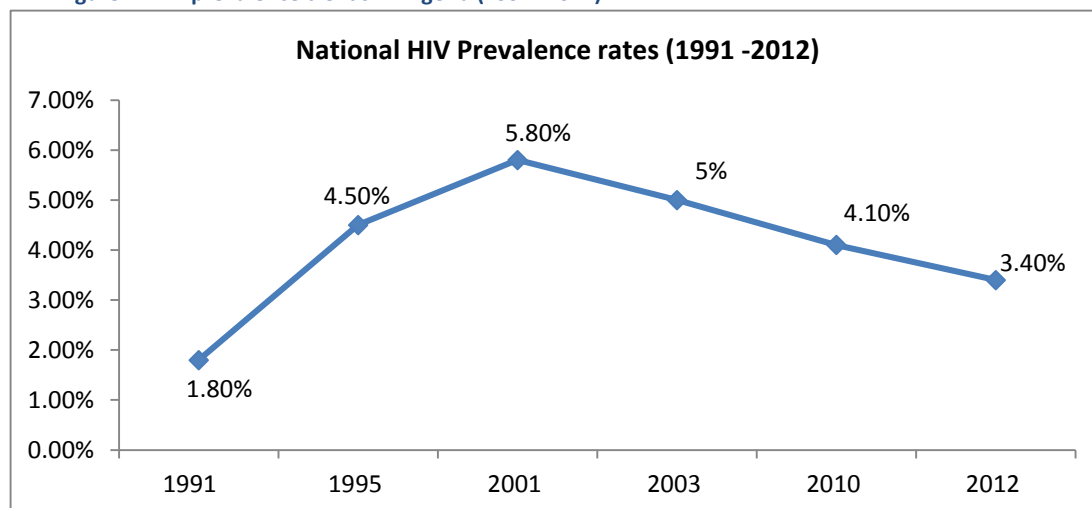
While TB heavily affects many sub-populations and geographic areas in Nigeria, there are certain groups where TB is particularly concentrated- in people between the ages of 35 and 54 in both sexes; and in men, at a ratio of approximately 2:1 for adult men and women. HIV demonstrates a similar pattern, but with highest prevalence amongst women between the ages of 30 – 34 and 45 - 49

Epidemiology of HIV in Nigeria

HIV Prevalence:

Nigeria's HIV prevalence increased steadily from 1.8% in 1991, to 4.5% in 1995, peaked at 5.8% in 2001 and started to decline to 5% in 2003 and 4.1% in 2010. According to NARHS, 2012, the current HIV prevalence in the general population is 3.4%; an estimated 3.46 million people are living with HIV in Nigeria in 2013.¹¹

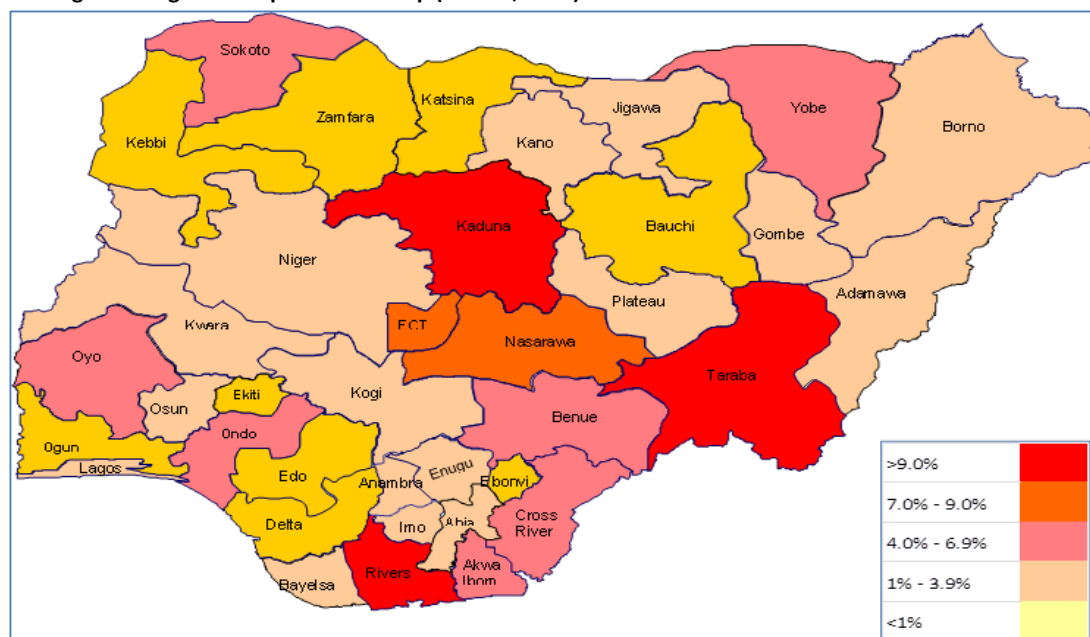
Figure 1: HIV prevalence trends in Nigeria (1991 -2012)



¹¹ UNAIDS

Geographical characteristics of the HIV epidemic

Figure 2: Nigeria HIV prevalence map (NARHS, 2012)



The 2012 NARHS data shows that HIV prevalence is not evenly distributed in the country (see Figure 2). The highest prevalence rates are noted in Rivers State (15.2%), Taraba State (10.5%) and Kaduna state (9.2%). The states with the lowest prevalence rates are Ekiti (0.2%), Zamfara (0.4%) and Ogun (0.6%). Of particular interest are the states with progressively rising HIV prevalence from 2003 to 2010. In this fold includes: Abia (4% to 7.3%), Akwa Ibom (6.5% to 10.9%), Anambra (4% to 8.7%), Bayelsa, (4% to 9.1%), Benue (8.5% to 12.7%) and Edo (4.1% to 5.3%).

Figure 3: Prioritization of states for HIV program

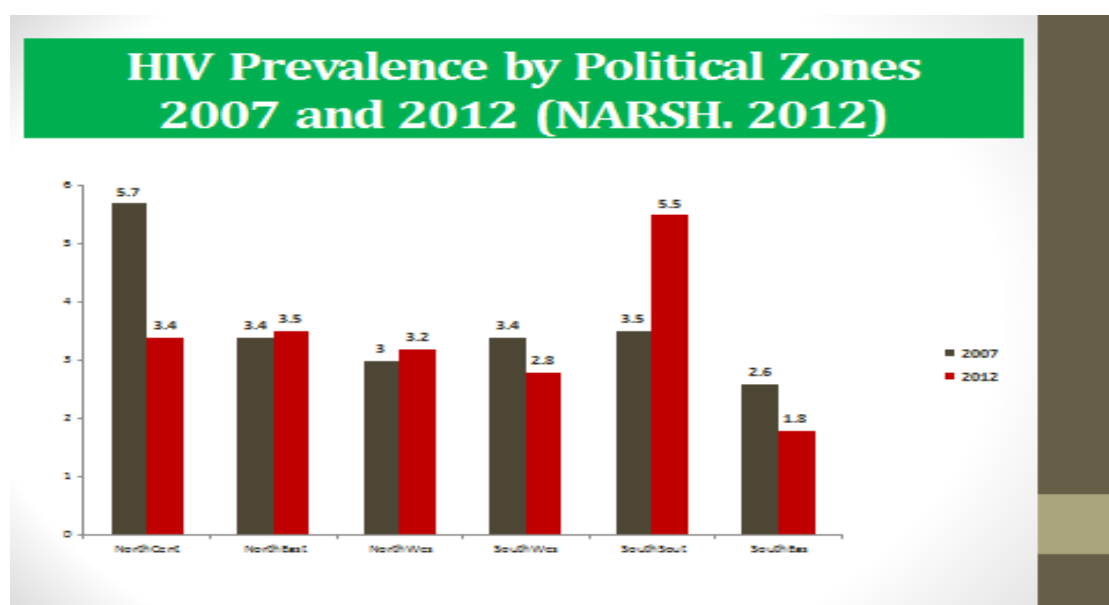
S/N	State	Category		
1	Kaduna	6 NFM priority states	12 +1 Epi priority states	20+1 Epi priority states
2	Rivers			
3	Akwa Ibom			
4	Imo			
5	Lagos			
6	Oyo			
7	Benue			
8	Kano			
9	Sokoto			
10	Taraba			
11	Nasarawa			
12	Cross River			
13	Plateau			
14	Niger			
15	Adamawa			
16	Borno			
17	Abia			
18	Jigawa			
19	Ogun			
20	Bayelsa			

The Epidemic and Impact analysis showed that 21 states (20+1) contributed 81% of the national HIV burden. Also, 12+1 states were responsible for 65.9% of the new HIV infections and 63.4% of the HIV burden. 6 states (Kaduna, Akwa Ibom, Benue, Lagos, Oyo and Kano) were responsible for 41% of HIV burden and 42% new HIV infections annually.

In a scenario of limited resource availability the Epi analysis recommends that focusing on these 6 priority states will demonstrate a strategic investment approach with substantial impact on the epidemic.

Diverse epidemics between political zones: NARHS PLUS 2012 revealed that the HIV prevalence has varied between political zones and during the period 2007-2012 changes have been observed with declining trends in the North Central, South West and South East, stable trends in North East and North West and increase trend in the South- South geopolitical zone of the country. The reasons for this are not immediately apparent.

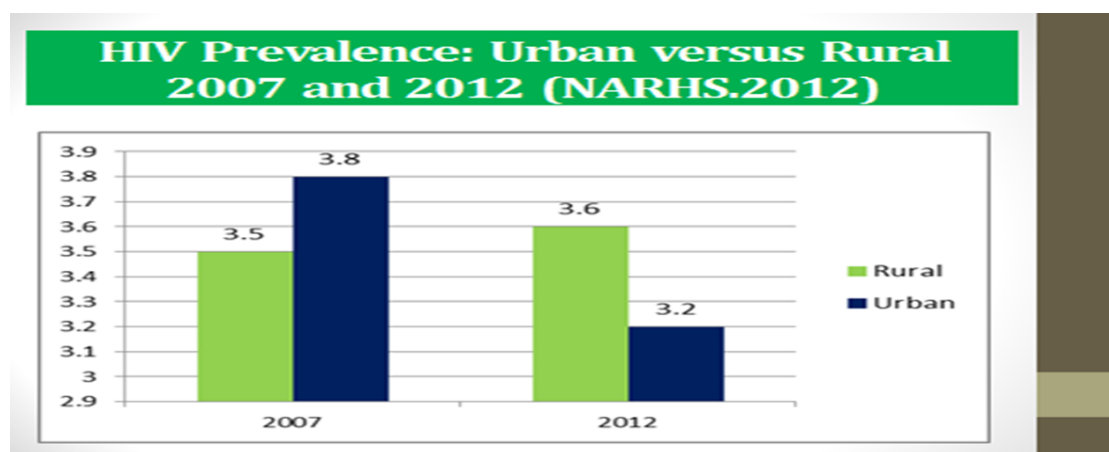
Figure 4: HIV prevalence by political zones (NARHS 2012)



Rural-urban heterogeneity:

The 2012 NARHS survey also showed a higher prevalence in rural areas (3.6%) when compared to urban areas (3.2%), a reversal of the status seen in the 2007 NARHS survey. This reversal is perhaps improved access to HIV and AIDS services in urban areas than in rural areas between 2007 and 2012

Figure 5: HIV prevalence trends disaggregated by location (NARHS, 2012)

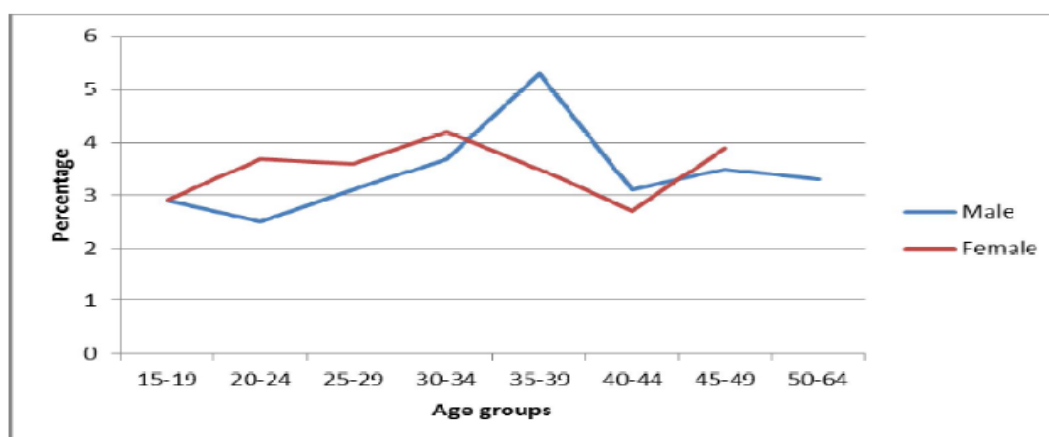


The age and sex distribution of the HIV epidemic:

From the analysis of the prevalence trend from NARHS 2007 and 2012, the burden of HIV is higher for

women than men in Nigeria. Although there has been decline in HIV prevalence among females from 4.0% in 2007 to 3.5% in 2012, and slight increase among men from 3.2% to 3.3%, the burden is still higher for women than men across all age groups, except for the 35-39 years and 40-44 years age groups. In both urban and rural areas, HIV prevalence is currently higher among females.

Figure 6: HIV prevalence by gender and age group, NARHS 2012.



Risk Factor Analysis

According to 2009, Mode of Transmission study, 37% of new infections are attributable to persons perceived as practicing “low risk sex” in the general population, including married sexual partners, 22% through MTCT and 38% by other modes of transmission. HIV/AIDS knowledge though increasing is still low in the general population, with 35.6% of males and 23.6% of females showing an appropriate level of knowledge. Condom use seems to be increasing across all age groups but very far from the expected 100% condom usage in high-risk sex. The lowest reported condom use is among young people aged 15-19, and especially young women who had sex with non-marital partners without the use of condoms. The analysis of risk behavior among MARPS indicated that FSW are more likely to use condoms with clients (70%) than MSM (52%), PWID (22%) and HIV risk perception is highest among the FSWs. The country may engage with stakeholders on the need to conduct another round of Mode of Transmission Study to inform programme implementation.

HIV in key populations:

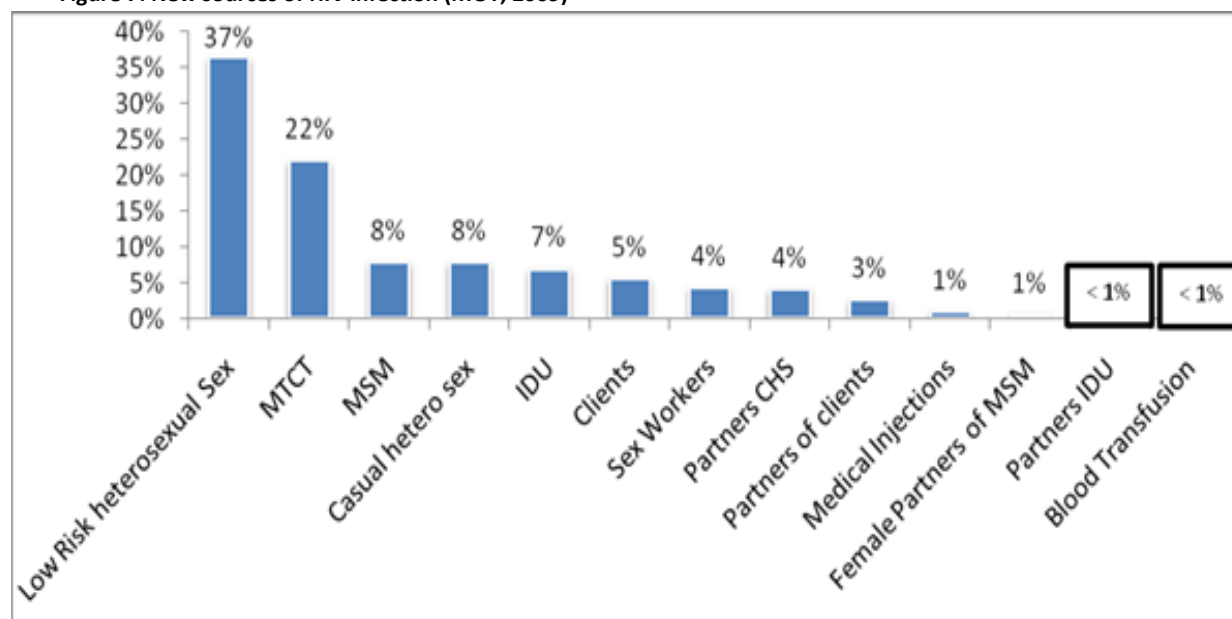
Nigeria's HIV and AIDS epidemic has been described as generalized but there are concentrated epidemics among key populations, i.e. female sex workers (FSWs), men who have sex with men (MSM) and injecting drug users (PWIDs) (FMOH, 2007; 2010b). Among female sex workers, HIV prevalence is consistently higher among the brothel-based sex workers although there were some declines between 2007 and 2012 (37.2% to 27.4%) compared to non-brothel-based (30.2% to 21.1%). This seemingly encouraging decline may be attributed to the prioritization of prevention interventions for these groups of key population by implementing partners and donors in the past five years. There has also been some notable declines among PWIDs (5.6% to 4.2%), Armed Forces (3.1% to 2.5%), Police (3.5% to 2.6%) and transport workers (3.7% to 2.4%). However, the situation is different among MSMs where the prevalence is rising from 13.5% to 17.2% during the same period. In contrast to the older estimate of about 1.2 million KPs, a size estimation exercise supported by The World Bank was conducted in 2012 initially in eight states then in 19 other states. There is a paucity of data to demonstrate factors associated with changes in trend among KPs. This clearly showed the need to have a more extensive mapping and studies among KPs.

In Nigeria the universal health coverage ensures that every individual enjoys equal access to health services, in respect of individual's social, cultural, biological and behavioural characteristics.

Sources of new Infections:

The National mode of transmission study 2009 indicates that 37% of new infections occur among persons perceived as practicing “low risk sex” in the general population including married sexual partners, MTCT, 22%, anal sex, 8%, casual heterosexual sex 8% , PWIDs, 7% and clients, 5%. Medical injections, blood transfusion, partners of PWIDs, and female partners of MSM account for 1% each. Sex workers and partners account for 4% of infections each.

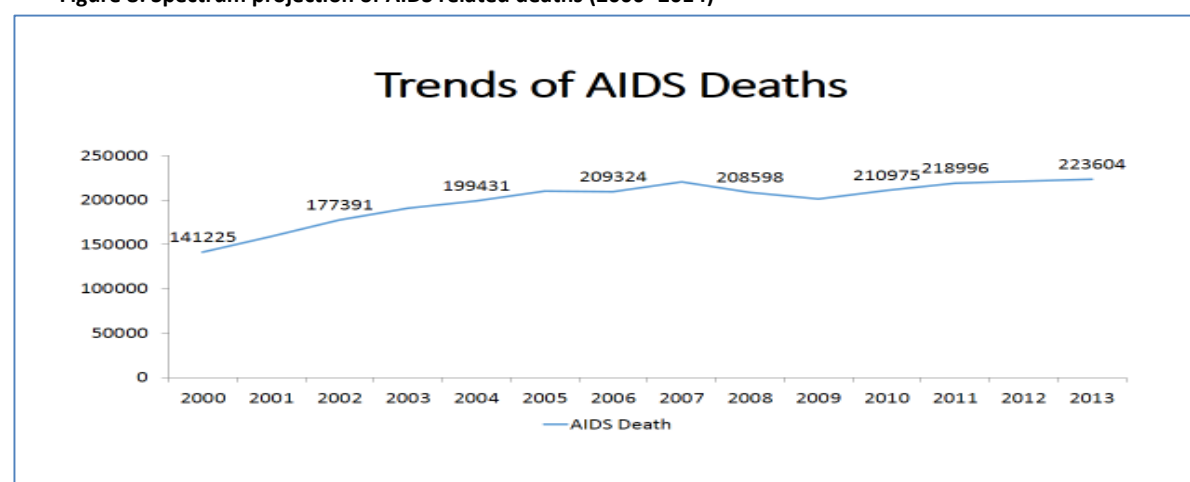
Figure 7: New sources of HIV infection (MOT, 2009)



HIV mortality trends:

In the absence of reliable mortality data from the Vital Registration System, estimates from Spectrum are used to plot HIV-related mortality trends. Estimated AIDS deaths have risen from 141,225 in 2000 to 223,604 in 2013. However The Country is in the process of conducting mortality assessment, which is expected to provide information on causes of death by disease specific areas especially HIV/AIDS, Tuberculosis and Malaria. The TOR for this assessment has been drawn up and it is hoped that the assessment will concluded before the end of the year.

Figure 8: Spectrum projection of AIDS related deaths (2000 -2014)



Epidemiology of Tuberculosis in Nigeria

Prevalence and incidence of TB in Nigeria

The first-ever national TB prevalence survey was completed in Nigeria in October 2012, with analysis and results finalized in December 2013. Based on the 2012 prevalence survey data, WHO in collaboration with the NTBLCP has updated its estimates for TB prevalence and incidence in Nigeria as follows:

Table 1: National TB prevalence & Incidence data (TB prevalence survey, 2013)

Indicator	Estimated rate (per 100,000 population)
Prevalence of all forms of TB in all ages	322
Prevalence among adult population (≥ 15 years = 56% of total population)	520
Prevalence among children (<15 years = 44% of total population)	39*
Incidence of all forms of TB in all ages	338

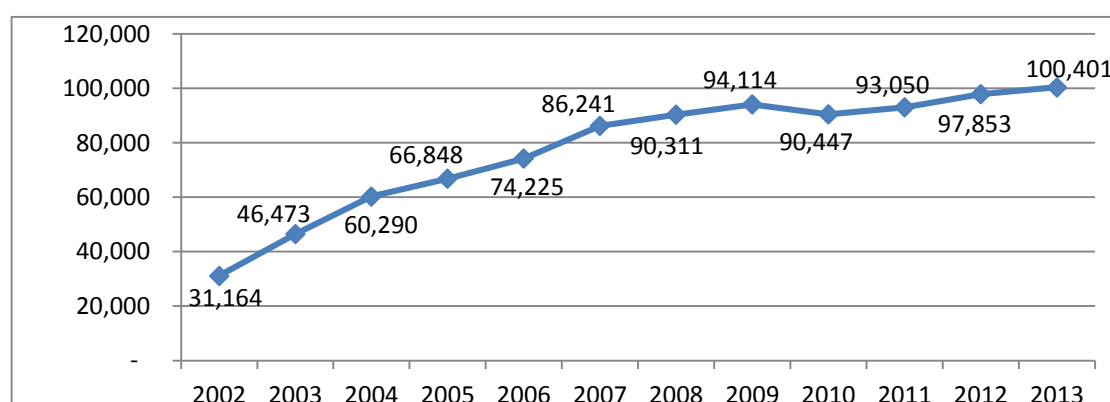
*Extrapolation based on current case notification among children

These estimates represent a doubling of the estimated prevalence and a tripling of the estimated incidence over the most recent WHO modelled estimates. Assuming a resident population of 169,645,996 in Nigeria in 2012, the estimated number of incident cases of all forms of TB would be 573,403. In 2012, however, Nigeria notified a total of 97,853 cases of all forms of TB. Using these updated figures, Nigeria's case detection rate for all forms of TB currently stands at approximately 17%, one of the lowest case detection rates in the world. Cases missed in Nigeria thus represent approximately 15% of the 3 million missing cases globally each year.

TB Case Notification:

Overall case notifications were consistently on the rise since the beginning of DOTS expansion in the country, but have plateaued since about 2008 despite efforts to engage the private sector and others in case-finding activities. Findings from the prevalence survey, NSP mid-term review, and Knowledge, Attitudes and Practices survey pointed to several key contributing factors: poor access to diagnostic services, inadequate public knowledge of TB and high levels of stigma, and inadequate penetration of community-based interventions into vulnerable communities.^{12,13} These are areas where more resources must be invested for maximum impact.

Figure 9: Trend in TB case notification, all forms (2002 – 2014)



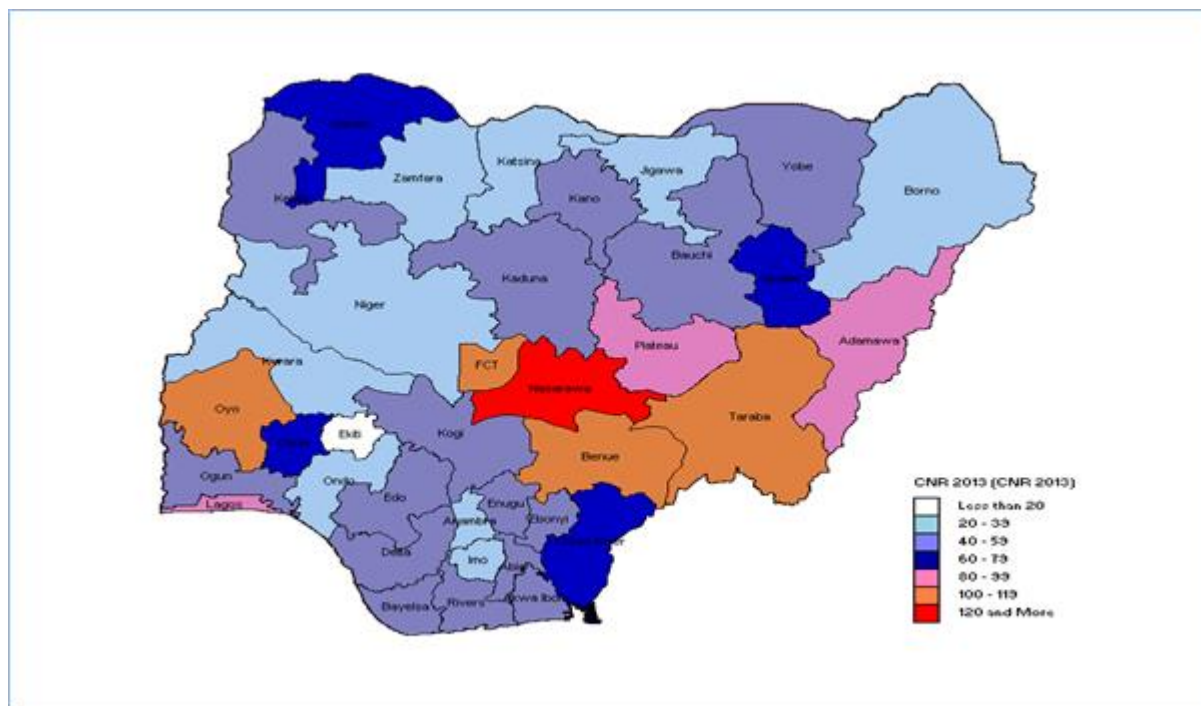
¹² 2012 TB NSP MTR

¹³ 2012 TB KAP and prevalence survey

Geographical characteristics of TB epidemic in Nigeria

The map below presents further disaggregated programme data at the state level. The 2013 annual national case notification rate (CNR) was 57 per 100,000. In the 37 states in Nigeria, the annual CNR varied between a minimum of less than 19 and a maximum of 123 per 100,000 (median 55 per 100,000 and inter-quartile range 35 to 65 per 100,000). The Federal Capital Territory, Nasarawa, Benue, Taraba and Oyo states report the highest CNRs. It is uncertain whether the important variability between CNRs at state level reflects differences in disease burden, differences in TB detection and reporting coverage, or both.

Figure 10: Map of 2013 state level Case Notification rate of all forms of TB. Data source: 2013 NTBLCP annual report



Age-sex characteristics of Tuberculosis:

Tuberculosis case notification rates among younger adults aged between 25-54 years are consistently higher than those older than 55 years or younger than 15. This age pattern is similar to the findings from the TB prevalence survey that showed higher disease burden in adults from 35-54 years. There are also higher prevalence rates in men than in women, with a ratio of about 2:1; and in urban areas, where several important risk factors for TB are concentrated amongst the urban poor. As previously described, few data on burden of TB in children under 15 years are available, but children likely represent a large pool of undetected cases. This informs the need to focus investment towards high risk populations in urban areas as well as in children.

TB mortality trends

TB-related mortality is difficult to estimate at present because of the weakness of data in the recently implemented vital registration system. The W.H.O. estimated TB mortality rate (excluding HIV-related TB) for Nigeria stood at 16 per 100,000 in 2013. In one retrospective study of causes of morbidity and mortality among 183 patients with respiratory illnesses treated at a tertiary care facility in Nigeria between 2006 and 2008, TB was found to be the leading cause of morbidity (42.1%) and mortality (50%). Mortality was higher in women and among 25-44 year olds, likely related to HIV and advanced

disease¹⁴.

Prevalence of drug-resistant TB

The first national drug resistance survey (DRS) was concluded in Nigeria in October 2010. The result shows a proportion of MDR-TB of 2.9% among new TB cases and 14.3% among re-treatment cases with a crude rate of 4.8% among all cases. These figures are far higher than the WHO estimated MDR-TB rate of 2.9% among new smear-positive cases and 14% among re-treatment cases (Global TB report, 2013).

TB in key affected populations in Nigeria

A number of different sub-populations have been identified as key affected populations in Nigeria, based on a combination of modelling, globally recognized risk factors for TB, prevalence survey data, programme data and project data.¹⁵ The benefits from intensified case-finding and case-holding activities are expected to be highest among these key affected populations. A total figure for KAPs is not provided, as some of these populations overlap.

Table 2: Key TB-affected populations and population size estimates, 2014.

Sub-population	Size estimate in 2014
PLHIV	3,459,363 ¹⁶
Contacts to bacteriologically positive pulmonary TB	1,248,247*
Urban slum dwellers ^{17, 18}	50,000,000
Nomads	9,400,000
Migrants and internally displaced people ^{19, 20}	Unknown (migrants); >500,000 (IDPs)
Prisoners	53,000 ²¹
People with diabetes ²²	1,200,000
Children	79,500,000 ²³
Health care workers, especially those in in-patient facilities, HIV and TB clinics, and laboratories	400,000 (including private facilities) ²⁴

*Assumes average of 4 contacts per bacteriologically positive case. Bacteriologically positive cases make up approximately 51% of those diagnosed.

¹⁴ Desalu O, Oluwafemi J, Ojo O. Respiratory diseases morbidity and mortality among adults attending a tertiary hospital in Nigeria. J. bras. pneumol. Aug 2009; 35(8)

¹⁵ See NSP-TB, p. 51 for a full discussion of how these KAPs were identified.

¹⁶ Nigeria Spectrum 2014, National file

¹⁷ Pepple, A.I., Minister of Lands, Housing and Urban Development. *Nigeria: Progress on improving the lives of slum-dwellers over the decade 2000 – 2010*. Presentation at Making Slums History International Conference, Rabat, Morocco, November 2012

¹⁸ UN data website, Slum population as percentage of urban. Accessed July 6, 2014 at:

<http://data.un.org/Data.aspx?d=MDG&f=seriesRowID%3A710>

¹⁹ Mberu B and Pongou R. Nigeria: Multiple forms of mobility in Africa's demographic giant. Migration Policy Institute. June 30, 2010, Accessed July 6, 2014 at: <http://www.migrationpolicy.org/article/nigeria-multiple-forms-mobility-africas-demographic-giant>

²⁰ UNHCR

²¹ Nigerian Prison services website

²² International Diabetes Federation website. Accessed July 6, 2014 at http://www.idf.org/webdata/docs/background_info_AFR.pdf

²³ National Population Commission projections, 2013

²⁴ HSS assessment report, 2014

Prioritization of states for the NFM application

A. Prioritization for Tuberculosis Component:

To ensure a strategic approach for the NFM investment, the National programme underwent a geographical prioritization exercise to select priority states. Key indices considered include:

- ☐ State specific gaps in Tb case notification to inform the geographical targeting that will guide implementation
- ☐ State HIV prevalence
- ☐ State specific gaps in AFB smear microscopy centres
- ☐ State specific gaps in DOTs (TB treatment) centres

Details of this ranking process are attached as an annex to this narrative²⁵.

As a result of the prioritization, states were ranked, and categorized into four bands based on the indices above. Band 1 describes the first 13 states that account for 50% of the estimated gap in TB case notification. Band 2 describes the first 21 states that account for 71% of the estimated gap in TB case notification. Band 3 describes the first 25 states that account for 80% of the estimated gap in TB case notification. Band 4 refers to all states and the FCT. Because of the central status of FCT and the rapid population growth rate (as mentioned earlier) as well as fast growing urban slum population, FCT is classified under band 1 priority for the purpose of programme implementation.

Figure 11: State prioritization based on ranking criteria

S/N	States	% contribution to estimated gap in TB case notification		
1	Kaduna	Band 1: 50% of estimated TB notification challenges	Band 2: 71% of estimated TB notification challenges	Band 3: 80% of estimated TB notification challenges
2	Lagos			
3	Kano			
4	Rivers			
5	Oyo			
6	Katsina			
7	Jigawa			
8	Borno			
9	Akwa Ibom			
10	Imo			
11	Sokoto			
12	Anambra			
13	Bauchi			
14	Delta			
15	Niger			
16	Ondo			
17	Benue			
18	Osun			
19	Zamfara			
20	Cross River			
21	Enugu			
22	Ogun			
23	Abia			
24	Kogi			
25	Yobe			

B. Prioritization for HIV component

A national dialogue was conducted to determine what approach the geographical targeting would adopt for the NFM application. Excerpts from the meeting minutes are included below.

Criteria for prioritization:

- ☐ Gap analysis based on epidemiological and program data with particular focus on treatment gaps.
- ☐ TB high burden states and prioritization by the TB program using their ranking criteria

²⁵ NTBLCP, State prioritization for TB case finding

- ❑ PEPFAR priority states were considered alongside the TB and HIV priority states (The scope and scale of PEPFAR investments both historical and planned for the out years were also considered).
- ❑ HSS/CSS component adopted a cross-cutting national approach.

After due review of the criteria, a ranking list was developed. Two states (Kano and FCT) from the top 6 ranked states were substituted based on the existing and planned coverage by the PEPFAR program. These states were substituted by Imo and Akwa Ibom based again on the leverage opportunities with the PEPFAR program. It is also assumed that the PCRPs resources will be applied to cover the other states in the ranking table. The ranking table is as depicted below:

S/N	HIV	TB	PEPFAR STATES	HIV TREATMENT GAP	RANKING for HIV
1	KADUNA**	KADUNA**	KADUNA	86,672	1ST
2	OYO**	OYO**	OYO	74,416	2ND
3	LAGOS**	LAGOS**	LAGOS	38,965	3RD
4	FCT	FCT	FCT	32,235	4TH
5	KANO	KANO	KANO	28,152	5TH
6	RIVERS**	RIVERS**	RIVERS	24,268	6TH
7	SOKOTO	SOKOTO	SOKOTO	19,467	7TH
8	IMO**	IMO**	IMO	19,009	8TH
9	BENUE	BORNO	BENUE	18,833	9TH
10	AKWA IBOM**	AKWA IBOM**	AKWA IBOM	16,708	10TH
11	PLATEAU	BAUCHI	NASSARAWA	15,892	11TH
12	TARABA	ANAMBRA	TARABA	9,663	13TH
13	CROSS RIVERS	JIGAWA	CROSS RIVERS	10,235	26TH
14	ADAMAWA	KATSINA			
15	BORNO				
16	ABIA				

** States prioritized for HIV/TB scale-up under the NFM Concept Note.

Key human rights barriers and gender inequalities that may impede access to health services.

Stigma and discrimination have undoubtedly continued to pose a serious barrier to HIV/AIDS prevention, treatment and care. The 2013 NARHS showed that among all the respondents, 66% were willing to work with an HIV infected colleague, 67% were willing to allow an HIV infected student or child in school, and 65% were willing to allow a female HIV infected teacher to continue teaching in school. About 48% of the respondents were also willing to share meals with HIV infected persons and almost half of respondents (42%) were willing to buy food from a shopkeeper known to be HIV infected. These proportions show some marginal improvements in attitude towards non-family members who were infected with HIV when compared to the findings from 2007 NARHS.

In trying to provide an understanding to the scope of stigma and discrimination against PLWHAs, several studies have been carried out over the past decade in different parts of the country. Fawole, et al, 1990; Uwakwe 2000; Alubo et al 2002; Oyediran 2005 have all classified stigma and discrimination into individual, community, institutional and self-stigmatization. Monjok et al, 2009 categorized the predominant stigma and discrimination against PLWHAs in Nigeria as: negative attitudes to PLWHAs, reluctance by health workers to treat PLWHAs, and perceived stigma of PLWHAs. Gender, social class, geographical area are some of the identified factors related to stigma and discrimination and in the Nigeria context all geographical zones seem to be affected the same way. Research has shown that interventions to reduce stigma in the national response is poorly coordinated and inadequate. This is an important area for which more concerted effort is required as the national response is being scaled up under the PCRPs.

The recent promulgation of the Same Sex bill by the federal government and the enforcement of sharia law in 12 northern states criminalize promotion of same sex activities in Nigeria. The interpretation of the law has varied based on suspicion of homosexual activity. There is a perception that this new law may further drive the MSM population underground making it difficult to reach them with prevention information and services.

Gender equality priorities are still generally neglected in most service delivery modalities; this is largely due to weak support and coordination mechanisms necessary for the achievement of more effective results (National Gender Assessment Report 2013).

The socio-cultural and economic norms and practices in Nigeria that may contribute to increasing the risk of HIV transmission among women and girls, men and boys, and transgender persons, as identified by desk research²⁶ and confirmed during the data collection workshop are outlined below. They are divided into six categories (details are provided in the Gender Assessment report attached to the application)

- ❑ **Child marriage:** About a third of adolescent girls (15-19 years) were already married in 2003, and out of this 16% were actually married by age 15.²⁷ Children of young ages are married to older men who likely have other wives and sexual partners. The girl's vulnerability is high because the HIV status of the prospective husband is not usually verified before marriage and because of the power imbalance inherent to such marriages. Child marriage is not by choice, and normally the girls do not have decision making power over their sexuality and health, which implies their inability to negotiate safe sex. The practice of child marriage is sometimes based on the religious/ cultural belief that it curbs promiscuity because it reduces the exposure of young girls to multiple sexual partners before marriage.
- ❑ **Gender-based violence:** There exists the belief that women are typically weaker, powerless and more dependent. This makes females more susceptible to violence, including intimate partner violence. Rape and sexual assault initiated by one or more persons against females makes them vulnerable to HIV. Types of sexual assault generally identified by the participatory evaluation process included wife battering with rape, "curative rape" of lesbians (using rape as a so-called "corrective" measure for their sexual orientation, also known as "homophobic rape") and employer's rape of female domestic workers who are often trafficked persons. These acts often receive no redress due to the unequal power relations involved, and also because victims are dissuaded by relatives not to speak up due to the societal shame that may surround the family of a rape victim, perceived loss of value and/or marriage prospects of the woman/ girl.
- ❑ **Harmful gender norms:** Harmful gender norms around masculinity stipulate that men engage in multiple sexual partnerships as a show of manhood. This, coupled with the commonly held view that condoms reduce sexual pleasure, translates to unsafe sex with more than one partner
- ❑ **Harmful traditional rites:** Female Genital Mutilation (FGM) is practiced by a few ethnic groups and is often taken as a rite of passage for girls used to prevent them from being promiscuous. Harmful effects may include Vesico-Vaginal Fistula (VVF), and the risk of HIV transmission through handling of body fluids. In some parts of the country, when a husband dies, the widow is restricted from moving around and expected to mourn, but when a wife dies, the widower is kept away from the ceremony and provided with a young woman to keep him company. This is done for the widower without regard to his HIV status or the status of the young woman. Also, in some States, widows are not allowed to remarry but they are allowed to continue having children, in which case they would be allowed to keep property of the former marriage. If she remarries, however, she will be disinherited. The consequence is that widows may seek out multiple sexual liaisons in a bid to have children, but particularly to have boys who would be counted culturally as the sons of the deceased husband. In the process, she becomes exposed to HIV infection.
- ❑ **Gender and TB:** The data from the prevalence survey appear to show a significantly higher burden of TB among men than among women. It must be noted, however, that for both groups, TB burdens are high. In adult males, prevalence of bacteriologically confirmed TB is estimated at 751/100,000

²⁶ National Gender Assessment Report 2013

²⁷ National Population Commission (2004) Nigeria Demographic and Health Survey 2003

and in adult females at 359/100,000. The ratio of observed prevalence in the survey to smear-positive case notification rates also differed by gender: for men, the ratio was 7.25, whereas for women it was 4.63. In other words, males with smear-positive TB are 1.56 times less likely to be diagnosed than their female counterparts. Both men and women respondents with symptoms of TB most often first sought care at general hospitals or chemists, with primary health centers as the third most frequent first point of contact. Behavior did not differ by gender for those who first sought care at general hospitals or chemists, but women who sought care at a primary health level did so almost twice as often as men. These findings require confirmation, but can point to potential opportunities to tailor interventions to increase service access for both men and women. Interventions aimed at reaching men and women at risk for tuberculosis must take into account the specific barriers to care that they face, while acknowledging that all Nigerians are facing significant barriers to accessing TB services, unrelated to gender. Further study will be required to determine specific gender-related barriers in Nigeria. In general, however, males' access to TB services is likely influenced by working hours and locations, incarceration, stigma, competing priorities, and lack of perceived threat to their health. Women likely face access issues because of religious and cultural restrictions on their independent movement, a lower family priority placed on their health, stigma and fear of being outcast from family or considered unmarried, competing priorities, and perceived lack of threat to their health.

- ❑ **Human rights and TB:** The right of all Nigerians to enjoy the highest level of health attainable and to have access to health services and other means needed to protect health is enshrined in Article 12 of the International Covenant on Economic, Cultural, and Social Rights and in Article 25 of the Universal Declaration on Human Rights, as well as related conventions on the rights of the child, of women, and of people with disabilities. Nigeria is a signatory to both of these key documents. Given the challenges with the health care system described, the right to health is not guaranteed for Nigerians at this time. A concerted government effort is underway to provide equitable and improved access to health care, as described in the National Health Plan 2009 – 2015. Implementation of the Plan is essential for fulfilling the right to health for all Nigerians.
- ❑ **TB & Stigma:** TB continues to be highly stigmatized, and people with TB have reported poor treatment by health care providers, employers, family members, and other social contacts. At the same time, existing religious law and new legislation may threaten the ability of the NTBLCP to reach some sub-populations at risk for TB²⁸. In the north of the country, homosexuality is punishable by death according to Sharia law. In addition, recent national legislation criminalizing homosexuality as well as participation in organizations that support homosexuality, and banning same-sex marriage have had immediate negative consequences for homosexual individuals and their supporters. Widespread anti-homosexual discrimination will likely prevent individuals who identify as homosexual or who support homosexual rights from presenting to health facilities for treatment of any health condition, including TB. The challenge of providing equitable access to health services for all Nigerians will have to address the issues of discrimination and stigma presented above.

The health systems and community systems Analysis

A health systems analysis was conducted as a precursor activity towards the development of the concept note. Key findings are summarized cross the six HSS blocks. The detailed assessment report²⁹ is attached to this application.

Health Systems Analysis

A. Health Information System /Monitoring & Evaluation

The assessment revealed a weak health information system (HIS) in Nigeria despite the significant investments made to date in this area of the health system. However, the analysis indicates that the HIS

²⁸ NTBLCP, TB KAP study , 2013

²⁹ Health Systems Assessment report, 2014

demonstrates the potential to be transformed into a strong and viable building block for the Nigerian health system. Most of the challenges are in the areas of Data Governance, Data Quality and Use of Information. The assessment concludes “.....the existing Health Information System requires strengthening in order to position it to assist health interventions to deliver on expectations. To achieve this, a phased and coordinated approach in support of health interventions is recommended”. The road map for implementing this coordinated approach is guided by the national HIS policy and elaborated in the HIS strategic plan.

Data governance is one of the most challenging aspects that the Nigerian health information system has faced over the years. Coordination of donors and the need to monitor their different programs has contributed significantly to the fragmentation of the data system and the development of parallel pathways to fulfil each donor requirement. Multiple data collection tools collecting the same data elements were observed to be circulating in many health institutions across the country leading to duplication of efforts and extra burden on facilities which in most cases are under staffed. In addition, this cause distortion and confusion in national monitoring system as different programs tracked different performance indicators through independent information systems. HIS is grossly underfunded by government at all levels in the country. There are no budget lines for HIS, where it exist, it may not be funded or fund grossly inadequate. However, existing policy stipulates that 2% of the health budgets at National, State or LGA levels be used for HMIS activities.

The implementation of National Health information system in Nigeria is being strengthened with funds from GFATM, GAVI, UN systems and other development partners. The collective effort of the stakeholders has increased completeness of the facilities reporting to the national HIS platform from less than 12% in 2012 to over 52% in June 2014. However, more work needs to be done to improve data quality, supervision, mentoring and monitoring, coordination, provision of data management tools and equipment, data analysis, dissemination and use,

The National Health Information System has been positioned to provide service delivery and other programme management data (where possible) data for majority of the national health programmes (e.g. ATM, MNCH) at primary, secondary and tertiary health facilities, thereby contributing to improved accountability, transparency and improvements in programme management.

Within the HIS/M&E thematic area of the ATM, the identified critical strategic areas of work include:

- a. To strengthen routine data generation and flow from public, programs, and private facilities and communities; with a special focus on integration/migration into DHIS2 platform through a well-coordinated roll-out plan (which includes provision infrastructure including internet access, mentoring, monitoring and supervision, local and international TA support).
- b. To review of the NHMIS /ATM tools, including community tools, to ensure effective response to ATM indicators within the DHIS2 platform
- c. To strengthen coordination, partnership, and integrated M&E supportive supervision, among various stakeholders to address governance and monitoring and evaluation processes.
- d. To strengthen ATM health intervention implementation research and results dissemination and use.

These priority areas will be the areas for strategic investment in this funding application.

B. Procurement Supply Chain Management

In general, Nigeria runs a decentralized system of procurement and supply of medical products. The medical products for priority programs such as HIV, TB, Malaria, RH, NTD, RMNCH and immunization are mainly managed at the federal level while all other products are procured and managed by states and facilities.

The country has recently constituted a National Product Chain Supply Management Program to coordinate all PSM activities in the country.

In 2013, average annual availability of tracer medicines was 88% for HIV³⁰ and 87% for TB³¹. The average availability for HIV rapid test kits was 60% during the same period while data for TB is not centrally collated. The LMIS reporting rate for 2013 was for 73% HIV and 96% for TB.

The current PSM strengthening strategies employed by the TB program include:

- ❑ The decentralization of management and warehousing facilities to zonal and state levels
- ❑ The quarterly review meetings at the zonal and state levels are used to collate reports, plan distribution and replenishment stock for state stores and facilities respectively.
- ❑ The use of private sector logistic suppliers from the central to the zonal stores while state officers provide logistic services for the state stores and facilities.
- ❑ The use of a PSM performance improvement tracking system to promote efficiency

The HIV strategies include:

- ❑ Decentralization of management and warehousing to axial stores in 6 zones
- ❑ Outsourcing distribution to 3rd party logistic providers to move products from the axial warehouses to the facilities
- ❑ Establishment Logistic Management Units at the state level for supply chain management activities and holding quarterly zonal meetings for monitoring

The ATM & RH programs are characterized by separate logistics infrastructures, with different distributions and reporting systems. There is inadequate coordination between IPs, PRs and the government resulting in duplication of efforts and wastage of resources. There is poor funding for periodic coordination meetings and activities.

While the private sector distribution to stores for the TB program is performing optimally, the public sector distribution to the health facilities experiences various challenges. These include inadequate transport facilities, inefficient distribution resulting in shortage in deliveries to facilities and inadequate feedback on supplies made to facilities.

The challenges in the HIV and TB PSM systems also include weak capacity in estimation of needs, inventory management, good storage practices, documentation, reporting and high rate of attrition of trained personnel at the facility level. Some state stores have inadequate storage capacity and infrastructure. In addition, the safety of new HIV and TB products are not actively monitored.

The key strategy to strengthening the national PSM system for ATM products is to integrate the various systems of the government, programs and partners such as PEPFAR. At the state level, the State Product Chain Supply Management Program will coordinate activities at the state and local government levels. This integration will ensure optimization of the resources available to the nation by eliminating wastage of resources through running of parallel programs. Involving the states in PSM management of their systems will ensure ownership and sustainability of the program. There will be synergy between programs as each one learns the good practices developed over the years. Gradually, all other products will be integrated and thus benefit from one PSM system for the country and respective states.

While this is laudable, it is expected that there will be resistance to the integration. This will be implemented in a phased manner with adequate advocacy to states and partners and their inclusion in the formulation and implementation of the various strategies.

This NFM application is modelled to address the noted challenges and further support efforts towards enhancing institutional capacity for effective implementation of PSM activities in Nigeria.

C. Service Delivery

As at December 2011, 34,173 health facilities from 36 States and FCT were listed in the Health Facility Directory³². Of this number 30,098 (88%) are primary health care (PHC) facilities, 3992 (12%) are secondary level facilities while 83 (1%) are tertiary level facilities. More than 66% of the facilities are public (government) owned. There is ongoing effort to make the master facility list interoperable with

³⁰ 2013 HIV LMIS semi-annual report

³¹ 2013 TB consumption data report

³² National Health Facility Directory, 2012

National DHIS platform to strengthen routine health data analysis.

Service Type	PHC		Secondary facilities		Tertiary facilities		Total
	Public	Private	Public	Private	Public	Private	
Proportion distribution of DOTS by ownership and level of care	69%	6%	14%	8.45%	2.5%	0.05%	100%
Absolute numbers of facilities providing DOTS services	3,722	324	755	456	135	3	5394
Proportion of DOTS facilities with microscopy	38	7	35	14	6	1	100%

A total of 7075 sites are offering HCT, while 5622 and 802 facilities are offering PMTCT and ART respectively³³. TB and HIV collaboration activities are in 34% of the total DOTS sites. PCR testing is available in 23 sites in the country while CD4 testing is available in 564 facilities (supported by PEPFAR).

There is increased effort to ensure commodity security and exclude fake drugs in the country³⁴. There has been marginal decline in average stock out of medicines and commodities at facility level 14% and 15% was recorded for Tuberculosis medicines and commodities in 2012 and 2013³⁵ respectively while the stock-out for HIV medicines and commodities is 7.9%³⁶.

Availability of basic amenities to support an enabling working environment and quality services (e.g., electricity or generator, emergency transportation system, and good sanitary and waste management practices) are poor in many of the PHC³⁷. The investment from GFATM round 8 grants impacted positively on the health system as evidenced by improvement in selected PHC infrastructures and service delivery.

The quality of service at the PHC facilities and limited period of its operation forces clients to secondary and tertiary facilities. Data from case management competency of health facilities staff across a number of tracer diseases that included Malaria and other common conditions with high burden shows that on the average only 37.4% of all cases considered were correctly diagnosed by all the health workers.³⁸ There is no national policy on maintenance of equipment but there is a national referral system but its functionality has not been assessed. Health facility Committees (HFCs) provide formalized engagement of communities in health care delivery as well as avenues for creating demand for services. Another operational structure that enhances community participation is the Ward Development Committees. These community level structures form linkages with health facilities, creating awareness for services, and sensitizing communities on health promotion and protection.

D. Human resources for Health

Federal, States and LGAs are expected to be actively using adapted versions of the National HRH policy and Plan by end of 2015. Only 15 states (42%) had adapted the HRH Policy. None of the 774 LGAs in the country have so far elaborated policies or strategic plans for HRH leading to poor coordination of efforts addressing critical shortage, mal-distribution of the available health workforce, weak HRH governance and capacity, limited production and training capacity.

A major challenge limiting effective and evidence-based planning and management of HRH in the health

³³ National validated HIV service data, 2013

³⁴ GPRHCS Survey, 2011

³⁵ NTBL programme report 2013

³⁶ HIV/AIDS logistics Unification report 2013

³⁷ PHC review 2012

³⁸ PHC review, 2012

sector is the dearth of HRH data and baseline information. With an estimated 20 doctors, nurses and midwives per 10,000 population³⁹, Nigeria falls short of the minimum threshold of 23 per 10,000 population established by WHO as necessary to deliver essential maternal and child health interventions. Imbalances in the skill mix and large disparities in the distribution of the health workforce between rural and urban areas and across the six geopolitical zones compound the matter further, with the northern areas being particularly under-resourced (USAID, 2009) (National Primary Health Care Development Agency, 2007).

Various staff category per 100,000 population vary from one zone to the other. For example, whilst national average for doctor per 100,000 population is estimated at 12, some zones notably North West and North East have as low as 4. Whereas the national Nurse/Midwife per 100,000 populations stands at 21, the South West, North West and North East zones have 16, 11, and 18 respectively. This suggests that any strategy to ensure equitable distribution of Doctors and Nurse-Midwives must be sensitive to the needs of the affected zones. This same distribution problem affects other professional groups.

Majority of health workers in PHC facilities across all the states are CHEWs. Doctors, Nurses and Midwives are more available in non-PHC Healthcare Centers. This is important in deciding the types and extent of services that can be expected to be delivered in a given type of health facilities.

E. Health Care Financing

The 2006-2009 National Health Accounts reveals the main sources of revenues for the health sector in Nigeria remain funds from households, domestic spending from the government, and external aid from development assistance. Based on the NSHDP mid-term review, at the federal level, the annual budgetary allocation to health, in absolute terms and as a proportion of total federal budget, increased from 2010 (3.9%) to 2012 (6%), but decreased again in 2013 (4%). At state level, an annual downward trend in budgetary allocation to health from 2009 to 2012 was seen in the FCT, Benue, Akwa-Ibom, Bauchi and Plateau states, while Kogi, Jigawa, and Sokoto states recorded an upward trend. Other states either showed no clear pattern in budgetary allocations to health or did not have adequate data for trend analysis. Data from the OECD Development Assistance Committee (DAC) shows that disbursements to the health sector from external sources increased from USD 820.5 million in 2009 to USD 942.9 million in 2012⁴⁰.

F. Health Policy and Governance

A fundamental requirement for stewardship and strategic direction is the availability of relevant policies in the health sector. Nigeria is reputedly not lacking in relevant health policies, including associated strategic plan of action to realize policy goals and objectives e.g., National Policy on HIV/AIDS; National Policy on Roll Back Malaria; National Policy on Tuberculosis and Leprosy Control; National Policy on Immunization; National Policy on Onchocerciasis Control; National Policies on Child Health, Blood Transfusion, Elimination of Female Genital Mutilation, Reproductive Health, Drug, Hygiene and Safety, Child Health, Food and Nutrition, Adolescent Health to mention a few. These policies are being implemented, albeit with mixed results.

Community Systems Analysis

The community is probably the most important link in the healthcare delivery in Nigeria as it forms the support structure for the implementation of PHC services. The National PHC Development Agency (NPHCDA) is the apex management and technical structure for PHC services in the country. Similar structures exist in all the local government areas. Multisectoral Ward and Village/Community Development Committees, where they exist, are responsible for coordinating all development activities

³⁹ Nigeria has a good supply of skilled health workforce by regional standards, with an estimated 30 doctors, 100 nurses and 68 midwives per 100,000 population, to compare with an average of 15 doctors and 72 nurses in sub-Saharan Africa Invalid source specified. (NB: data are for 2006).

⁴⁰ Mid Term Review of the NSHDP (2010-2015), 2013

including the provision of primary health care services

Health care delivery at the PHC level is construed to be universally accessible to individuals and families in the community with their full participation in ownership in the spirit of self-reliance and self-determination. The PHC system in Nigeria makes structural and managerial provision for the establishment and functioning of effective development committees at all the Local Government Areas levels; with the institutionalization of Ward Development Committee (WDC) as part of the PHC structure at the grass-root level. The Ward Development Committee (WDC) is the closest managerial link between health facilities and the villages /communities in the implementation of PHC services. Presently, only 33% of WDC is activated and the major challenges remain the fact that they work on volunteerism basis and are susceptible to political influence.

Civil society including NGOs, FBOs, and CBOs, are key players in the provision of community level PHC services. Though different projects have been implemented in Nigeria with some form of community based interventions, unfortunately, weak system coupled with a largely dearth of data to establish the effectiveness of these various projects have been a bane to the effectiveness of community system. The GF supported implementation of CSS in Nigeria under the Rd9 intervention with focus on strengthening the capacity of CSOs to conduct demand generation activities for ATM services. The GF grant strengthened the capacity of 370 ATM CBOs (11%) in demand generation, out of the 3,100 ATM CBOs in the country.

In a recently conducted Community Evaluation study supported by GF, it was noted that there is integration of the ATM services by CBOs, involvement of the community people for the purposes of ownership and sustainability and increased health literacy of individuals at the grassroots among others. However, the report also documented obvious gaps in the community intervention in the country. This includes, not reaching potentially hard to reach clients like migrants, mobile population and KAPs; weak programme capacity by the CBOs; frequent attrition of CBOs staff; non availability of a national CSS integrated framework among others (TB/HIV/AIDS community assessment report and CSO community dialogue report, 2014). Also, the National HSS Evaluation 2013 showed the gaps in community system strengthening to include:

- ❑ Leadership: not enough attention has been paid in strengthening community systems, even with long history of talks about community ownership and participation. The mechanism to achieve this has been weak and leadership diffused. The vacuum has often tended to be filled by CSOs/NGOs, yet this has resulted in the need for some upfront capacity building which have not been readily forthcoming. Neither donors nor government have any sustainable strategy for engaging CSOs
- ❑ Capacity of implementing CSOs is comparatively weak. This is because they do not have enough exposure and resources
- ❑ There are challenges to coordination of CSOs and institutionalization.
- ❑ The ability of CSS practitioners to attract and retain competent staff is weak, and overstretched.
- ❑ More often than not, while government policies recognize the need for community systems to be mobilized for an all-inclusive process, the mechanism through CSO is given scant attention, this is responsible for non-availability of National CSS framework.

There is a need to strengthen the capacity of CSOs to advocate and lobby duty bearers for enabling environment in terms of stigma reduction, gender equality and human right in creating access to ATM services for all as well as engaging other community actors including WDC members in generating demand for ATM services.

Challenges to implementation of National TB and HIV programs:

The health sector continues to face major challenges, including:

- ❑ Limited financial resources: Funding for ATM has been largely dependent on international donors. Government investment in health while substantial, pales significantly with the size of the population and the inherent disease burden for ATM
- ❑ Health System Challenges: As articulated above to include poor infrastructure, dearth of adequate human resources for health; weak supply chain structures; lack of integrated data systems for ATM programs

- ☐ Weak social infrastructure across the country – e.g. electricity supply, potable water, access roads all contribute to limitations in service access.
- ☐ Growing insecurity in some geographic locations .e.g. North East Nigeria limits service penetration across all programs.

1.2 National Disease Strategic Plans

With clear references to the **current** TB and HIV national disease strategic plan(s) and supporting documentation (including the name of the annexed documents and specific page reference), briefly summarize:

- a. The key goals, objectives and priority program areas under each of the TB and HIV programs including those that address joint areas.
- b. Implementation to date, including the main outcomes and impact achieved under the HIV and TB programs. In your response, also include the current implementation of TB/HIV collaborative activities under the national programs.
- c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints and barriers described in question 1.1 are currently being addressed.
- d. The main areas of linkage with the national health strategy, including how implementation of this strategy impacts the relevant disease outcomes.
- e. Country processes for reviewing and revising the national disease strategic plan(s). Explain the process and timeline for the development of a new plan and describe how key populations will be meaningfully engaged.

A. Analysis of the National strategic plans for TB and HIV in Nigeria

TB National Strategic Plan (2015 – 2020):

Nigeria has recently revised its national strategic plan to replace the previous plan spanning 2010 -2015, in response to new data, availability of new technologies, and a thorough assessment of programme gaps involving all stakeholder groups. This new National Strategic Plan for Tuberculosis Control, 2015 – 2020 focuses on five strategic priorities, aligned with the three pillars of the global post-2015 TB strategy:⁴¹

- ☐ Rapidly increasing detection of TB in adults and children
- ☐ Improving treatment success in specific geographic areas
- ☐ Integrating TB and HIV services
- ☐ Building capacity for diagnosing and treating drug-resistant TB
- ☐ Creating strong and sustainable systems to support these achievements.

⁴¹ The three pillars include integrated, patient-centred care and treatment; bold policies and supportive systems; and intensified research and innovation. WHO presentation on the new post-2015 targets, accessed at: http://www.who.int/tb/post_2015_tb_presentation.pdf?ua=1, June 6, 2014.

NSP-TB Goal

The goal of the new TB NSP is to ensure universal access to high-quality, patient-centred TB prevention, diagnosis, and treatment services for Nigerians with all forms of TB by 2020, regardless of geographic location, income, gender, age, religion, tribe, or other affiliation. The NSP-TB has 11 objectives, including 6 core technical objectives and 5 supporting objectives related to CSS, advocacy for resource mobilisation, and HSS. These objectives reflect Nigeria's epidemiological and health systems priorities as articulated in the mid-term review of the NSP 2010-2015, the prevalence survey, and the epidemiological assessment.

Objective 1:

Rapidly increase case finding activities and diagnostic capacity to increase the Case Notification Rate of all forms of TB from 57.3 per 100,000 population in 2013 to 287 per 100,000 population in 2020

Objective 2:

Align treatment capacity scale-up with the increased diagnostic capacity to increase treatment success rate from 87% in 2013 to 90% by 2020 among drug-susceptible patients.

Objective 3:

Implement new strategies to improve the control of TB in children in line with the global road map for childhood TB, diagnosing 226,051 paediatric TB cases between 2015 and 2020.

Objective 4:

Provide access to high-quality integrated services for all people co-infected with TB and HIV.

Objective 5:

Provide access to DR-TB diagnosis to all presumptive DR-TB cases people who require it by 2020 in line with the national diagnostic algorithm.

Objective 6:

Enrol 100% of diagnosed DR-TB patients on appropriate treatment by 2020.

Objective 7:

Strengthen the collaboration with and capacity of community-based organizations and networks to support NTBLCP objectives and activities.

Objective 8:

Strengthen political commitment and mobilize domestic resources at all levels to fund essential TB services in Nigeria.

Objective 9:

Strengthen NTBLCP systems and capacity to support full implementation of the National Strategic Plan at all levels.

Objective 10:

Strengthen linkages between levels of the health system to improve management and accountability.

Objective 11:

Contribute to the strengthening of the health care system, especially primary health care, in collaboration with other disease programmes and agencies for integrated delivery of prevention, diagnosis, and treatment services for TB, HIV, and malaria.

Implementation to date – Key Impact and outcome achievements

The National Strategic Plan for Tuberculosis 2015 – 2020 provides a thorough discussion of current program performance and challenges in Section 3.5, pp. 54-62. To summarize, NTBLCP continues to strengthen its performance, with slow but steady increases in case notification and treatment success. The programme has made progress in expanding DOTS, integrating HIV into TB services, and initiating a DR-TB diagnosis and treatment system. With the support of its technical partners, NTBLCP has developed numerous plans and guidelines covering laboratory scale-up; PMDT scale-up; DR-TB; pediatric TB; TB/HIV; infection control; Community TB care (CTBC); and ACSM.

Case notifications have been consistently on the rise to 100,401 cases (all forms) notified in 2013, but seem to have reached a plateau since 2008 despite the more intensified approach to PPM activities (24% of 2012 notifications were from private facilities and providers).

Case diagnosis: Out of all notified TB cases in 2012, 59% were confirmed through smear-microscopy, 37% were based on a clinical diagnosis, and only 5% were extra-pulmonary TB. The proportion of extra-pulmonary TB is lower than might be expected in a population with high rates of HIV and a high proportion of children. This suggests a potential under-diagnosis of this form of TB due to limitations in diagnostic capacity and provider experience. In spite of these efforts, case detection remains below 20% of the expected incident cases, and the number of undiagnosed TB cases in Nigeria thus represents approximately 15% of the 3 million cases missed globally each year. Poor access to basic diagnostics nationwide, low public awareness and recurring industrial actions by health care workers are several of the major contributors to low case detection. At present, there are 1,602 microscopy sites in Nigeria, representing a ratio of 1:109,000 population and these are not evenly distributed, so that some areas of the country are very poorly covered.

Treatment success has gradually increased over the last ten years to 86% in 2012, reaching the national target for 2015. Loss to follow up has decreased from 13% to 7%, and the death rate has remained relatively low and constant at around 5%. While the overall performance of the country on TB treatment is on track to reach the new target of 90% treatment success, there are some states where performance is inadequate. The four states noted in the mid-term evaluation as underperforming on treatment success included Kwara, Lagos, Ogun, and Anambra. In Kwara, the TSR declined to 62% in 2012 while loss to follow up increased to 29%. Lagos, Ogun, and Anambra also have unacceptably high rates of loss to follow up, at 16%, 15%, and 21% respectively. (Nigeria TBLCP MTR report final draft-0305.2013, p.9).

HIV/TB Integration: The scope of work for staff at DOTS centres in the implementation of integrated TB/HIV collaborative activities is expanded beyond provision of TB services to include joint TB/HIV services such as: HCT for TB suspects and TB patients; provision of CPT and referral/provision of ART services for HIV positive TB patients

- **HCT for TB patients:** Access to HIV services for TB patients has increased rapidly since 2007. In 2013, 88% (88,317) of the 100,401 notified TB patients were counselled and tested for HIV. Out of these, 19,423 (22%) HIV-positive TB patients were notified, primarily through the TB programme.
- **CPT and ART for HIV positive TB patients:** In 2013, the percentage of HIV-positive TB patients on co-trimoxazole preventive therapy and anti-retroviral therapy during TB treatment were 87% and 67% respectively.

- **IPT:** In 2013, 7,973 PLHIV were placed on IPT at the HIV service delivery centre, this represent 1.7% of eligible PLHIV without active TB who are in need of the services. Barriers to expansion of IPT include weak capacity to implement by service providers and lack of sufficient knowledge among service providers.

Case detection of Drug Resistant TB (DR-TB): In 2009, 107 cases of DR-TB had been identified by culture and drug-sensitivity testing (DST) at 3 institutions⁴². Since the mid-2011 roll-out of GeneXpert machines, the testing of 3,993 patients (by end 2012) led to identification of a further 357 DR-TB cases. In 2013, a total of 11,142 presumptive DR-TB cases were evaluated using *GeneXpert*, of which 665 (6%) were positive for rifampicin resistance. However, only 335 (50%) of these were enrolled on treatment, because of the national policy that currently requires hospitalization for the full 8-month intensive phase and a lack of sufficient in-patient beds. This policy is being changed to reduce the time spent on admission during the intensive phase for the majority of the patients (from 8 months to 3 months), as well as initiate patients on treatment on an ambulatory basis, while ensuring access to quality hospital-based specialist care within each state for patients that require such mode of management – 12 of such centres have been established so far.

DR-TB treatment success rate: For DR-TB patients diagnosed from July 2010 through November 2011, treatment success was 62.3%, but notably cure was only 37.7%. Loss to follow-up in these cohorts was almost 10%, reflecting the need to strengthen patient support systems, and deaths were high at 27.9%.

Childhood TB: Nationally, the proportion of paediatric TB cases among all cases notified, increased from 3% in 2010 to 6% in 2011 and 2012 although this varied between the states. Ebonyi had the lowest proportion of child cases (3%), while Oyo had the highest proportion. This 6% in 2012 is still a very low proportion of new cases notified in children less than 15 years. Very few doctors or DOTS Centre staffs have received any training in paediatric TB. Although the NTBLCP Workers' Manual 5th edition includes guidelines, score charts and algorithms for the diagnosis and treatment of paediatric TB, very few paediatricians, doctors, DOTS centre staff or laboratory staffs in the health facilities are aware of this, or are following them. The MTR found that are no childhood TB specific national program tools available other than a contact tracing register for child contacts less than six years. This register was rarely used. There are very weak linkages between paediatric doctors and the TBL programme generally and also within facilities, between the DOTS clinics and maternal child health programs and paediatric wards/clinics.

PPM: Scale up of PPM services within the private, military, paramilitary, police, prisons and custom health services was undertaken with the goal of contributing at least 15% of total TB cases detected (excluding those from tertiary health institution) by the end of 2015. PPM has been implemented in all States resulting in a total of 685 health facilities now providing TB services in a DOTS Centre, up from 76 facilities in 2005. Expansion of DOTS services has included private for profit, faith based facilities, community pharmacies (Cross River State), military and prisons. Together these facilities contributed 24% of all new TB cases in the country in 2012.

Monitoring & Evaluation (M&E). A key objective in the NSP for 2010-2015 is to strengthen the M&E system at all levels in order to ensure that over 95% of planned activities are implemented, monitored and evaluated.

The MTR found that from the national level to state and LGA levels there were no

⁴² National Strategic Plan 2010-2015.

comprehensive, result-based plans with complete result/logic frameworks, performance monitoring plans nor annual operational plans with which the coordinating teams could plan their implementation and monitor their own progress quarter by quarter and year by year. While data recording and reporting is being done well in the various TB registers, there is no synchronizing of registers from the various units within a facility, no analysis performed and no evidence of data use for performance improvement. Nationally the databases in use are not designed well for analyses and monitoring of progress.

The NTBLCP website has been developed, but is not yet fully operational. Once fully functional, it will be an important means of dissemination of programmatic information

The NSP-TB and NFM priorities

The NTBLCP and its stakeholders have considered the national priorities articulated in the NSP-TB and available resources for implementation in selecting the priority interventions for inclusion in this Global Fund application. The NFM application reflects the highest priority actions for the NTBLCP toward control of TB in Nigeria, with the highest potential for yielding significant results. The application includes interventions for diagnostic scale-up, active outreach for case-finding in the most important KAPs, and PPM to rapidly increase case notification; community-based treatment support to maintain high levels of treatment completion and avoid creation of drug resistance; intensive integration of TB and HIV services; and scale-up of capacity to diagnose and treat DR-TB. To support achievement in these areas, interventions aimed at strengthening community-based organizations; creating strong PSM and HMIS systems; improving supportive supervision and accountability; and strengthening the primary health care system are also targeted. Acknowledging the limited resources available to the Programme, NTBLCP has also identified priority geographic areas for Global Fund support, comprising 13 states and the FCT, which represent more than 50% of the missed TB cases in Nigeria and include the states with the highest burden of HIV. These priorities are described in detail in the sections that follow.

HIV National Strategic Plan (2010 – 2015):

Following the midterm review of the NSF 2005-09, Nigeria initiated low intensity activities and processes to better inform the development of the NSP 2010-15. The NSP is planned for review which should commence in the fourth quarter of 2014 and the process has been preceded by a mid-term review concluded in December 2013. The results are detailed in the section describing performance to date. As an intermediary supplement to the NSP, the nation in consideration of the noted gaps in attaining set NSP targets developed a two year acceleration plan – The Presidents Comprehensive Response Plan (2013 -2015) with the goal to accelerate the implementation of key interventions over a two year period to bridge existing service access gaps, address key financial, health systems and coordination challenges and promote greater responsibility for the HIV response at Federal and State levels.

HIV-NSP Goal

The Overall goal of the current NSP is to to reduce new HIV infections, and improve the quality of life for the infected and affected⁴³.

Objective 1

To reduce the incidence of HIV/AIDS by ensuring that at least 80% of sexually active adults (including discordant couples and people in concurrent multiple partnerships) are accessing HCT services in an equitable and sustainable way by 2015; at least 80% of

⁴³ National HIV M&E plan (2011-2016)

most at-risk-populations accessing HIV counselling and testing by 2015; At least 80% of all HIV positive pregnant women have access to more efficacious ARV prophylaxis by 2015; At least 80% of all HIV exposed infants have access to ARV prophylaxis by 2015

The National scale up plan towards elimination of mother to child transmission (eMTCT) was developed after the NSP with the goal of 90% coverage by 2015 in line with the global target⁴⁴.

Objective 2

Ensure that all eligible PLWHIV receive quality treatment services for HIV/AIDS and opportunistic infections (OIs) as well as TB treatment services for PLWHIV co-infected with TB

Objective 3

To promote the survival and improve the quality of life of PLHIV and people affected by HIV/AIDS (PABA) especially OVC.

Objective 4:

To protect the rights of PLHIV and PABA and empower them and other groups made vulnerable by HIV/AIDS especially MARPs so as to reduce their cultural, legal, and socioeconomic vulnerabilities and ensure their full participation in the national HIV/AIDS response and other development initiatives.

Objective 5

To strengthen structures and systems for the coordination of a sustainable and gender-sensitive multisectoral HIV/AIDS response in Nigeria

Objective 6:

To strengthen and embed a sustainable systems based approach to delivering a cost-effective, multidimensional and gender sensitive monitoring and evaluation system which supports the continuous improvement of the national response

Priority Program areas

- ☐ Promotion of Behavior Change and Prevention of New HIV Infections
- ☐ Treatment of HIV/AIDS and Related Health Conditions
- ☐ Care and Support of PLHIV, PABA, and OVC
- ☐ Policy, Advocacy, Human Rights, and Legal Issues
- ☐ Institutional Architecture, Systems, Coordination, and Resourcing
- ☐ Monitoring and Evaluation Systems comprising M&E, Research, and Knowledge Management

Implementation to date – Key Impact and outcome achievements

A mid-term review of the HIV NSP (2010-2015) was completed in December 2013 and provides a strategic overview of implementation to date of the NSP. Of peculiar mention is the approach adopted in the MTR that allowed for sub-national review of performance at State level. This provided the unique context required for the design of programs that are state specific and responsive to the epidemiologic peculiarities of the states. The detailed report is attached as an annex to this concept note.

At Impact level, some key achievements are noted. While there is no national HIV incidence study, estimates show a decline in the national HIV incidence in those aged 15 to 49 years over the last 3 years: 0.27 in 2010, 0.26 in 2011 and 0.24 in 2012 (Spectrum

⁴⁴ National scale up plan towards eMTCT FMOH 2010

Modeling, 2012). The estimated number of new infections per annum has also dropped from 220,000 in 2010 to 210,000 in 2012 for the those aged 15 and above; and from 66,000 in 2010 to 60,000 in 2012 for those 14 years of age and less. The number of mothers requiring PMTCT has also dropped from 210,000 in 2010 to 200,000 in 2012. Overall, these figures represent a 5.6% decline in number of new HIV infection between 2010 and 2012.

An overview of performance across key thematic areas is presented below.

HCT achievements⁴⁵;

- ❑ The number of sites providing HCT increased from 1,064 in 2010 to 1,357 in 2011 and 2,624 in 2012. This number still falls below the projected 23,640 sites required for adequate service provision (FMoH, 2012).
- ❑ The proportion of persons who desired HCT increased from 43.0% in 2003 to 73.0% in 2010⁴⁶. Clearly an unmet need for HIV testing still exists in spite of the intensified intervention efforts.
- ❑ Clearly an unmet need for HIV testing still exists in spite of the intensified intervention efforts.

Prevention of Mother to Child Transmission of HIV⁴⁷

- ❑ The number of pregnant women counselled tested and received results (PMTCT for HCT) in 2011 were 1,120,178; in 2012 was 1,250,000 and increased to 1,706,524 in 2013.
- ❑ The national coverage for PMTCT ARV update has risen from 11% in 2011 to 17% in 2012 and 30% in 2013.
- ❑ Of HIV exposed infants, 6.2% received ARV prophylaxis and 4.1% received virologic tests to determine their HIV status within 2 months of birth. These figures fall short of the 2012 targets of 16.8% and 18.9% respectively. This emphasizes the need to fund and prioritize EID.

Behavior Change for young adults:

Review of the 2012 NARHS Plus data shows significant improvement in behaviour of adolescents and young adults. There is a reduction in the percentage of adolescents and young adults who have sexual intercourse with more than one partner; an increase in the percentage of those who use condom when having sex with none marital partners; and a decrease in those who engage in transactional sex. The percentage of those who had their first sexual debut before the age of 15 years also decreased significantly (6.7%) and had exceeded the target of 12.0% for males and 23.0% for females in 2015⁴⁸.

For other behavior change indicators, please refer to page 38 of the MTR report attached.

Prevention in Key Affected Populations:

⁴⁵ See page 27 of the MTR report.

⁴⁶ NACA: President's Comprehensive Response Plan for HIV/AIDS in Nigeria 2013-2015

⁴⁷ See page 33 of the MTR report

⁴⁸ NARHS, 2012

The most at risk populations (MARPs), for HIV infection (FSW, PWID and MSM), also referred to as key populations, are responsible for 40% of new infections⁴⁹. Local epidemic appraisals were conducted to strengthen the evidence base for prevention programming at the community level. Twenty-two states estimated the sizes and completed geographical mapping of MARPs

- ❑ FSW reported a reduction in the frequency of alcohol usage, more regular and consistent use of condoms, avoidance of sharing sharps, a decrease in number of concurrent partners, and regular visits to the hospital for care. In addition, there is a sense of increased perception of risk for HIV infection as the number of FSW who had undertaken repeated HIV tests was high⁵⁰.
- ❑ MSM reported an increase in the likelihood of staying with one sex partner and reduced alcohol use. There was also an increase in the number of MSM who now perceive themselves at risk for HIV infection; many had erroneous belief that anal sex was safe. There was increase uptake of HCT services⁵¹.
- ❑ Analysis of pooled data from the programs for MSM conducted by Population Council Nigeria and IHVN shows that 45%⁵² of MSM could correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. This exceeds the national 2012 target by 5.9%.

The National HIV Treatment Program:

- ❑ At the end of 2012, 516 (2.0%) health facilities in Nigeria were providing ART services. This was a 15.7% increase over the number of ART sites in place in 2010, and a 5.1% increase from the 491 sites in 2011⁵³.
- ❑ Overall, the national treatment program has reached 639,397 persons eligible for ART in 2013 from 491,021 people in 2012. However, in 2012 only 31,565 children received ART of the 12.1% estimated 256,155 children in need of ART. This low paediatric ART coverage also emphasize the need to focus on paediatrics ART.

The National Joint TB and HIV Program achievements

Figure 12: Performance trends for TB/HIV indicators (2007 -2013)

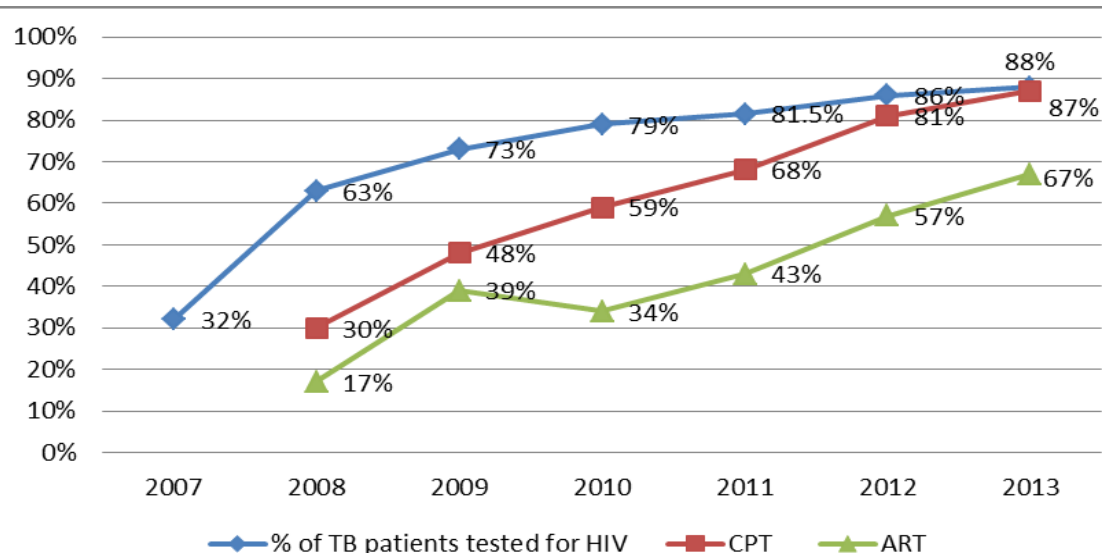
⁴⁹ NACA, UNAIDS, World Bank: Modes of HIV transmission in Nigeria: analysis of distribution of new HIV infections in Nigeria and recommendations for prevention. 2009; 2010.

⁵⁰ National Agency for the Control of AIDS. Report of the evaluation of the Global Fund supported interventions for HIV /AIDS Response in Nigeria. 2013

⁵¹ National Agency for the Control of AIDS. Report of the evaluation of the Global Fund supported interventions for HIV and AIDS Response in Nigeria. 2013

⁵²Population council programme in FCT, Kaduna, Lagos and Oyo showed 2110 of 4731 while IHVN showed 1462 of 3200. Thus total of 3572 MSM of 7931 MSM reached met the target indicator in 2012.

⁵³ FMOH, Program report 2012



- ❑ Efforts at TB/HIV co-management have improved significantly in the last three years but the results are still mixed.
- ❑ In 2013, 19,423 HIV-positive TB patients were notified, primarily through the TB programme. Access to HIV services for TB patients has increased rapidly since 2007
- ❑ The installation and use of the GeneXpert MTB/RIF for the diagnosis of TB/HIV co-infection since 2011 has helped improve TB/HIV co-management. The diagnostic tool has been installed in 33 sites in Nigeria as of the end of 2012.
- ❑ The 2012 achievement for TB screening of those in HIV care fell short of the 2012 target by 18.0%. On the other hand, the 2012 achievement for HIV screening of those in TB care exceeded the set 2012 target by 4.5%.
- ❑ The percentage of new adults and children in HIV care who received IPT for the prevention of TB infection increased by only 0.2% from baseline; this is 31.4% below the 2012 target.

B. Limitations to Implementation across TB and HIV national programs

- ❑ Health systems issues are the single largest barrier to rapid scale-up of services across the disease programs and beyond, as has been documented in numerous assessments. Any efforts to scale up service delivery must address these issues. This requires partnership across multiple disease programs and multiple sectors to create a sustainable response. In particular, advocacy to build political will and improve resource allocation from federal, state, and local governments is essential
- ❑ There is poor engagement of the private sector in the planning and implementation of HIV and TB programs. This reduces the resources that could otherwise be mobilized from this sector and it reduces the reach of the interventions by missing out the community members who might otherwise be reached through the private for profit health sector.
- ❑ Resource limitations and inadequate funding of the national strategic plans has curtailed the scope and scale of the programs. The overt high dependence on external funding sources is a trend that must be addressed. The PCRPP is a bold movement in that direction but it would need to be scaled up and sustained for all the disease programs.
- ❑ The social antagonism toward some key affected populations continues to drive them underground, thereby making them difficult to reach with prevention and treatment programmes. The recently passed same-sex marriage bill is a potential limitation to

service access by the MSM population more from a misinterpretation of its content than actual implementation of restrictive policies. Also, the continued police harassment of FSW limits access to them with programs. There is also an existing stigma and discrimination toward PLHIV which presents as a challenge to equitable access to services.

- ❑ While efforts at data collection have improved over the years, there is still cause to be concerned about the quality of the data collected for the national response. The success of the response depends on a large extent on the evidences generated by the various segments of the response.
- ❑ The weak community involvement across the disease programs requires greater investment and attention. This will greatly draw on their comparative advantage at creating demand for services and the support structures they provide to affected populations
- ❑ The supply chain will need to be strengthened in an integrated manner to provide some commodity security for the disease programs.
- ❑ Limited service integration continues to plague the two programs. Vertical programming continues to be applied with the consequent loss of cost effective utilization of limited resources. Inertia to change will be a challenge but a purposeful effort at achieving integration at service delivery points and sub national coordination levels should be sustained.
- ❑ Industrial actions (labor strikes) by various cadres of health care worker continue to limit access to services for both diseases. Some of these actions last for several months at a time, compromising the ability of patients to access anything but emergency services.

C. Linkages to the National health Strategy

The National Strategic Health Development Plan 2010 – 2015 (NSHDP, or National Health Plan) describes Nigeria's overall approach to improving the health of its people, and forms the health sector component of the government's Vision 20:2020 for Nigeria, which aims to elevate Nigeria to one of the top 20 economies in the world by the year 2020. As stated in the Plan, "The overarching goal of the NSHDP is 'to significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system'."

The National Health Plan contains the umbrella framework that should guide and inform approaches to all disease-specific programmes, including TB and HIV. It includes eight strategic priority areas for action based on a thorough analysis of health challenges in Nigeria. These priority areas include leadership and governance; health service delivery; human resources for health; health financing; national health management information system; community participation and ownership; partnerships for health; and research for health.

These priority areas are very much in line with the priorities identified for the strategic plans for HIV and TB, which reflect the need to consider the larger health systems challenges as an integral part of addressing issues specific to TB and HIV control. The strategic plans have defined interventions that contribute towards achievement of the NSHDP priorities. The explicit relationship between the NSHDP priorities and the HIV and TB Objectives and strategic interventions is presented below.

NATIONAL HEALTH PLAN PRIORITY	RELATED LINKAGE OF HV & TB NSP PLANNED ACTIVITIES
Leadership and Governance	<ul style="list-style-type: none"> • Joint strategic planning at federal-State and State-local levels • Advocacy for incorporation of TB & HIV considerations in all major health policy documents • Civil society monitoring of programme performance; annual reviews by the programme and external evaluations • Institute rigorous monitoring and evaluation and continuous quality improvement processes
Health Service Delivery	<ul style="list-style-type: none"> • Inclusion of TB & HIV in the essential package of services and in the national health insurance scheme • Incorporation of TB and HIV services (screening and referral or diagnosis and treatment) in all primary health facilities • Integrated training (TB, HIV, and malaria) and rigorous supportive supervision of health facilities • Education, outreach, screening, referral and treatment support services for TB, HIV, and malaria through community-based organizations • Financial support for indigent clients to access TB services including chest x-rays
Human Resources for Health	<ul style="list-style-type: none"> • Formulate and implement a human resources development plan for TB and HIV • Develop integrated training for health care workers in TB, HIV, and malaria • Evidence-based planning for expansion of services to achieve universal coverage • Supportive supervision at all levels with results-based incentives • Engage other health providers in the public sector, in the private sector, faith-based organizations, and community-based organizations in TB and HIV control activities • Conduct operations research on innovative approaches to improve staff retention in rural communities • Expand the dialogue and advocacy with regulatory bodies for a paced task shifting approach.
Health Financing	<ul style="list-style-type: none"> • Advocacy at the federal, State and LGA levels for increased allocation of resources for essential TB and HIV control functions • Increase in scope and scale of national and community health insurance schemes • Greater involvement of the private sector in health
National Health Information System	<ul style="list-style-type: none"> • Development of an integrated electronic data management system aligned with the NHMIS for TB and HIV • Procurement of equipment's and provision of training for health workers at all levels • Increase the capacity of health workers at all levels to analyze data and its use for programme improvement

	<ul style="list-style-type: none"> • Provide training and integrated supportive supervision, for monitoring and evaluation of health interventions
Community Participation and Ownership	<ul style="list-style-type: none"> • Build on existing community systems strengthening activities under Global Fund projects to develop a strong network of community organizations working on AIDS, TB, and malaria (ATM) • Provide ATM organizations with comprehensive integrated training on the three diseases to support outreach and care provision activities • Provide training and supportive supervision for monitoring and evaluation of community-based activities and conduct related operational research • Develop clear mechanisms for community-health facility interactions and activities • Support community participation in local, state, and federal decision-making processes
Partnerships for Health	<ul style="list-style-type: none"> • Public-public and public-private mix activities to increase service access to TB and HIV interventions. • Alliances between all agencies, ministries and parastatals involved in the TB and HIV control programs to strengthen and integrate care delivery systems • Intensified community engagement • Advocacy to and engagement with the corporate sector and media to support TB and HIV control interventions
Research for Health	<ul style="list-style-type: none"> • Operations research for TB and HIV • Engagement of professional bodies, academic institutions, and others to support research • Provide health staff at all levels with opportunities for training on operations research

D. Country processes for reviewing and revising the national disease strategic plan(s) including engagement of key populations.

The HIV NSP development process will commence in the last quarter of 2014. However, the MTR which was conducted in 2013 adopted an inclusive process with engagement of key populations. An improvement on this process is planned during the revision exercise with a broad stakeholder base including engagement of TB stakeholders and a wider representation from Key affected populations.

The revised TB NSP was developed through an inclusive and transparent process in response to the new information available to the NTBLCP and its desire to aggressively address urgent issues in TB control in Nigeria. There were a number of steps in this process, beginning with the mid-term review and continuing through the finalization of this the NSP and beyond.

All processes undertaken by the NTBLCP in the development of this NSP reflect the Program's commitment to engaging all stakeholders, including people with TB, PLHIV,

community-based organizations, faith-based organizations, technical partners, donors, the National Agency for Control of HIV/AIDS (NACA) and other government departments, State and local TB control officers, the Country Coordination Mechanism, Global Fund representatives and others. More than 85 participants representing these constituencies participated in an intensive three-day workshop in Abuja in November 2013 to launch the process, perform a thorough gap analysis, identify root causes of program underperformance with a focus on case detection, propose solutions, and set provisional targets for the new NSP based on the current epidemiological information available.

A subset of the larger group worked together to develop the NSP outline, drafted the first version of the document, and circulated it for comment to the wider group. During this process, additional consultations were held with key constituencies to further obtain their input to the NSP. These constituencies included TB patients, civil society and community representatives; State level officers; technical experts, NACA and NASCP staff, WHO, donors, and the Country Coordinating Mechanism (CCM).

1.3 Joint planning and alignment of TB and HIV Strategies, Policies and Interventions

In order to understand the **future** plans for joint TB and HIV planning and programming, briefly describe:

- a. Plans for further alignment of the TB and HIV strategies, policies and interventions at different levels of the health systems and community systems. This should include a description of i) steps for the improvement of coverage and quality of services, ii) opportunities for joint implementation of cross-cutting activities, and iii) expected efficiencies that will result from this joint implementation.
- b. The barriers that need to be addressed in this alignment process.

Background:

The TB and HIV control programme set up the TB/HIV working groups with clear ToR to support Government in promoting coordination and collaboration between the two programmes at all levels. This working group with membership from the HIV and TB programmes, PEFAR/USG Implementing Partners (IPs), CDC, USAID, TB CARE I, WHO, GFATM PRs and SRs, civil society, private and other sectors meets quarterly (copies of previous 2 meetings of the National TB/HIV WG attached). Additionally, the TB and HIV programme also hold planning meetings, frequency of which has increased in the last few years, this has resulted in the expansion of DOTS services to ART sites and the decentralization of HIV services to DOTS centres. The involvement of the TB and HIV programmes in the development of the strategic plans, Guidelines, job aids for the two programmes further strengthened the process of working together between the two programmes. Furthermore, the two programmes also collaborated in mobilizing resources from USAID and GF to enhance implementation of TB/HIV activities in the country. The two programmes also leveraged on the strength of each other in the provision of commodities required for TB/HIV collaborative activities e.g. HIV programme provides the rapid test kits for testing of TB suspects and patients at the DOTS centres while the TB programme provides the INH tablets for IPT among PLHIV at HIV service delivery centres in line with the National TB/HIV strategic framework. The two programmes also work together in the area of conducting programme reviews and supervision as typified by the recently concluded midterm review of the 2010 - 2015 TB NSP.

The collaboration between the two programmes has resulted in an increased in capacities of staff at both TB and HIV clinics to deliver joint TB/HIV services, with resultant increases in trend of major key TB/HIV indicators measuring services uptake (e.g. % of TB patients tested for HIV increased from 10% in 2006 to 88% in 2013,).

However the collaboration especially at the state, LGA and facility levels is still suboptimal and need to be strengthened for the objective of TB/HIV collaborative activities as stated in the 2015-2020 TB NSP to be achieved. Therefore the two programmes will work together to strengthen this through capacity enhancement; provisions of SoPs; mentoring of state, LGAs and facility staff; enhancing joint planning, development of state level TB/HIV plans; advocacy for establishment of TB/HIV desk in the State Agency for the control HIV/AIDS (SACA) to work with the ministry counterparts, support for functionalities of the WG at all levels especially the facility level and strengthening regular joint monitoring and supervision activities. The capacities of CBOs and CVs will be enhanced to provide integrated ATM services to strengthen collaboration at the community level.

a) Further alignment of TB and HIV program strategies, policies, and interventions

i. Plans for alignment

Going forward, the HIV and TB program strategies will be aligned, their policies harmonised and interventions integrated to allow better targeting of limited resources, and to increase the effectiveness, efficiency, coverage, quality, and sustainability of both

programs. In pursuance of these outcomes, the National HIV Strategic Plan for 2016-2020 will be developed with participation of the TB program to ensure alignment and harmonization with the National TB Strategic Plan 2015-2020 that was recently developed with participation from the HIV program. Teams from both national disease programs will jointly review the TB and HIV Strategic Plans annually to ensure continuing relevance, integration and complementarity and to participate in joint midterm and final evaluations of the TB and HIV strategic plans. With support from the national level, State TB and HIV Strategic Plans will be subjected to review processes similar to those of the national disease strategic plans. State TB and HIV programs, in collaboration with the National Primary Health Care Development Agency, will jointly build the capacity of Ward Development Committees to provide leadership in the delivery of TB and HIV (and malaria and integrated maternal, newborn and childhood health) services.

ii. Integration of TB and HIV services

A fuller integration of TB and HIV activities at all levels of the healthcare system is being planned and is premised on a co-location and one stop-shop principles on the one hand and informed by the cost effective expansion of TB and HIV services on the other. Interventions especially at the primary care facility and community levels will be integrated: facility level TB care and HCT services will be provided at the same place and time, and to the extent possible, HTC services will be expanded to the many already established DOTS sites. Trained CBOs and community volunteers will concurrently carry out education, outreach, screening, demand creation, referral and treatment adherence support, and stigma and discrimination reduction for TB and HIV and malaria. Adequately trained and resourced LGA health staff and Ward Development Committees will provide on-going mentoring and facilitative supervision for all community level service providers. This will improve both coverage and quality of TB and HIV (and other healthcare) services.

iii. Opportunities for joint implementation of TB and HIV activities

The provision of integrated TB and HIV services presents credible opportunities for the joint implementation of crosscutting activities in key health subsystems for TB and HIV joint programming including Funding and Resource Mobilisation, Health Workforce Development, Laboratory and Diagnostic Services, Procurement and Supply Chain (PSC), and Health Information System. Common crosscutting activities that will be jointly carried out by the TB and HIV programs through gradual and consensus-driven processes include:

- Integrated training of health workforce in the provision of clinical and laboratory services especially at the primary care and community levels according national guidelines
- Facilitative monitoring and supervisory visits to health facilities and community-based activities: This ensures the simultaneous provision of appropriate technical and administrative support and identification of critical challenges that need addressing in both disease programmes
- Strengthening the Health Information System (HIS): Integrating data from service statistics, reviews and evaluations and studies of the TB and HIV programmes into the DHIS-2, the official HMIS platform in the country, will improve access to strategic information for decision making at the various levels of the health system.
- Strengthening the Procurement and Supply Chain System: The delivery of TB and HIV services at health facilities and in the communities is dependent on an efficient and effective PSC for the delivery of goods and services. Joint strengthening of the PSC by TB and HIV (and Malaria) programmes is important for successful outcomes in all three disease programmes
- Joint advocacy and funding resource mobilization: the progress and outcomes of both diseases are intricately interconnected and mutually reinforcing; joint advocacy and resource mobilization from domestic and external sources will benefit both programmes

iv. Potential Efficiencies from joint implementation of TB and AIDS activities

Joint training of healthcare workers, monitoring and facilitative supervisory visits, and reviews and evaluations of the TB and HIV programmes, and improvements in the procurement and supply chain have great potential efficiencies to produce more goods and services for less amount of money spent. The efficiencies gained from the joint implementation of crosscutting interventions will be used to provide additional support for increasing the coverage and quality of services and contributing to the sustainability of the TB and HIV programmes.

b) Barriers to the alignment process and mitigation approaches

There are a number of barriers that may hamper the alignment process, including:

1. *Resistance to change:* The resistance to change to a fully integrated system has been expected due to the long period of vertical programming for the two diseases. Program staff have fallen into their comfort zones with vertical programming, will need to be orientated gradually; integration will be driven by consensus on the need for and understanding of the advantages of integration, particularly as it reflects the need to leverage resources and improve service efficiencies. This integration has become much more important in the current situation of limited funding availability from both domestic and international funding sources.
2. *Inadequate resources and covert competition:* Inadequate funding resources require a national process of prioritization, which creates a covert environment of competition for the limited resources. The recommended gradual orientation process outlined above will be required to address this barrier. Empowering program staff and management around resource mobilization skills and the use of more cost-effective approaches to service delivery will help address the funding limitation challenges. TB and HIV stakeholders will mount intense and sustained advocacy engagements with political and business leaders with a view to increasing domestic funding for the two diseases.
3. *Risk of burnout of health workers from work overload:* Integration at the facility level increases the work load for the already-stretched health workforce. The risk of burnout is an ever-present one. The attempts at task-shifting and creating less specialized cadres to help with the current work load is also an approach that will be used to address this barrier across the two programs. Additionally, strengthening community structures will help health promotion activities, ultimately reducing the need for specialized health services. Community testing and self-testing are new innovations that might reduce the work burden of health staff significantly.
4. *Staff attrition:* Staff attrition remains a serious challenge in the health sector across sub-Saharan Africa. The GON will continue to work around developing staff retention strategies to address the challenge of staff attrition. Special incentive packages for rural health workers are one of the strategies under consideration.
5. *Funding Limitations:* Significant amount of funding will be required to ensure that integrated training manuals, guidelines are developed for both facility and community systems and personnel. Re-training of health and community personnel will also require some funding which will need to be pre-positioned before full integration can occur.
6. *Lack of a feedback loop for data:* Data management processes are currently inadequate and there is not enough recurrent feedback to the different levels on progress relating to the various indicators that they are working on

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources that are insufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the TB and HIV national programs and how this funding request fits within these, briefly describe:

- The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).
- How the proposed Global Fund investment has leveraged other donor resources.
- For program areas that have significant funding gaps, planned actions to address these gaps.

A. Funding availability for the disease programs

Funding Landscape for National TB Program

Financing of the TB program in Nigeria is heavily dependent on external donors. Major donors include the Global Fund and the US Agency for International Development, which together will contribute approximately 79% of the overall funding available for TB control in Nigeria during the upcoming implementation period. The NTBLCP is currently operating with funds from a Global Fund grant that ends in 2015. The Principal Recipients under that grant are the Association for Reproductive and Family Health (ARFH) and the Institute for Human Virology Nigeria (IHVN). The NTBLCP is a sub-recipient to these in-country non-governmental partners for implementation of TB program activities.

The table below describes the funding available for the national TB program.

Table 3: Funding landscape for National TB program (2015 -2017)

Source	Total	Percentage of Available funding
Current GF Grants	\$110,417	0.1%
USG	\$39,000,000	18.0%
The Leprosy Mission in Nigeria (TLMN)	\$ 892,755	0.4%
GoN	\$ 59,169,471	27.3%
NFM Allocation	\$117,737,008	54.3%
Total NSP Budget (2015 - 2017)	\$ 722,191,073	100%
Total Available Funds	\$ 216,909,651	28%
Financial Gap (2015 - 2017)	\$ 505,281,422	72%

There are no adequately resourced program areas in the TB program. This is evident by the

size of the financial gap depicted in the table above.

Funding Landscape for National HIV Program

The National HIV program has been heavily dependent on donor financing and this has remained the picture since the commencement of the multi-sectoral response. In the past few years, the donor funding for HIV/AIDS has been on the decline, due to the impact of the global economic recession. The proportion of HIV spending by donors declined steadily from about 17.0% in 2010 to 8.2% in 2012⁵⁴. This suggests the need to explore additional or expanding other sources of HIV/AIDS funding. On the other hand, HIV funding by public source in Nigeria has been low and unstable. Governments at all levels need to commit more to HIV funding, and the PRCP with its \$40 million commitment annually for two years is a significant move in that direction. The table below describes funding projections for the upcoming implementation period.

Table 4: Funding Landscape for National HIV program (2015 -2017)

Source	Total	% of available funding	% of budgeted need
Current GF Grants	\$40,139,364	2.0%	0.9%
USG	\$1,375,842,843	69.1%	29%
United Kingdom	\$27,000,000	1.4%	0.6%
GoN	\$ 310,097,452	15.6%	7%
Private Sector	\$2,815,311	0.1%	0.1%
NFM Allocation	\$234,043,479	11.8%	5%
Total NSP Budget (2015 - 2017)	\$4,690,014,553		100%
Total Available Funds (2015 -2017)	\$1,989,938,449		42%
Financial Gap (2015 - 2017)	\$2,700,076,104		58%

The funding gap for HIV is huge as depicted above.

A key strategy adopted in this application is to strongly weight leverage opportunities from investments from other donors and the disease burden in the selection of priority states. Specifically, In prioritizing states to target in this application, due consideration has been given current investments by the US Government in states and the change in geographical strategy proposed in the Country Operational plan developed for FY2105. The layout as planned will ensure complementarity of the two funding sources to ensure impact of interventions in the prioritized states.

In the FY2015 Country operational plan, PEPFAR Nigeria will be focused on 8 states in Nigeria (Akwa Ibom Cross river, Benue, Lagos FCT, Rivers, Nasarawa and Kaduna), while the remaining 28+1 will be “maintenance” states. Of the 8 focus states, 2 are prioritized (Akwa-Ibom and Kaduna) for additional 50% scale up for treatment above achievements recorded in 2014; and 75% coverage for PMTCT in the same states.

In the other six focus states (Benue, Nasarawa, Lagos, CRS, FCT and Rivers), PEPFAR will be targeting 15% scale up of treatment services and 50% coverage for HIV+ pregnant women needing ARVs. For the maintenance states, PEPFAR will only do 5% scale up of treatment and seek to achieve 23% coverage for HIV+ pregnant women needing

⁵⁴ NASA, 2012

prophylaxis. Resources have been allocated to states accordingly.

In FY15 (Oct 2104 - Oct 2015) PEPFAR resources for prevention (including MARPS) will be progressively withdrawn from all other states in Nigeria to focus on the 8 states. Essentially, from October 2015, PEPFAR will no longer be funding prevention efforts in the non-focus states. The prioritization process for this application has taken cognisance of this and will seek to target investments for KAPs to include the states with no investments from PEPFAR. Note is made that these are interim plans by PEPFAR and are yet to be approved. Should any changes occur, a strategic adaptation might be made if necessary.

Another source of funding that has not been maximized in the past is the private sector. Proactive engagement of the private sector will be strengthened for increased investments in health. National consultations with key private sector bodies will be intensified. A two pronged approach will be adopted to maximize gains from this sector. A resource mobilization component will seek to get direct private sector contributions to health in general and the two diseases in particular. The recently formed Private Sector Health Alliance is a good entry point amongst others for this approach. The second arm to the push for greater private sector investment would be the use of the private for profit health facilities as a service delivery mechanism. Current evidence from private sector involvement from both the USG-PEPFAR program in Nigeria and the Agbami health clinics initiative for TB have revealed the potentials of this approach for increasing service coverage. The Presidents Comprehensive Response Plan (PCRP) for HIV also prioritizes the Private for profit health sector as a means to increasing service access.

Across the two disease programs, some program areas have no earmarked funding or others have insufficient funding allocated. This is in keeping with the realities of the dearth of resources. In the face of the limited resource envelop, prioritization involved the making of necessary difficult decisions. However, there is ongoing advocacy to increase budgetary allocation and release by all levels of government to disease programs. This advocacy will seek to achieve greater financial resourcing from state governments which have hitherto not contributed much to the disease programs in previous years. This is another strong focus of the PCRP which will seek to stimulate greater state investments in the ATM diseases. States are also encouraged to seek innovative financing mechanisms including adequate harvesting of the private sector potential to supplement government investments in health.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

- a. For TB and HIV, indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

compliance		
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
iii. Increasing government contribution to disease program	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<p>b. Compared to previous years, what additional government investments are committed to the national programs (TB and HIV) in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.</p> <p>c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.</p>		
<p>National TB program</p> <p>Within the duration of the implementation period for this application, the government is projected to contribute \$12,000,000 (2015), \$14,000,000 ((2016) and \$16,000,000 (2017) respectively to the National TB program. These investments are expected to count towards the willingness to pay allocation from the Global Fund. These funds are pooled resources from the federal and State levels and expected to be utilized amongst others for the purposes of Human resources for health and procurement of some quantities of first line anti-TB drugs and Isoniazid for IPT.</p> <p>National HIV Program</p> <p>Within the duration of the implementation period for this application, the government of Nigeria has projected to contribute \$77,068,717 (2015), \$84,775,588 ((2016) and \$93,253,147 (2017) respectively to the National HIV program. These investments are expected to count towards the willingness to pay allocation from the Global Fund. These funds are sourced from National budget for HIV, funds from the MDG project and funds from the Subsidy Reinvestment Program (SURE-P) which represents the \$40,000,000 annual commitment for the PCRP. These additional funds will be utilized for staff salaries, purchase of HIV test kits, ARV drugs, prevention interventions and commodities; other systems strengthening investments like renovation of facilities; printing of HMIS tools, trainings, and program coordination amongst others. These contributions are complemented by funding from other sources and have been factored in the gap analysis tables for priority modules attached to this concept note.</p> <p>Assessment of the completeness and reliability of financial data</p> <p>The financial data are sourced from National budgets for 2014 and projections for the out</p>		

years of 2015, 2016, and 2017. Operative assumptions are annual increases in the national health budget that are patterned along the sides of the expected growths in the economy as postulated in the Mid Term Expenditure frameworks and projections of growth in oil earnings (the mainstay of the economy). Sums from the SURE-P and MDG sources are budget estimates with similar growth assumptions where applicable. Note is made of the intention to sustain advocacy to State governments to significantly increase their contributions to TB and HIV programs using the PCR estimates of burden as advocacy points.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and outlines how the investment is strategically targeted to achieve greater impact on the diseases and health systems. While the investments for both the HIV and TB programs should be described, the applicant should also provide information on the expected impact and efficiencies achieved from planned joint programming for the two diseases including cross-cutting health systems strengthening as relevant.

3.1 Programmatic Gap Analysis

A programmatic gap analysis should be conducted for the six to twelve priority modules within the applicant's funding request. These modules should appropriately reflect the two separate disease programs in addition to cross-cutting modules for both programs such as Health System and Community Systems Strengthening.

Complete a programmatic gap table (Table 2) for the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps in the narrative section below.

Programmatic gap analysis tables have been completed for the quantifiable priority modules. These have been attached to this concept note narrative. For the others, a narrative is provided below to describe the programmatic gaps.

Module: Procurement Supply Chain Management

The set target for PSM is to have 95% of the facilities delivering TB and HIV services reporting no stock out by December 2017. There are 5646 HIV and 3557 TB stand-alone⁵⁵ facilities and 1832 joint TB/HIV facilities. The scale up strategy for the joint TB/HIV concept note is to restrict scale-up to existing stand-alone sites, this strategy is expected to increase facilities offering both TB and HIV services and decrease the stand-alone facilities.

The existence of weak supply chain systems has been identified as a barrier to efficient

⁵⁵ Stand-alone implies facilities that have related services for only one of the disease programs –either TB or HIV

scale-up of services and thus a priority area of program underperformance on the National TB and HIV programs. The MTR clearly highlighted the poor coordination of the supply chain management systems across programs and the overdependence on leadership and expertise of international IPs for forecasting and quantification as major challenges that must be addressed to achieve marked improvement of the country's supply chain management systems; the report listed the strengthening of the technical and management capacities of the National Product Supply Chain Management Program (NPSCMP) as one of its recommendations .

From January 2014 till date, the NPSCMP facilitated three collaborative meetings of major stakeholders in the supply chain landscape with participants from USAID, BMGF, NPHCDA, UNICEF, UNFPA, CHAI, GAVI, NTBPLC, NASCP, IHVN, SFH, ARFH, GF and NACA. The major output of these meetings was a Nigeria Supply Chain Integration Strategy (NSCIS) aimed at strengthening Federal and State governments' coordination of supply chain management as well as warehousing and distribution of quality medicines and other health products across all programs. The strategy is to harmonize existing TB and HIV LMIS systems, and engender sustainable systems through establishment of state product supply chain management programs; warehousing and distribution will be strengthened by upgrade of existing government infrastructure, development of efficient Public Private Partnerships.

Collaborations amongst PEPFAR, GF, NACA and other stakeholders have led to the initiation of PSM HSS initiatives like the Abuja & Lagos Warehouse-in-a Box (WIB) project, the PEPFAR/GF/GoN HIV Supply Chain unification project and the pilot of state LMCU in three states; these and other existing PSM HSS projects have been estimated at \$23.3million. The budget for the NSCIS for 2015–2017 has been estimated at \$67,843,360, a budget that includes \$12,000,000 (18%) committed by PEPFAR and GF for the WIB project, leaving a funding gap of \$55,843,360 (82%).

A funding allocation of \$ \$11,000,000 (16%) is being applied for on the TB/HIV PSM HSS application. This in addition to \$3,808,061 (6%) from the Malaria PSM HSS allocation and \$5,000,000 (7%) contingency funds from the GF for Pharma upgrade of existing warehouses are expected to reduce the funding gap for the project to \$36,035,299 (53%). The country is in the process of advocacy to major donors and other stakeholders in the country, including the private sector, and there are clear indications that the outstanding gap will be filled by commitments yet to be specified by USAID, BMGF and other stakeholders.

Module: Community Systems Strengthening

Components for health systems strengthening have often been designed and implemented narrowly, to the exclusion of the role that community systems play as part of health systems; for instance, as providers of services such as health promotion, community based distribution of commodities, care and support, and “demand creation” for services. Community Systems also includes other aspects that are also not often considered as part of the health system, such as building capacity and assuring the voice of “Right-Holders” and mechanisms to assure the accountability of “Duty Bearers”. Poor engagement of the community members remains a major determinant of poor health outcomes.

It is at the geo-political Ward level that community health systems converge, and the more easily identifiable structural and functional response, at this level of the health system, is the Ward Development Committee (WDC). The WDC's primary function is responsibility in

identifying health and social needs and to plan for community action.

Evidence from assessment⁵⁶ of WDCs shows that a majority (85%) of the community members where WDC exists are aware of the existence and activities of the WDCs in their wards, and (96.6%) found them (WDCs) to be very relevant for active participation of the community members in the planning and implementation of PHC services at the community level.

The GF in addition to PEPFAR and the GoN have invested in Nigeria community systems strengthening for effective implementation of GF ATM related services. But this investment has been hardly sufficient to bridge the gap. Government of Nigeria (GoN) and some partners have made several efforts, and are still making efforts to ensure that the Ward structure is put in place to bring services closer to the people.

Under the present HIV grant, the GF is supporting the strengthening of community systems through the SRs who are working with 370 CBOs that have been trained to generate demand for ATM services in GF supported facilities in an integrated manner. And with respect to the current TB grant, 4,400 Community Health Promoters (CHP) would be engaged to work in 10 LGAs in the 6 states where the project is being implemented. The (CHPs) will create awareness of TB; refer suspects, track defaulters and support treatment. They will also carry out Social mobilization and community advocacy to increase PMTCT Uptake. The current malaria project is implemented nationally under SRs. There are about 6,000 Role Mother Care-givers (RMC) implementing the project. The RMC create awareness and treatment at the community.

Identified Gaps

A recent evaluation conducted with support from the GF on the *Effectiveness of GF-Supported Community- Based Intervention in Nigeria (attached)*, revealed both the gaps and strengths of the intervention. Some of the strengths of the intervention include some capacity building through training and mentoring of selected CBOs, integration of the ATM services by CBOs, involvement of the community people for the purposes of ownership and sustainability among others. However, the report also documented a number of gaps in community interventions, and these include:

- a) Leadership: not enough attention has been paid in strengthening community systems, even with long history of talks about community ownership and participation. The mechanism to achieve this has been weak and leadership diffused. The vacuum has often tended to be filled by CSOs/NGOs, yet this has resulted in the need for some upfront capacity building which have not been readily forthcoming. Neither donors nor government have any sustainable strategy for engaging CSOs
- b) Capacity of implementing CSOs is comparatively weak, because of insufficient exposure and resources, including challenges to coordination and institutionalization.
- c) The ability of CSS practitioners to attract and retain competent staff is weak, and overstretched.
- d) More often than not, while government policies recognize the need for community systems to be mobilized for an all-inclusive process, the mechanism for CSOs engagement is given little attention, as a result of the absence of a National CSS engagement framework.
- e) The need to sustain continuous assessment of the relevance, functionality and health

⁵⁶ NPHCDA/Partners WDC Assessment Draft Report (Nov. / Dec, 2013)

outcomes impacts of investment in WDCs.

These gaps will be prioritized for mitigation in this application..

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request for TB and HIV, including both the proposed investment of the allocation amount and the request above this amount. Include the specific elements related to joint programming such as health systems and community systems strengthening. Describe how the request addresses the gaps and constraints described in sections 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

Strategic Overview of Application:

Nigeria Context

Rapid scale-up of resources for HIV programming through the 2000s allowed major gains in Nigeria showing decline of one third of new infection (30%). Nearly 700 000 people have been put on life-saving ART and close to 58 000 pregnant women HIV+ put on ART for the prevention of mother to child transmission of HIV in 2013;. However, the gains have not been broad enough and the epidemics continue. Overall, new infections are not declining rapidly enough to allow us to bend the curve and reverse the growing need for ART in the near future.

Chronically underfunded and underperforming over the years, the TB programme is in a dire state and in need of urgent support. The 2012 TB prevalence and drug resistance survey confirmed Nigeria's status as a high burden TB country with an estimated TB prevalence of 332/100,000 population, more than half a million cases of TB disease, and a high drug resistance of about 3% in new and 14% in retreatment TB cases. The 2013 TB case notification rate is estimated at only 17%. With a high TBHIV co-infection rate of 22%, poor TB programming is fuelling the HIV epidemic and vice versa.

At the same time the growth of new resources has slowed, leading to recognition that we must maximize the impact of the resources we have, demonstrate these impacts unambiguously, and use that as a success to mobilize new resources for both the TB and HIV programmes. Clearly we must do better than we are doing now if we are to achieve the end of AIDS and control TB. The question then is: how?

Strategies

This Concept Note is designed to promote necessary strategic changes in the way we do business. Key strategies include:

1. State level ownership and leadership will be in place to ensure that the State TB and HIV Annual Work Plans are developed, funded and implemented based on the local needs and challenges each state is facing with the focus on high burden LGAs and populations most affected by HIV and TB.
2. Resources from all sources together for comprehensive HIV and TB epidemic responses in Nigeria are not enough and a shortfall of about half a billion, one billion, and 1.5 billion USD for HIV programme in 2015, 2016 and 2017 respectively. Similarly the TB programme will experience gaps of about 170, 194 and 263 million USD in 2015, 2016, and 2017 respectively. This calls for a focused approach on location, right population groups (drivers of the two epidemics) and close programme measurement to allow quickest identification and correction of gaps and joint activities in the two

programmes. On-going effort is in place to mobilise domestic resources for both the TB and HIV programmes.

3. Geographic prioritisation is addressed by focusing on six states with more than half of the new infections and nearly 40% of disease burden for HIV and heavy burden of TB disease. A more subnational prioritisation would be attempted in the first six months at state level to identify high burden LGAs and focus attention on those in the prioritised states. However, the “maintenance” states will continue to receive support from Government and the private sector to ensure country wide coverage is sustained. The critical element to this will involve greater resourcing for the twin epidemic from state governments. The PCRPs will also seek to fill the gaps in funding to the other states not prioritized in this application. The PCRPs operational plan will be adapted to reflect these considerations.
4. Prioritisation of HIV population group will be location specific going by the mixed epidemic in Nigeria; there is a plan to prioritise location specific population groups that are drivers of the epidemic. By addressing the drivers first, the epidemic would recoil and ART cost would stabilise. Vulnerable populations including KAPS (FSW, MSM and PWIDs) with relatively larger than national average HIV prevalence will be prioritized for near universal access with TB and HIV prevention and treatment services. Other vulnerable populations like prisoners and urban slum dwellers will be prioritized also for TB case detection and treatment services. Traditional programs for HIV positive pregnant women and HIV-exposed children will be scaled up in the priority states towards achieving universal access in those states. This will be hinged on the leverage approach by co-locating investments with the USG as applicable.
5. Prioritisation of interventions within the HIV core high impact interventions (HCT, ART, PMTCT, Condom and Behaviour change) will be tailored as well since there are not enough resources to do everything,
6. Program correction at earliest opportunity, real time monitoring and use of program data to monitor gaps between expected and actual coverage are to be initiated at least for priority location, priority population groups and priority interventions. Such efforts are under development in collaboration with UNAIDS for HIV and with the WHO for TB.
7. Integration of HIV and TB services into SRH, MCH, and ANC services and deployment of multi-skilled healthcare providers at facility level (task shifting) and community health providers at the community level to address HIV/TB/Malaria issues
8. Greater involvement of the private sector (private –for- profit) in service delivery and resource mobilization.

The Concept Note (CN) Funding Request

For the Concept Note development, the GF has allocated US\$234,043,479 for HIV and US\$117,737,008 for TB interventions to Nigeria for the period 1 July 2015 to 31 December 2017. This excludes the current pipeline of funding from existing Global Fund grants.

\$40,139,364 has been identified as pipeline funds for HIV and will be factored into the application process. \$110,417 has been identified as pipeline funds for TB and will be factored into the application process. Proposed distribution of all pipeline funds is as depicted below.

S/N	Priority Module	Applied Pipeline
-----	-----------------	------------------

1	Prevention for General Population	\$1,000,000
2	Prevention programs for adolescents and youth, in and out of school	\$952,359
3	Prevention programs for Vulnerable populations (MSM ,PWIDs, FSWs)	\$1,000,000
4	PMTCT	\$3,392,875
5	Treatment , Care and support	\$33,794,130
6	TB Care and Prevention	\$107,440
7	MDR-TB	\$2,977
		\$40,249,781

HIV: The total cost of budgeted need for the country from 2015 to 2017 as projected in the NSP is US\$ 4,690,014,553, this is as shown on table 5 (Funding Landscape for National HIV program 2015 -2017).

The total available fund from various sources is \$1,989,938,449 with the breakdown of contribution as shown in table 5 above. The funding gap is \$2,700,076,104 (57.6%). The Global fund allocation will contribute towards filling the existing gap.

The GON is committed to providing 15.6% (US\$ 310,097,452) of the available cost. The GF allocation to the HIV program in this application is US\$ 234,043,479 representing 5% of total funding needs. Donors, current GF grants, and GF NFM allocation will provide 85.4% of \$1,989,938,449 current available funding.

TB: The full cost of meeting national targets over the period of the request (2015-2017) is US\$722,191,073. The total available funding for the implementation period is \$216,909,651. The GON is committed to providing 27.3% (US\$59,169,471) of this amount. Donors, current GF grants, and the current GF allocation are providing 72.7% (US\$157,740,180) of available funding. The gap for the National TB program is 72% (US\$505,281,422). The GF allocation to the TB program is US\$117,737,008 representing 16.3% of funding needs for the upcoming implementation period.

In addition, the concept note makes a case for the Global Fund to invest an additional **US\$ 198,945,957** as above allocation amount of which **US\$ 139,902,189** is designated as incentive funding and **US\$ 59,043,768** as Unfunded Quality Demand.

The full complement of requested funding will significantly move the Joint TB and HIV national program towards achieving National targets and related Impact in the national response.

For this application, the allocated funding envelope has been earmarked to 14 country priority modules as described in the table below.

Table 5: Strategic Overview of the funding application

Module	Allocation	Above Allocation			Full Request
		Incentive	Unfunded Quality Demand	Total Above allocation	
Prevention for General Population	6,500,000	5,500,000	-	5,500,000	12,000,000
Prevention programs for Vulnerable populations (MSM)	4,721,435	-	-	-	4,721,435
Prevention programs for Vulnerable populations (FSWs)	6,686,487	-	-	-	6,686,487
Prevention programs for Vulnerable populations (PWID)	3,592,078	-	-	-	3,592,078
Prevention programs for adolescents and youth, in and out of school	2,000,000	9,154,914	-	9,154,914	11,154,914
PMTCT	27,478,841	6,546,948	-	6,546,948	34,025,789
Treatment , Care and support	148,453,913	48,024,755	-	48,024,755	196,478,667
TB Care Prevention & Treatment	67,461,012	26,957,112	-	26,957,112	94,418,124
MDR-TB	33,227,398	19,784,674	59,043,768	78,828,442	112,055,840
TB/HIV	6,979,530	11,061,813	-	11,061,813	18,041,343
CSS	6,000,000	-	-	-	6,000,000
HMIS -M&E	12,000,000	7,621,676	-	7,621,676	19,621,676
PSCM	11,000,000	1,003,543	-	1,003,543	12,003,543
Program Management	15,679,793	4,246,754	-	4,246,754	19,926,547
Totals	351,780,487	139,902,189	59,043,768	198,945,957	550,726,444

Funding application and response to Gaps in National Programming

An analysis of the funding application and its response to the depicted gaps in national programs for TB and HIV are best elucidated through a review of each of the priority modules.

Priority Module One: - Prevention programs for general population

Related Gap:

Noted gaps include low HCT service coverage in general population at 23%, (FMOH 2013 Program data); Low HCT coverage in key populations⁵⁷ MSM (6.24%), FSW (1%); as at 2010, the percentage of 15- 64 who received an HIV test in the past 12 months and know their results was only 11%⁵⁸; the 2012 NARHS showed that only 54% of the sexually active respondents reported using male condoms within the last 12 months preceding the survey. The focus states are Kaduna, Oyo, Akwa Ibom, Rivers, Lagos and Imo. The target population that serve as a link to the general population in fueling new HIV infections include road transport workers, artisans (welders and fitters, automobile mechanics) and construction workers. Others are mine workers, migrant/mobile workers in agriculture and persons in closed settings (prisons). Together, they have an estimated population size of 1,137,877 in the 6 focus states. The leveraging of other counterpart resources and

⁵⁷ Consolidated National data, FMOH, 2013

⁵⁸ IBBSS, 2010

activities in the 6 focus states will be necessary to achieve the desired impact among the target population. Furthermore, in order to achieve the greatest impact, attention will be focused on the community-based approach to HCT services delivery

Application response to Gap:

This module has been prioritized based on the need to have a balance between prevention and treatment for HIV and to make available, interventions to target key populations that current epidemiological evidence⁵⁹ has shown to have 1) a disproportionately larger than National average HIV prevalence 2) issues of increased vulnerability and 3) limited program coverage from existing funding pool in the country. The application response to the gap is detailed in the attached mapping of interventions⁶⁰ in priority modules to identified gaps from the country Epi Analysis and Mid term Review.

Global Fund support to existing programs, and adaptation to maximize impact.

The current Global fund grant supports the National prevention for general population program through the MPPI approach across 36 states in the country. This support will be adapted to target six priority states contributing 41% of the national HIV burden for maximal impact. Efforts are also made in this application to attain universal coverage for bridge populations with HCT as part of a package of prevention services. The other components of the package will be leveraged from the existing prevention programs in the target states.

Priority Module Two, Three and Four: - Prevention programs for Vulnerable & Key Populations (MSM, FSW and PWID)

Related Gap:

Coverage of prevention interventions remain low for the key affected populations (see HCT above); higher than national average HIV prevalence persists in these populations⁶¹; legal barriers to service access with increased vulnerability (same sex bill⁶², criminalization of prostitution and Sharia law enforcement in some northern states)

Application response to Gap:

This module and related funding seeks to attain universal coverage of the key affected populations with the MPPI mix of services. Specifically, MPPI coverage by 2017 will be FSWs (85.5%), MSMs (62.4%) and PWIDs (74.4%).

Global Fund support to existing programs, and adaptation to maximize impact.

The current Global Fund support is being adapted to respond to the evidence made available from the MARPS size estimation study, 2012 and the National Epidemic Appraisal 2013 which mapped locations and generated size estimates. Interventions are being channeled to specific locations where these key populations are concentrated.

The KAP intervention is of nationwide coverage. Specific KAP locations within states outside the 8 USG priority states (Akwa Ibom Cross river, Benue, Lagos, FCT, Rivers,

⁵⁹ HIV Epi-Analysis, 2014

⁶⁰ For this concept note and in consideration of page limitations, a mapping of interventions to identified gaps was done and is attached to this concept note for better clarity.

⁶¹ See Mode of Transmission study, 2009 and National Epidemic Appraisal report, 2013

⁶² Same sex bill was passed by the national assembly in 2013 prohibiting promotion of same sex relationships in Nigeria

Nasarawa and Kaduna), will be targeted. This approach is informed by the USG plan to achieve total coverage for KAP populations within their priority states. This presents a key leverage opportunity for this module and it is anticipated that coverage levels for KAP populations will significantly increase through this approach. The Size estimation and mapping will inform the targeted locations. This intervention will be implemented in strong collaboration with the KAP secretariat to ensure that strategic adjustments are made based on direct evidence from the key populations. Note is made also of the need to improve the available data on the KAP. A provision has been made in this application to include a module on KAP size estimation in the planned IBBS 2014 and future ones. The results from this will further inform strategy decisions.

Priority Module Five: - Prevention programs for Adolescents and Youths

Related Gap:

Low knowledge of HIV transmission and prevention among adolescents: % of adolescents (15-19 years) with comprehensive knowledge of HIV/AIDS is 22.4% for females and 29.3% among males⁶³; Issues of vulnerability associated with transactional and inter-generational sex; NARHS, 2013 reported the proportion of young people (15-24 years) that used condom during last sex with non-marital partner within the last 12 months is 54.8%.

Application response to Gap:

The FLHE intervention is to be scaled up incorporating TB control information. The selected intervention will directly impact on the knowledge of young people on HIV transmission and prevention, and will constitute the foundation for appropriate attitude and HIV-preventive behavior. The use of a co-curricular approach in addition to the curricular approach is expected to particularly foster life-skills and further promote relevant attitudinal and behavioral changes.

Global Fund support to existing programs, and adaptation to maximize impact.

Current Global fund support is to be adapted to include both curricula and co-curricula approaches for fostering life skills and further promote behavior change. Also, the current approach adopts geographical targeting in the six priority states in this application.

Priority Module Six: - Prevention of Mother to Child Transmission (PMTCT)

Related Gap:

Low PMTCT coverage in the country (30% in 2013)⁶⁴; limited utilization and capacity of the community systems for demand creation⁶⁵; resource limitations.

Application response to Gap:

This application is being led by evidence generated from the Epi-analysis and the Mid Term review report of the national program. As a result a mix of geographical targeting for scale up of PMTCT services and maintenance for sustainability in the other states is being adopted. Six high burden states will be prioritized for scale up (active process) while

⁶³ NDHS, 2013

⁶⁴ GARPR, 2014

⁶⁵ HSS/CSS assessment Report, Global Fund, 2014

maintenance of PMTCT services in existing GF supported sites (passive process) will continue in other states and FCT. Community structures will be strengthened to increase demand and uptake of services. The funding allocation in conjunction with other available in-country resources will enable the prioritized six states achieve approximately 95% PMTCT coverage by 2017 and move national PMTCT coverage levels to 63% in 2017. The additional incentive funding will increase PMTCT coverage in the remaining 7 states of the "12+1" to 95% and move national coverage to 66% by 2017. The strategy to be employed to achieve this ambitious movement in coverage level will include scale up of involvement of private for profit facilities in PMTCT service delivery in the prioritized states. There are good results from similar approaches in the PEPFAR program and this will be improved upon and replicated nationally. Table below depicts planned PMTCT coverage landscape in the six priority states by 2017.

Figure 13: PMTCT coverage landscape by 2017 in priority states

State	Projected PMTCT Need 2017 (SPECTRUM)	PEPFAR projected contribution (using FY15 targets)	GF Allocation target	Total	% Coverage
Akwa Ibom	13,510	5,260	7,575	12,835	95%
Imo	4,213	1,055	2,947	4,002	95%
Lagos	7,370	5,590	1,412	7,002	95%
Kaduna	20,325	6,580	12,728	19,309	95%
Oyo	8,079	1,121	6,554	7,675	95%
Rivers	4,712	2,430	2,046	4,476	95%
Totals	58,209	22,036	33,263	55,299	95%

Global Fund support to existing programs, and adaptation to maximize impact.

The geographical targeting is the most notable adaptation to existing Global Fund support. Also key is the linkages with the National TB program where all pregnant women will be offered TB screening alongside HIV testing in all facilities.

Priority Module Seven: - Treatment Care and Prevention (HIV)

Related Gap:

The national ART coverage remains low. The national treatment program has reached 639,397 people (including 47,313 children), which represents 44% of the estimated number of adults in need of ART and only 12.1% of the estimated number of children in need of treatment⁶⁶. Addressing the low ART coverage particularly for the pediatric age group is a national priority. With the adoption of the 500 WHO recommended 500 CD4 cut off for ART eligibility, the need has significantly increased. On this premise, the national target revision exercise has therefore set national coverage targets at 60% in 2015, 65% in 2016 and 70% in 2017.

⁶⁶ FMOH programme data, 2013

Application response to Gap:

A strategic investment approach has been adopted in this application. Limited resources will be invested in geographical locations identified by the EPI-Analysis as contributing the most to the national HIV burden. The prioritized six states contributing 41% of the national burden will be targeted. Attaining increased coverage in these states as planned with the current funding allocation and above allocation requests will increase the national adult coverage towards 67% by 2017⁶⁷. The figure below shows the coverage progression across the states for the three years of this application.

Figure 14: ART coverage progression in six priority states

2015						
STATES	ART Need Adults & Children	Current on ART	GF contribution (From allocation)	PEPFAR Contribution	Total	Coverage
Kaduna	112875	30,834	1,200	34,156	66,190	59%
Akwa Ibom	76873	15,651	3,000	6,207	24,858	32%
Imo	53230	6,889	4,000	2,409	13,298	25%
Rivers	85865	14,583	3,000	3,936	21,519	25%
Oyo	61753	10,726	2,200	3,056	15,982	26%
Lagos	152444	42,773	1,684	17,543	62,000	41%
2016						
STATES	ART Need Adults & Children	Current on ART	GF contribution (From allocation)	PEPFAR Contribution	Total	Coverage
Kaduna	117806	66,190	584	34,156	100,930	86%
Akwa Ibom	77777	24,858	2,000	6,207	33,065	43%
Imo	56474	13,298	4,000	2,409	19,707	35%
Rivers	91084	21,519	3,500	3,936	28,955	32%
Oyo	66643	15,982	3,000	3,056	22,038	33%
Lagos	159806	62,000	2,000	17,543	81,543	51%
2017						
STATES	ART Need Adults & Children	Current on ART	GF contribution (From allocation)	PEPFAR Contribution	Total	Coverage
Kaduna	122,417	100,930		34,156	135,086	110%
Akwa Ibom	78,845	33,065	1,500	6,207	40,772	52%
Imo	59,661	19,707	3,000	2,409	25,116	42%
Rivers	96,321	28,955	5,000	3,936	37,891	39%
Oyo	72,309	22,038	3,584	3,056	28,678	40%
Lagos	165,286	81,543	2,000	17,543	101,086	61%
Critical assumptions:						
* PEPFAR targets are presumptive and yet to be approved. A flat line projection is assumed for 2016 and 2017. These assumptions will be re-evaluated based on the outcome of the COP 15 process.						
* Needs are calculated using SPECTRUM estimates at 500 CD4 cut-off for ART eligibility						
* Current on ART are projections from 2013 National data (State specific) with an annual increase of approximately 8% to estimate the 2015 values.						

Global Fund support to existing programs, and adaptation to maximize impact.

The geographic targeting is a unique adaptation in this application to maximize impact. The movement towards stronger linkages between TB and HIV programs is a major paradigm shift that will reduce the co-morbidity of the two epidemics in Nigeria.

Priority Module Eight: - TB Care Prevention and Treatment

Related Gap:

The highest priority TB gap noted in the MTR and the prevalence survey report is low TB

⁶⁷ Programmatic Gap Analysis, GF concept note development, 2014

case detection. In 2013, Nigeria notified about 17% of the estimated incident cases. Such a low case detection is on the order of what was seen before the implementation of the DOTS strategy in many countries. Missing 83% of cases each year allows for significant ongoing transmission and excess morbidity and mortality on a magnitude that negates other program efforts to control TB.

Application response to Gap:

This application applies more than half of the allocated funding to improving case detection in 13 focus States and the FCT, which together account for approximately 50% of the missed cases in Nigeria. Basic services will be maintained in the rest of the country, while in the focus states the NTBLCP will scale-up LED fluorescent microscopy services to achieve a ratio of 1 microscopy site to 50:000 population, scale-up GeneXpert in collaboration with NACA to provide diagnostic services to PLHIV and others at risk of missed or delayed diagnosis (e.g., children), and target urban slums for active case-finding through community-based outreach as locations with high concentrations of key affected populations. In addition, NTBLCP will integrate TB screening and referral/sputum collection into existing health services where people with TB symptoms access care, particularly at general hospitals and patent medicine vendors, through introduction of Standard Operating Procedures for routine screening of clients for TB symptoms and referral to DOTS centres for evaluation.

Global Fund support to existing programs, and adaptation to maximize impact.

Global Fund, through the existing TB grant, is supporting general expansion of DOTS services across the country. The approach has until now relied heavily on passive case finding using smear-microscopy. In this application, geographic focus is narrowed; active case-finding in key affected populations and intensified case-finding among PLHIV and others presenting to facilities for care is used; public-public and public-private strategies are expanded to identify people with TB symptoms at low cost to the system and individuals seeking care; and superior technologies for diagnosing TB (LED FM and GeneXpert) are scaled up.

Priority Module Nine: - MDR-TB

Related Gap:

Programmatic management of drug-resistant TB (PMDT) began in Nigeria in 2010. Scale-up has been slow, diagnostic capacity is limited, and the policy of hospitalizing patients for the full 8 months of the intensive phase of treatment impedes enrollment of diagnosed cases on treatment because beds are not available to accommodate the growing numbers of patients. With the introduction of large numbers of GeneXpert machines through NACA, a rapid increase in the number of rifampicin-resistant cases is anticipated and will require scale-up of culture and DST capacity as well as rapid scale-up of treatment capacity

Application response to Gap:

The highest priority for the NTBLCP is to scale up treatment capacity to accommodate the existing DR-TB patients and provide for increasing numbers to be initiated on treatment rapidly. This includes scaling up of the current national strategy of ambulatory care for DR-TB patients. This will in turn require training of more State and Local Government teams, facility-level providers to treat DR-TB, and community volunteers to provide treatment support services. In addition, existing facilities will be identified at zonal level to ensure that at least one treatment site is available for XDR-TB in each zone in the country

and more 8 additional States have MDR-TB treatment centres established. Second-line drugs will be purchased in sufficient quantities to treat all diagnosed DR-TB cases. Diagnostic capacity expansion will focus on improving the capacity of the two NRLs and six zonal labs to perform solid culture, LPA, and first-line DST (as well as second-line DST at the NRLs), and establishing two additional reference laboratories to increase diagnostic and follow-up capacity.

Global Fund support to existing programs, and adaptation to maximize impact.

Global Fund has supported the implementation of PMDT in Nigeria, including the purchase of second-line drugs from the GDF. In this application, the approach will be adapted to focus on ambulatory care for patients with rigorous supervision and strong community support to ensure treatment completion.

Priority Module Ten: - TB and HIV Integration

Related Gap:

The two disease programs have erstwhile operated as vertical programs with minimal collaborative activities; resources were not being leveraged resulting in loss of cost-efficiencies; proxy indicators of TB and HIV integration (TB screening in HIV patients; HIV testing in TB patients; IPT for HIV positive clients enrolled in care, ART for TB/HIV co-infected patients etc.) have not been optimal, as only 68% of PLHIV screened for TB, 5% of eligible PLHIV received IPT and 67% of TB/HIV co-infected on ART in 2013.

Application response to Gap:

This application seeks to make giant strides towards TB and HIV joint programming. The geographical targeting adopted in this application ensured an overlap of TB and HIV high burden states amongst other parameters. Scale up of TB services will prioritize facilities with HIV services on offer and same will apply to HIV scale which will prioritize DOTS centers. Integration of TB screening to all HIV services and HIV testing for all presumptive and diagnosed TB patients is a marked response to identified gaps. Use of integrated HSS and CSS interventions is also being adopted in this application. Integration of the HMIS and PSM systems is being prioritized. Health workforce will also have capacities built to be able to provide basic HIV and TB related services including linkages to higher levels of care. Community systems will now function to generate demand and provide follow-on community support for HIV, TB and Malaria services and clients. An intended outcome of this investment will be the attainment of 100% screening of HIV-positive patients for TB in HIV care or treatment settings. In 2013, about 68% of HIV positive patients were screened for TB. The country need and target for this indicator are the same based on the National Strategic Plan, the needs are 1,039,104 in year 1; 1,214,300 in year 2 and 1,387,484 in year 3.

The need to be covered by the domestic and other sources are 68% (702,916), 75% (915,252) and 71% (990,261) of the need in year 1, 2 & 3 respectively. Additionally, the country need already covered by the existing GF grants is 16% (169,106) in year 1 only. Thus creating the gaps of 16% (167,082) in year 1, 25% (299,048) in year 2 and 29% (397,223) in year 3. The Targets to be financed by the allocation amount is 5% (50,000) in year 1, 8% (100,700) in year 2 and 13% (185,900) in year 3. Therefore the target to be financed by above allocation amount is 11% (117,082) in year 1, 16% (198,348) in year 2 and 15% (211,323) in year 3. The above allocation will ensure the achievement of the national target.

Global Fund support to existing programs, and adaptation to maximize impact.

This process has for the first time adapted existing processes towards joint planning and implementation of HIV and TB programs. Resources are being better leveraged at National level and the one-stop-shop approach to service delivery will be strengthened at State and facility levels. The expected grant will be used to maintain TB/HIV services in all the states, however 6 states (Kaduna, Lagos, Cross River, Akwa-Ibom, Oyo, and FCT) with high TB and HIV burden will be prioritized for scale up, expansion and implementation of targeted TB/HIV services to maximize impact. The funding request takes into consideration the possible risk to effective provision of TB/HIV services such as industrial action and security challenges. Mitigation measures considered as priority activities in this application include the engagement of private facilities and task shifting

Priority Module Eleven: - Procurement Supply Chain Management**Related Gap:**

Inadequate coordination of pharmaceutical management components within and across disease programmes; suboptimal delivery of HIV/TB drugs and commodities to facilities; Inadequate storage infrastructure and systems across disease specific and national needs; post marketing quality control and assurance is inadequately implemented under existing grants and rational use has not been adequately addressed in the many attempts to increase access to medicines and commodities

Application response to Gap:

The application will seek to strengthen Federal and State governments' coordination of supply chain management across all programmes through the establishment of state Logistics Management Coordination Units (LMCU) domiciled in the Directorate of Pharmaceutical Services of the State Ministry of Health (SMOH). In the same vein, the National Procurement and Supply Chain Management Program (NPSCMP) will be financially supported and repositioned to effectively provide National PSM oversight function at all levels of the system. The application will also strengthen the public private partnership for supply chain management in the country. Integration of supply chain components across HIV, TB and other diseases (e.g. warehousing, distribution, LMIS) will also be attained through this investment. Four government owned pharma-grade warehouses will be Identified and upgraded to serve as zonal warehouses to address the challenges of inadequate storage infrastructure. Quality assurance and Rational drug use interventions will be implemented to address the issues of post market quality control and assurance.

Global Fund support to existing programs, and adaptation to maximize impact.

Current Global Fund support will be adapted to position for the integrated approach to be utilized under this application. Impact here will be that of improving efficiencies of the system –both functional and cost efficiencies.

Priority Module Twelve: - Community Systems Strengthening (CSS)**Related Gap:**

The CSS gaps identified from the CSS assessment, 2014 are depicted in section 3.1 of this concept note. They include amongst others, challenges with coordination of civil society organizations (CSOs); weak capacity of CSOs and Community based organizations (CBOs); limited access to potentially hard-to-reach populations like migrants, mobile populations and other key affected populations. Other gaps include weak referral systems, weak community-facility linkages, and limited capacity of CSOs at mainstreaming human right, gender and stigma reduction into public health programmes.

Community Systems Strengthening will intensify efforts at build the institutional capacity of ATM network organizations at national and state levels in the priority areas to plan and manage activities for measurable results. The application will primarily focus on strengthening capacity of Community actors especially the national networks and CBOs to lobby and advocate for enabling environment for Nigerians, irrespective of their gender, health status and sexual orientation to access ATM services in term of stigma reduction, gender equality and human rights in terms of service. The intervention will also be strengthening the capacity of CBOs in community based programme management and demand generation for ATM services in GF supported health facilities.

Organizations will be supported to develop plans for resource mobilization advocacy and to monitor and report on gender and human rights issues that affect key populations. Linkages between community organizations and the health system will be formalized through MOUs and will be strengthened through the redeployment and reinforcement of District Health Information Management System and support to Ward Development Committees as the existing interface mechanism. Capacity of WDC members will be strengthened to supervise health activities, mobilize and stimulate active involvement of prominent and other local people in the planning, implementation, and evaluation of health projects and take active role in the supervision and monitoring of health activities at PHCs.

Supervision of community activities will be integrated into on-going programme supervision to identify any challenges early on and correct them. Services delivered by community organizations will target key affected populations for HIV, TB, and malaria, including hard-to-reach and marginalized populations in the priority areas.

Application response to Gap:

The application will seek to build CSO and CBO institutional capacity for planning and leadership; promote community based monitoring for accountability; promote social mobilization for demand creation; establish and sustain community linkages collaboration and coordination for access to HIV, TB and Malaria services.

Community Systems Strengthening will intensify efforts at build the institutional capacity of ATM network organizations at national and state levels in the priority areas to plan and manage activities for measurable results. The application will primarily focus on strengthening capacity of Community actors especially the national networks and CBOs to lobby and advocate for enabling environment for Nigerians, irrespective of their gender, health status and sexual orientation to access ATM services in term of stigma reduction, gender equality and human rights in terms of service. The intervention will also be strengthening the capacity of CBOs in community based programme management and demand generation for ATM services in GF supported health facilities.

Organizations will be supported to develop plans for resource mobilization advocacy and to monitor and report on gender and human rights issues that affect key populations.

Linkages between community organizations and the health system will be formalized through MOUs and will be strengthened through the redeployment and reinforcement of District Health Information Management System and support to Ward Development Committees as the existing interface mechanism. Capacity of WDC members will be strengthened to supervise health activities, mobilize and stimulate active involvement of prominent and other local people in the planning, implementation, and evaluation of health projects and take active role in the supervision and monitoring of health activities at PHCs.

Supervision of community activities will be integrated into on-going programme supervision to identify any challenges early on and correct them. Services delivered by community organizations will target key affected populations for HIV, TB, and malaria, including hard-to-reach and marginalized populations in the priority areas.

Global Fund support to existing programs, and adaptation to maximize impact.

Integrating the mandate of CSOs and CBOs to cover community support for HIV, TB and Malaria services is a critical adaptation to GF support to existing programs for maximizing impact.

Priority Module Thirteen: - HMIS/M&E

Related Gap:

The HSS assessment conducted by the FMOH, 2014 highlighted several weaknesses in the HMIS and M&E program area. These include resource limitations; the existence of vertical data reporting systems; reluctance of the vertical data collection system to integrate with the central repository for health Information; poor coordination; low capacity for data analysis; continued use of paper based reporting; non-use of health information for policy and decision making; low investment in information system by Government; poor dissemination of information products at all levels; data quality issues at all levels; irregular conduct of surveys relating to HIV and TB; and limited attention to operations research.

Application response to Gap:

This application has prioritized the integration of the TB and HIV modules for DHIS2.0; nation wide roll out of the DHIS2.0 platform for routine reporting; joint data quality audits for the two programs; joint health sector data reviews; funding support for surveys for the generation of key impact data and monitoring of the dual epidemic; and system strengthening interventions including human resource development, strengthening coordination mechanisms and institutionalizing Continuous Quality Improvement (CQI).

Nigeria has conducted IBBSS on two occasions since 2007. The process for conducting the 3rd round of IBBSS field data collection is scheduled to start by September, 2014. It is expected that this trend will continue with funding made available for the 2016 IBBSS. The key populations involved in these surveys are MSM, PWID, FSWs, Long Distance Transport Workers, and Uniform Service Men. There are varying figures thrown up as KAP size in Nigeria, It is expected that the next round of IBBSS in 2016 will provide a reliable data for KAP size in Nigeria.

NARHS was last conducted in 2012, and the next is due in 2017. From the funding trend, GoN, GF, and other donors including UKAIDS and USAID have been supporting the

conduct of this survey. The trend is expected to continue in 2017. Data from the ANC sero-prevalence and NARHS survey are used in estimates and projections of HIV situation in Nigeria.

There is a human resources development plan and policy that guides training/production of health workers, recruitments, distribution and motivation. Training institutions are encouraged to incorporate most current advice (especially ATM and MNCH) on managing disease conditions into the training curriculum. Effort will be made to finalise the task-shifting policy for health workers. The North /South divide in HRH is noted. There will be advocacy/continuous engagement with relevant stakeholders including the health workers to work in less served areas, hard to reach areas and rural areas especially in the northern part of the country which are the worst hit by the dearth of HRH.

Global Fund support to existing programs, and adaptation to maximize impact.

The joint planning, implementation and systems strengthening interventions for both TB and HIV is a significant adaption being courted in this application.

3.3 Modular Template

Complete the **modular template (Table 3)**. Note that the template allows access to modules that are specifically relevant to TB and HIV components, in addition to modules that are cross-cutting for both diseases.

To accompany the modular template, for both the allocation amount and the request above this amount, explain:

- a. The rationale for the selection and prioritization of modules and interventions for TB and HIV, including those that are cross-cutting for both diseases.
- b. The expected impact and outcomes of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

3-4 PAGES SUGGESTED

See the Modular Template, attached.

Country dialogue and prioritization process of the modules:

In order to prioritize the modules for this application, a country dialogue process was embarked on with stakeholders in health, HIV and TB technical experts, the donor community, and civil society groups representing the populations affected by the two diseases. Documentation of the related processes is attached to this application.

These considerations are as depicted below:

The stakeholders considered the following general and specific factors for prioritization:

General Considerations:

- ☐ In view of the limited funding availability for the two diseases, a strategic approach for investments will need to be adopted for impact
- ☐ The Epidemic analysis should guide the selection of interventions and geographical priorities
- ☐ Provision to be made to maintain PLHIV already enrolled in the program through Global Fund support
- ☐ Reaching the most vulnerable populations based on the current epidemiology of the two diseases as a national priority, e.g., HIV and TB prevention programs for youths and adolescents, FSWs, MSMs and PWIDS.
- ☐ Scaling up high-impact and cost-effective interventions, e.g., PMTCT, MPPI, and Xpert technology.
- ☐ Investments from the application should at a minimum be seen to be leveraging existing in-country investments....considerations for joint investments in states with ongoing USG and GON support as an agreed approach for impact.
- ☐ Aligning with the priorities in the revised strategy documents was needed.
- ☐ Institutionalizing an integrated approach to service delivery for the two diseases, including intensified case-finding through integrated HTC and TB screening, community tracing of contacts and loss to follow-up clients, adherence monitoring mechanisms, procurement and supply chain management, health-care worker capacity strengthening, HMIS etc.

Specific Considerations:

- ☐ Analysis of the epidemiology of HIV and TB in Nigeria to identify geographical areas with the highest burden. For geographical targeting, the recommended six priority states from the Epi Analysis are selected for the HIV component. These overlap with the 13 prioritized states for TB which are also selected on basis of burden and HIV prevalence amongst others.

- ❑ Interventions for Key Affected Populations (FSW, MSM and PWID) will be targeted in geographic locations identified by the MARPS size estimation and Epidemic Appraisal studies.
- ❑ For improved access to services and institutionalization of the community-based approach, the critical enablers of removing legal barriers and community systems strengthening modules were prioritized. This approach will strengthen community systems to collectively address the issues of service integration, demand creation, stigma and discrimination derived from local practices and beliefs, and advocacy for a rights-based approach to service delivery for the two diseases.

OVERVIEW OF PRIORITIZED MODULES

Module 1: HIV Prevention Programs for the General Population:

Application summary for module:

Allocation	Incentive Funding	Unfunded Demand	Quality	Full Request
\$6,500,000	\$5,500,000	\$0.00		\$12,000,000

Rationale for the selection: General population contributes 42 percent of new HIV infections in Nigeria. In view of the limited funding allocation, strategic targeting for high impact is very important. From the gap analysis, it is obvious that there is the need to close the gap in HCT service delivery. The allocated fund is too limited to allow for a robust combination prevention approach in the general population. A strategic intervention is selected and a target population identified to address this gap with a view to contributing to the reduction of new HIV infections in the general population through robust linkages and integration with sexual and reproductive health (SRH) other prevention and treatment activities.

HIV Counselling and Testing (HCT) is universally acknowledged as the entry point to prevention, treatment, care and support.⁶⁸ A US study (HPTN 043) at four sites in Africa attributes an overall reduction of 14% in HIV incidence to a community-oriented programme of HCT.⁶⁹ The need to maintain a balance between prevention and treatment also was considered. The government is also committed to the scale-up of HCT services among the general population as well as in key populations⁷⁰.

This intervention will leverage from the activities of other funding partners like government, USG and the World Bank in the 6 States. CSS interventions will create increased demand for uptake of HCT services in the 6 states. Linkages will be established with treatment, care and support interventions and integration into the TB programme for maximum impact.

Prioritised Interventions:

1. Community-based HCT:

Allocation amount: \$6,500,000

Target population: In view of the limited fund allocation, it is not possible to exclude vulnerable populations as the bridge to the general population in fuelling new HIV infections. The target population is therefore focused on vulnerable women and men in closed settings (prisons), artisans, and migrant and mobile workers in mining, agriculture,

⁶⁸ FMOH: National Guidelines on HIV Counseling and Testing. November 2011

⁶⁹ NIMH Project ACCEPT (HPTN 043). A cluster-randomized trial of community mobilization, mobile HIV testing, post-test support services, and real-time performance feedback for HIV prevention in entire communities. <http://www.hsnc.ac.za/uploads/pageContent/3266/ProjectAcceptCROI.pdf> (accessed 28th October, 2013)

⁷⁰ 2012 Mid-Term Review of the National Strategic Framework Report

construction and transport sectors in 6 focus states: Kaduna, Akwa Ibom, Oyo, Rivers, Lagos and Imo. Some of the characteristics of this target population include being migrants and clients of sex workers. Most of them can easily be reached through their registered unions and institutions.

Implementation approach: Community based approach will be adopted in identifying and selecting intervention sites in the 6 focus states. For greater effectiveness this intervention will leverage on the funding support to HIV prevention, treatment, care and support activities in the 6 States. For example, (a) identify and establish partnerships with mobile HIV counselling and testing providers from the public and private sectors in Kaduna, Akwa Ibom, Oyo, Rivers, Lagos and Imo State. Partnerships will be forged with HIV counselling and test providers who test for other health conditions also; (b) develop and implement a calendar of events, promote mobile HIV counselling testing in prisons and at transport hubs, construction sites, mining companies, agriculture sites with migrant workers and hot spots and brothels where sex workers are located, vulnerable worker's families and communities as part of an integrated wellness approach. The five broad complementary streams of work will include procurement and distribution of RTKs, advocacy with Unions, partnerships and access to HIV counselling and testing, demand generation and HIV counselling testing for target workers and monitoring, evaluation and reporting.

It is anticipated that activities in the CSS component will raise awareness and create demand for the uptake of HCT services. After counselling and testing for HIV, linkages will be established, and referrals made, for access to treatment services for those who test positive, and uptake of prevention methods such as condoms, for both clients who test positive and negative. This will not be a stand-alone intervention.

Expected Impact: The allocated amount will enable the delivery of community-based HCT services to 1,269,159 clients. With an estimate number of 1,137,877 persons in closed settings, artisans and vulnerable mobile and migrant workers in the 6 States, all of them will have the opportunity of accessing HCT services, at least once in 3 years. In 2015, 20 percent of the workers will be reached with HCT services. For the subsequent years, 40 percent of the vulnerable workers will be reached annually. This implies that about 100 percent of the target population and some members of their families will access HCT services. As a bridging population, reduction of new HIV infections among this target population will cut down on new infections in the general population.

2. Condom Supply:

Target population: Same as community HCT above

Above Allocation amount: \$5,500,000

Implementation approach: Enhancing the National Response (ENR) for HIV/AIDS programme, funded by DfID, is coming to an end in 2014. This programme provides more than 70 percent of the condom needs of Nigeria annually. There is therefore an anticipated huge gap in meeting the condom needs of Nigeria after 2014. However, in view of the fact that this HCT intervention will be leveraging on the demand created through other funding sources in the 6 selected states, there is the urgent need to meet the anticipated increased demand in condom needs of the target population. The above allocation will therefore bridge the shortfall in condom supply during the interregnum until the government fully takes over or other sources of funds are secured.

Expected impact: Every attempt to comprehensively meet the gaps in service delivery to this target group will enhance the impact it will have in stopping new HIV infections from crossing over into the general population. There would be increased demand for condoms as clients get tested, hence the above allocation will meet some of this gap for greater efficiency and effectiveness of the intervention.

**Modules 2, 3 and 4: Prevention programs for Vulnerable populations
(MSM, FSW and PWID)**

Application summary for module:

KP	Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
MSM	\$4,721,435	0	0	\$4,721,435
FSW	\$6,686,487	0	0	\$6,686,487
PWID	\$ 3,592,078	0	0	\$3,592,078

Rationale for selection: These modules were selected based on the available epidemiological evidence that shows higher than national average HIV prevalence in this key population (FSW-21%, MSM-17.2% and PWID -4.2%)⁷¹. Their significant contribution to sources of new HIV infections demands that they be targeted for prevention services. These KP and their clients contribute 35% of new HIV infections in Nigeria⁷². Issues of their relatively higher vulnerability including criminalization, legal and policy barriers and stigma also inform the need for their prioritization. The absence of government funding for specific interventions targeting these population is also important.

Selected interventions: Behavioural change as part of programme for vulnerable group

Allocation amount for FSW: \$6,686,487.00

Allocation amount for MSM: \$4,721,434.62

Allocation amount for PWID: \$3,592,078.29

Target Population: Key Populations (FSW, MSM PWID)

Implementation Approach: National MPPI approved package

Geographic coverage: Selected based on the KP mapping and size estimation exercise – (Benue, FCT, Lagos, Kano, Kaduna, Cross River, Gombe, Anambra and Rivers). Also based on available recourses interventions would be extended to adjoining states outside the selected states mentioned above, KP community have proposed to work in the five states currently covered by USG, World Bank and Global Fund, in order to leverage on the facilities and programmes that will be provided in those states. The community has also chosen to work in Kano due to high prevalence of HIV in the state. Apart from leveraging on existing interventions, the 2013 KP size estimates conducted by NACA in the states indicate high growth rate of HIV with FCT at 9.3% growth rate and the least being Anambra with 2.8%. The groups have also chosen to work in the same states to leverage on the services which are peculiar to them such as condom and lubricant programming, advocacy and capacity building trainings and knowledge building of Law enforcement agencies, paralegal trainings amongst others. The prevention in general population module is expected to cover procurement of condom and lubricant need on behalf of the KP community and reflect the cost accordingly.

⁷¹ IBBSS, 2010

⁷² MOT study, 2009

Expected Impact:

- ❑ Reduce new infection rate among MSM by more than 60%. Of the 97,204 MSM's according to the MARP size estimation, a total of 60,689 will be reached with intervention by USG, World Bank, existing Global Fund grant and a portion of the 15 million allocated to the community leading to approximately 62.4% reach during the implementation period.
- ❑ Reduce new infection rate among FSW by more than 80%. Of the 608,000 FSW according to the MARPS size estimation, a total of 556,610 FSW will be met with intervention by leveraging investments from USG, World Bank, existing Global Fund grant and this allocation to the community leading to approximately 85.5% coverage during the implementation period.
- ❑ Reduce new infection rate among PWID by more than 70%. Of the 766,262 PWIDs according to the MARPS size estimation, a total of 589,346 will be met with intervention by USG, World Bank, existing Global Fund grant and a portion of the 15 million allocated to the community leading to approximately 74.4% reach during the implementation period.

Module 5: Prevention programs for adolescents and youth, in and out of school**Application summary for module:**

Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
\$ 2,000,000	\$9,154,914	\$	\$ 11,154,914

Rationale for selection: This module was prioritised in view of the high proportion (31.4%) of Nigeria's population that are young people (age 10-24 years); the fairly high contribution of young people to current burden of the disease, particularly in some parts of the country (compared to the national average of 4.1%, the ANC sero-prevalence rate is 5.4% in North Central zone for 15-19 years, and 8.0% in the south-south zone for 20-24 years; the potential contributions of young people to the future trajectory of the infection and their centrality to the "AIDS-free generation" agenda; and the cost-effectiveness of school-based interventions to reach most young people (who are schooling) and achieve desired impact).

Prioritized interventions: The interventions entail a combination of curricular (Family Life and HIV Education [FLHE] and co-curricular approach in school settings in 6 priority states with the highest HIV burden in Nigeria. The curricular approach is expected to directly influence knowledge and serve as foundation for attitudinal and behavioural change. Complementarily, the co-curricular approach will build on the foundation that would be provided by the curricular approach, contribute to the development of life skills and promote relevant attitudinal and behavioral changes among young people. Furthermore, these interventions will build on previous HIV interventions/projects supported by the Global Fund for young people and consolidate the gains thereby made

Allocation amount: \$2,000,000

Target Population: Young people in Senior Primary School and Junior Secondary School classes

Geographic coverage: Six prioritized states– Kaduna, Akwa Ibom, Oyo, Rivers, Lagos and Imo

Expected Impact: The intervention is expected to reach 322,692 in-school young people across 6 states, and to result in increased percentage of young people who have comprehensive knowledge on HIV/AIDS prevention, and the percentage of sexually active young people who use male condom consistently during sexual intercourse with non-marital partners, and ultimately contribute to the NSP's target of increasing the proportion of young people (15-24 years) who adopt appropriate HIV and AIDS-related behaviour to 80% by 2015.

Above Allocation: \$9,154,914

However, with the provision of the above allocation funds, the programme will cover 1376 schools in the 12 states with the highest burden of HIV and the Federal Capital Territory ("12+1States"), with additional 4,500 teachers trained annually, and the number of students to be covered will increase by about 400% compared to the coverage to be achieved through the (regular) allocation.

Module 6: Prevention of Mother to Child Transmission (PMTCT)

Application summary for module:

Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
\$27,478,841	\$ 6,546,948	\$0.00	\$ 34,025,788

Rationale: This module was prioritized as it is a high-impact intervention. With Nigeria contributing 30% of the global PMTCT burden and having only 30% coverage nationally⁷³ it becomes critical to scale up this intervention if Nigeria is to meet its time bound national and global commitments.

Selected Interventions:

A. PMTCT Prong 3 :

Allocation Amount: US\$26, 468,343

Under Prong 3 Intervention, the allocation will be used for

- Maintenance of PMTCT services in existing GF supported sites across all 36states and FCT and;
- Scale up of PMTCT in 6 priority states

❑ Maintenance: \$18,027,803

Maintenance funds will be used to support continuation of PMTCT services in health facilities across 36+1 Nigerian states that are currently being funded for PMTCT through Global fund under the existing grant.

Target Population & Geographic Scope: Target population consists of all pregnant women who present for counselling and testing at health facilities currently being

⁷³ GARPR, 2012

supported by Global fund across all 36 states of Nigeria and the Federal Capital Territory. Rationale: The national coverage at the end of 2013 was 30%. Achievement of 90% coverage for PMTCT, which has been moved from 2015 to 2018, can only be achieved with total country coverage for PMTCT. This maintenance funds will continue to provide access to PMTCT services for non-prioritized states where demand creation activities have been conducted in the past.

Implementation Approach: All women presenting for PMTCT services will be availed services across already existing sites across the country. HIV counselling and testing will be implemented using a provider initiated and opt-out approach. All women who test positive for HIV will be provided with ARVs immediately and for the period of the pregnancy and post-partum till cessation of breastfeeding in line with the WHO option B approach using test and treat strategy. The women will also be provided with CD4 testing and essential laboratory tests. ARV prophylaxis will be provided to all HIV exposed infants. Adherence support and client tracking will be done and is provided for under the ART, Care and Support module. PMTCT services will be provided mainly at ante-natal, delivery and post-natal clinics of health facilities; we will strengthen integration of TB, family planning, RMNCH and malaria services in PMTCT settings. All pregnant women will be routinely offered HCT, STI and TB screening, malaria prevention and treatment services, and FP services within the ANC settings. Joint planning, assessment of sites, supervision, training and mentoring of HCW on implementation of strategies will be carried out by the HIV, RMNCH and SRH programmes.

In order to, scale up EID uptake, and provide access for HIV exposed infants of women who did not benefit from the PMTCT programme, there will be provider initiated testing and counselling in emergency paediatric units, immunization, well baby clinics and in-patient wards.

❑ **Expected Impact:** This investment will result in increasing national PMTCT coverage to 66% (2015), 62% (2016) and 63% (2017). This level of scale up will achieve 95% coverage in the 6 priority states by 2017.

Scale up: \$8,440,541

The proportion allocated for scale up will be used to scale up across 6 prioritized states in Nigeria which constitute about 41.5% of the HIV burden in Nigeria. Scale up refers to assessment, activation of health facilities to commence provision of PMTCT services, training and capacity building and demand creation. It will also involve increasing the number of clients accessing services in already existing facilities.

Target Population & Geographic Scope: In-order to expedite achievement of national coverage, and to have maximum impact from the available funds, we will strategically invest a portion of the allocation funds in the 6 prioritized states namely Oyo, Lagos, and Kaduna, Imo, Rivers and Akwa-Ibom states. Target population consist of all pregnant women in and around the health facilities across the 6 prioritized states. These 6 prioritized states are a subset of the 12+1 states which are responsible for about 66% of the HIV burden according to the Epi and Impact analysis report

Implementation Approach: As described for maintenance. However, an active demand creation process will be employed in the 6 priority states.

Expected Impact: Increase PMTCT coverage in the 6 priority states to 95%

Above Allocation Amount: (Incentive Funding): \$6,303,857

Target Population & Geographic Scope: Target population consist of all pregnant

women in the remaining 6+1 of Nigeria's 12+1 HIV priority states, who are tested and found HIV +. These states are Benue, Cross River, FCT, Kano, Nasarawa, Sokoto and Taraba states.

Expected Impact: The allocation amount was applied to cover for scale up for only 6 of the 12+1 states. This investment will help Nigeria scale up PMTCT significantly across the 12+ 1 states that contribute to 66% of HIV burden in the country i.e. to further support intervention scale up in the remaining 6+1 states. The above allocation funds, along with other domestic funds available from other sources (PCRP, PEPFAR) will enable these 6+1 states to also reach 95% coverage of the PMTCT need, thereby enabling attainment of eMTCT in all 12+1 HIV priority states.

B. PMTCT Prong 4

Allocation Amount: US\$ 1,010,498

Under Prong 4 Intervention, the allocation will be used for

- Maintenance across all 36+1 states and;
- Scale up of PMTCT in 6 priority states

❑ Maintenance: \$695,190

Maintenance funds will be used to support continuation of Early infant diagnosis (EID) services in health facilities across 36+1 Nigerian states that are currently being funded for PMTCT through the existing Global fund grant.

Target Population & Geographic Scope: As in maintenance for Prong 3 including their infants/children

Implementation Approach: Early infant diagnosis will be provided for all HIV exposed babies. HIV positive infants will be referred for ART (this will be covered under the ART module) The WHO Option B approach will be employed, therefore all women requiring ARV for their own health will be served under Adult ART funds allocation.

❑ Scale up: \$315,308

The proportion allocated for scale up will be used to scale up across 6 prioritized states in Nigeria which constitute about 41. 5% % of the HIV burden in Nigeria. Scale up refers to assessment, activation of health facilities to commence provision of PMTCT services, training and capacity building and demand creation. It will also involve increasing the number of clients accessing services in already existing facilities.

Target Population & Geographic Scope: Target population consist of all pregnant women and their infants/children across the 6 prioritized states (Oyo, Lagos, and Kaduna, Imo, Rivers and Akwa-Ibom state).

Implementation Approach: As described for Prong 4 scale-up but with active demand creation. Demand creation funding will be covered under the CSS module.

Above Allocation Amount: (Incentive Funding): \$243,090

Target Population & Geographic Scope: As in allocation section.

Expected impact: The allocation funds, along with other domestic funds available from other sources (PCRP, PEPFAR) will increase national EID coverage to 65% by 2017. The

above allocation funds will be used to support intervention scale up to further increase national EID coverage to 67% by 2017.

Module 7: Treatment , Care and support (HIV)

Application summary for module:

Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
\$148,453,913	\$ 48,024,755	-	\$ 199,478,667

Rationale for selection: A high impact intervention. This module was also prioritized based on the critical role treatment, care and support plays in reducing AIDS related morbidity and mortality in PLHIV. The choice gives the opportunity to complement the efforts of other in-country partners (PEPFAR & World Bank) in reducing HIV treatment gaps, which remains significant despite its reduction from 69% in 2010 to 59% in 2013⁷⁴

Selected Interventions

A. Anti-Retroviral Therapy (ART)

Allocation Amount: \$108,460,430 (Maintenance)

Target population& Geographical scope:

This amount will be utilized to procure ARVs and cover other service delivery costs for maintenance of the patients already enrolled in the program through the existing Global fund grant as at June 2015 and to sustain them till December 2017.

Allocation Amount: \$27,984,942 (Scale up)

Target population& Geographical scope:

The target population will be all ART eligible HIV positive patients based on the revised National Guidelines 2014 (see approved draft). The current epidemiological analysis and the need to invest strategically for impact inform the prioritization of six states (Kaduna, Imo, Rivers, Akwa Ibom, Oyo and Lagos). These states contribute 41% of the National burden and AIDS related mortality.

Implementation approach:

The provision of ART would be gender sensitive , will target the youth (15-24years) and address the needs of the women as they are more affected by the epidemic (NARHS, 2012). The revised National guidelines (2014) will be implemented to increase the number of those eligible for ART (adults with CD4 count ≤ 500 , children ≤ 60 months and all TB-HIV co-infections among others). Scale up of paediatrics ART will be prioritized, key approaches will include improving access to PITC amongst children <15 and strengthen existing DBS transport systems, between health facilities and PCR labs in the National EID network to reduce overall turnaround time. Secondly, improving coverage and access to HIV treatment services to children using a family centred approach to care in existing and new treatment sites. In addition, increase capacity of health care workers to identify and manage HIV exposed or infected children and improving retention amongst HIV positive children in care and treatment.

⁷⁴ Nigeria Epidemic Analysis, 2014

Adoption of National decentralization guidelines and scale-up plan will be done giving priority to TB-DOTS centres without ART services and existing high volume PMTCT sites. Improvement of TB-HIV referral system will be ensured (strategy) as well as instituting clinical audit /CQI processes for both diseases. TB screening for all paediatric patients in the ART clinic will also be prioritised. Training and re-training of health care workers (HCWs) will be undertaken. Develop new linkages and leverage on existing public- private partnerships of the national ART and TB programs.

Expected Impact:

This investment will put 15,084 new patients on ART annually totalling 45,252 over the three year period. It will help achieve 58% (2015), 63% (2016) and 67% (2017) of National ART needs based on the 500 CD4 cut off for ART. The selected states will also make significant progress with coverage with Kaduna state achieving Universal coverage. Note is made that this will be achieved with leverage of PEPFAR investments in these states as proposed in the COP15.

Above Allocation: \$ 44,819,794

Target population & Geographical scope:

The geographical scope will expand services under allocation amount to saturate the 6 states and the 12 +1 priority states. This will help avert 65.9% of all new HIV infections in the country⁷⁵ and help attain universal coverage targets as set by the country.

Implementation approach:

The implementation approach is as described above for allocation amount.

Expected Impact:

This investment will help achieve 61% (2015), 65% (2016) and 69% (2017) of National targets.

B. Treatment Adherence

Allocation: \$1, 922,778

Target population & Geographical scope:

All HIV-infected patients, TB-HIV co-infected patients on ART and Anti-TB drugs (including DR-TB) and patients on IPT. However, the six states with the biggest treatment gap and TB burden will be given priority. Adherence to ARVs is one of the primary factor impeding effective HIV treatment in Nigeria and number of people living with HIV receiving adherence support increased from 253,374 in 2010 to 447,697 in 2012, but has declined to 155,558 in 2013⁷⁶

Implementation approach:

This will involve providing adherence support at community and facility level, community tracking of defaulters and harmonisation of adherence systems to enable support groups (SGs) and/or CBOs to offer all encompassing counselling on adherence to ART and TB drugs.

Based on the lessons from the current GF R9 Phase 2 implementation, only support groups with pre-set and agreed upon capacity requirements and are located within the GF supported facility catchment area (LGA) will be engaged to provide treatment adherence support services. This will contribute to ensure sustainability and effective facility/community linkages. It is planned to have one support group per LGA. The

⁷⁵ Modelling, Nigeria Epidemic & Impact Analysis, 2014

⁷⁶ Ditto...

adherence supporters will work hand-in-hand with the facility staff to get a list of defaulters and missed appointments for tracking, counselling and referral services. SGs will equally conduct home visits and also support the PMTCT clinics in clients tracking as "*Role Model Caregivers*". The facility staff (HCWs) will provide day-to-day supervision and over-sight on service delivery to ensure quality of services provided by adherence supporters. HCWs will also participate in other SGs activities such as community dialogue meetings, support group meetings, etc. as co-facilitators to ensure quality and provide expert advice as the need arises. Refresher training on adherence support, stigma reduction, M&E, project and financial management will be conducted for the selected SGs including training on harmonised adherence strategies which will include the health workers. Services will include counselling, home visit, clients tracking, food and nutrition support, psychosocial support, referral services, etc. This will involve capacity building of implementing SGs on effective adherence counselling, regular technical assistance and oversight, capacity building on effective collaboration, service quality, integration and coordination.

Above allocation: \$3,204,960

Target population & Geographical scope: As in allocation section

Implementation approach: Scale up of the activities earmarked for funding from the allocative amount

Expected Impact: This investment will result in increased coverage of adherence monitoring activities for TB and HIV treatment beyond the 6 priority states

C. Prevention, diagnosis and treatment of opportunistic infections

Allocation: \$1,180,199

Target population & Geographical scope:

All eligible HIV positive patients will be targeted in the six priority states (Kaduna, Imo, Rivers, Akwa Ibom, Oyo and Lagos) with the biggest treatment gap and high TB burden⁷⁷

Implementation Approach:

In 2012 only 56% of PLHIV (109189) who were enrolled into care were placed on CPT, and of this number only 9.3% (10171) were children⁷⁸. Implementation will include provision of CPT, TB screening, IPT and treatment for STIs (emphasis on Syndromic management) to eligible patients. There will also be capacity building for HCWs in the management of OIs and infection control at ART and TB-DOTS clinics.

Expected impact: Reduced morbidity and mortality due to OIs and improved infection control at health facilities.

D. Treatment Monitoring

Allocation: \$7,905,562

Target population & Geographical scope:

All HIV positive patients enrolled into care and placed on ART. Investment in the six states

⁷⁷ Epi Analysis, 2014

⁷⁸ HIV NSP MTR, 2013

with the biggest treatment gap and TB burden will be prioritized. All patients enrolled into treatment are recommended to receive the minimum package for treatment monitoring according to the National ART Guidelines⁷⁹

Implementation approach:

Treatment monitoring will basically cover immunologic (at least twice a year CD4 count), Virologic (at least once a year viral load), chemistry, haematological tests and routine TB screening according to the National Guidelines. Optimising utilisation of gene Xpert, TB culture and DST services through strengthening referral of patients with suspected TB/DR-TB from the ART clinic will be done. Linking new ART sites with the nearest HIV RNA and DNA PCR sites to ensure improved access to EID and virologic monitoring will be ensured. The strategy for ensuring qualitative laboratory services for TB-HIV co-infection management will entail leveraging on the existing HIV and TB programmatic Lab SOPs/guidelines and quality assurance systems. A pharmacovigilance system to monitor adverse drug reactions from ant-TB, ARVs and other drugs will be put in place or fortified where they exist.

Expected Impact: All patients enrolled in the ART program will be managed with the complement of recommended routine of laboratory tests to ensure quality of care.

Module 8: TB Care Prevention & Treatment

Application summary for module:

Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
\$ 67,461,012	\$ 26,957,112	\$0.00	\$ 94,418,124

Rationale: The single greatest challenge to TB control in Nigeria and the highest priority for the NTBLCP is an extremely low case detection rate, calculated at 17% in 2013 based on the new prevalence survey data (see National Strategic Plan for Tuberculosis 2015-2020, p.47). The global TB control community has committed to finding the estimated 3 million missing cases that go undiagnosed every year around the world. In Nigeria alone, an estimated 455,846 cases were missed in 2013, representing 15% of the global gap in case notification. With improvements to case-finding in Nigeria, the country could contribute to a significant narrowing of the global gap.

Treatment capacity must be increased to meet the anticipated increased demand for services, in line with the expected number of cases diagnosed. This includes procurement of first-line anti-TB drugs and expansion of treatment facilities.

The NTBLCP has chosen two priority strategic interventions for the allocated funding that will yield the greatest contribution to case notification and will maintain treatment success at a high level to avoid development of drug resistance, ongoing transmission, and excess morbidity and mortality.

Selected Interventions:

A. Case detection and diagnosis

Allocation amount requested: \$40,817,324

Target population & geographic scope: To achieve rapid increases in case notification

⁷⁹ Draft National ART guidelines, 2014

target populations will include people with TB symptoms attending health services (for any reason), urban slum dwellers, and children within 14 focus states of the country that represent more than 51% of missed cases in Nigeria (Akwa Ibom, Anambra, Bauchi, Borno, Imo, Jigawa, Kaduna, Kano, Lagos, Oyo, Rivers, and Sokoto, plus the FCT and its environs – see Annex 2 of the NSP-TB). An additional target population will be contacts to bacteriologically positive pulmonary TB cases, a high-risk, high-yield population, which will be covered nationwide. Rationale for targeting these sub-populations is presented in the NSP-TB, pp. 51-53. PLHIV are addressed as a KAP under the TB/HIV module.

Implementation approach: Existing smear microscopy and treatment services will be maintained throughout the country to support passive case-finding. To increase identification of people with TB symptoms, NTBLCP will use community organizations to provide outreach for demand creation and expand active case-finding and referral/sputum collection in 10 urban slums per year in the 14 priority regions. Active TB case finding among slum dwellers will entail house-to-house visits within the slums during hours when people are likely to be at home to identify presumptive TB cases using a standardized screening tool. This will be done by trained community health workers and volunteers identified through Ward Development Committees and local community-based organisations. (All community-based interventions will provide integrated TB and HIV services.) We will also engage patent medicine vendors (as a major first point of care—see NSP-TB p. 78) in identification of people with TB symptoms and referral to diagnostic facilities/sputum collection for evaluation. NTBLCP will further expand case-finding by integrating TB screening and referral within the routine activities of health care providers in general hospitals where many people with symptoms first seek care (see NSP-TB, p. 78), including integration of screening for children within pediatric services. This intervention has potential for high yield at low cost. In addition, we will work with the Primary Health Care Development Agency to ensure that TB screening and referral services are integrated into the training of new primary health centre staff, so that at least 15,000 PHCs nationwide are capable of screening and referring clients or collecting sputum for diagnosis.

A scale-up of diagnostic LED FM smear microscopy will be concentrated in the 13 + 1 focus states, where currently only 665 microscopy facilities exist for a total population of approximately 84 million people, representing a ratio of 1:126,244. An analysis of data from Nigeria showed a positive correlation between the number of microscopy centres per population and the case notification rate in various states, indicating that improving access to facilities providing basic TB services is an important and cost-effective means of increasing case notification. (See NSP-TB 2015-2020, p.57). With Global Fund support, NTBLCP will establish 1,180 new microscopy sites within existing facilities to bring the ratio to 1:50,000 within the priority states. Sites will be chosen for proximity to KAPs, particularly urban slum dwellers, and to achieve coverage in areas where services are not readily available. (GeneXpert in priority states will be supported through the allocation to the TB/HIV module and through other donors.)

Expected impact: As a result of the activities described above, we expect to diagnose a total of 429,114 cases (all forms) between 2015 and 2017, including 34,846 children.

Above allocation amount requested: \$16,310,416

Target population & geographic scope: With additional funding, NTBLCP will expand the intensified intervention package described above to eight more states that represent an additional 20% of the missed TB cases in Nigeria (Benue, Cross River, Delta, Enugu,

Niger, Ondo, Osun, Zamfara).

Implementation approach: The approach will be the same as described above. NTBLCP will establish 569 new LED FM microscopy sites within existing facilities in these states to bring the ratio to 1:50,000. Sites will be chosen for proximity to KAPs, particularly urban slum dwellers, and to achieve coverage in areas where services are not readily available.

Expected impact: As a result of all the interventions described above, we expect to diagnose an additional 171,142 cases (all forms) between 2015 and 2017, including 13,691 children.

B. Treatment:

Allocated amount requested: \$26,643,688

Target population & geographic scope: All diagnosed TB cases including HIV-positive TB patients will be targeted throughout the 36 states of the country and the Federal Capital Territory. Emphasis for expansion of treatment services will be placed on matching the anticipated increased need in the 13 + 1 focus states, with expansion in other regions as needed to provide basic coverage.

Implementation approach: Treatment services will be continued at the current 5,389 DOTS centres and initiated within an additional 1,815 existing facilities. Treatment services will be co-located with diagnostic services to provide patient-friendly one-stop services. First-line drugs will be procured from GDF to cover the anticipated need, including fixed-dose combination drugs, formulations for children, PLHIV on second-line ARVs, and for IPT for child contacts (<6 years old) of TB cases, in whom active TB has been ruled out. Services will include robust community-based treatment support to ensure treatment success greater than 85% and prevent the development of drug resistance. Intensive treatment support and monitoring will be focused in poor-performing areas with unacceptably low treatment success (<85%).

Expected impact: With the allocated amount, NTBLCP expects to put 429,114 TB patients on treatment and successfully treat a total of 378,136 drug-susceptible TB patients, including PLHIV and children.

Above allocation amount requested: \$10,646,696

Target population & geographic scope: The above allocation amount will allow for treatment of patients diagnosed from the above allocation funding under the detection and diagnosis intervention and will be used for procurement of FLDs and community-based treatment support.

Implementation approach: As described above under the allocation amount.

Expected impact: The above allocation amount will procure an additional 171,142 courses of first-line TB treatment and allow 150,605 more patients to complete treatment successfully.

Module 9: Multi Drug Resistant-TB (MDR-TB)

Application summary for module:

Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
\$ 33,227,398	\$ 19,784,674	\$59,043,768	\$ 112,055,841

Rationale: Nigeria is a high-MDR TB burden country. The PMDT programme began in 2010, but scale-up has been slow and has not kept pace with the need. In 2013, a total of 665 DR-TB cases were diagnosed (12.5% of the estimated 5,311 DR-TB cases). Formerly, treatment of DR-TB patients relied on hospitalization for the entire 8-month duration of the intensive phase. This has prevented all diagnosed patients from being started on treatment. However, with the change of the policy by mid-2013 to include a shortened duration of hospitalization in one treatment centre (first 3 months of the intensive phase), followed by ambulatory phase of treatment for the remaining 17 months or a full 20 months of ambulatory treatment. While, this change in policy is expected to allow for more patients on treatment, it is noted that in 2013, only 52% (345) of the diagnosed 665 DR-TB cases were started on treatment. With the expansion of GeneXpert testing, NTBLCP expects a significant increase in the diagnosis of DR-TB, even without expansion of risk categories for testing. To prevent unnecessary ongoing transmission, morbidity and mortality related to DR-TB, both diagnostic and treatment services must be scaled up more rapidly with rigorous monitoring of patients to prevent loss to follow-up and development of additional drug resistance.

Selected interventions: (in order of priority)

A. Treatment: MDR-TB

Allocation amount requested: \$20,584,156

Target population & geographic coverage: This intervention targets confirmed DR-TB patients according to national guidelines. This amount includes \$ 18,971,642 which covers the direct cost of providing treatment, patient support and personal protective equipment to aid in infection control, to 1,795 patients and their caregivers for the 20-month period of treatment, and \$ 1,612,513.84 which covers the cost of MDR-TB specific health system strengthening activities such as upgrade of treatment wards and trainings for State DR-TB teams and facility staff. The geographic coverage is nationwide.

Implementation approach: The first priority for the NTBLCP with respect to DR-TB is to scale up treatment capacity by shifting to a predominantly ambulatory model, with hospital discharge at 2 or 3 months for patients requiring admission in the early phase of treatment. An additional four treatment wards will be refurbished in four States to ensure that referral centers for patients with complicated co-morbid conditions and XDR-TB have access to the required treatment. The risk in shifting to initiating treatment on an ambulatory basis is the possibility of losing patients before they complete the 20-month treatment if tracking and patient support systems are not well-developed. Focus will be placed on training service providers to manage DR-TB patients appropriately on an outpatient basis and linking them with the State-level DR-TB teams who are trained to manage complications. NTBLCP will procure second-line and ancillary drugs from the GDF to treat DR-TB patients. In addition, NTBLCP will develop a strong community support system for DR-TB

patients with well-defined linkages between treatment supporters and health facility staff. To alleviate the severe financial burden of DR-TB on families, NTBLCP will also provide patient support for subsistence, nutrition, and transportation for treatment for patients requiring such, to ensure adherence and improved patient outcomes.

Expected impact: With the allocation funding, a total of 1,795 patients will be able to access appropriate treatment, making up about 12% of the country targets, with expected improvement in treatment outcome from the current 62% success rate to 70%, as well as improved health, community systems and monitoring and evaluation systems to support further scale up of DR-TB services in Nigeria.

Above allocation amount requested: \$ 57,392,690

Incentive Funding: \$ 13,565,254

Unfunded Quality Demand: \$ 43,827,436

Target population & geographic scope: The incentive funding amount will provide DR-TB treatment, patient support and personal protective equipment for an additional 750 MDR-TB and 30 XDR-TB patients and their caregivers nationwide. This amount includes \$ 7,926,870 which covers the direct cost of providing treatment for 750 MDR-TB patients, \$1,504,883 which covers the direct cost of providing treatment for 30 XDR-TB patients for the full duration of their treatment, and \$ 4,133,501 which covers the cost of MDR- and XDR-TB specific health system strengthening activities such as upgrade of 4 additional treatment wards, the training of 258 CBOs on MDR-TB treatment support and training of facility staff and 100 LGA DR-TB teams.

The unfunded quality demand will provide treatment and patient support services for an additional 3,150 MDR-TB and 30 XDR-TB patients nationwide. This amount includes \$33,292,854 which covers the direct cost of treatment and patient support for 3,150 MDR-TB patients, \$ 1,504,883 of which covers the direct cost of treatment for 30 XDR-TB patients and \$ 9,029,699, of which covers the cost of MDR- and XDR-TB specific health system strengthening activities such as the establishment of an additional 17 treatment wards, training of additional 258 CBOs and 100 LGA DR-TB teams. The geographic coverage is nationwide.

Implementation approach: If additional funding were made available, NTBLCP would use it to ensure treatment and patient support for an additional 750 MDR-TB patients through the incentive funding and 3,150 patients through the unfunded quality demand, as well as 30 XDR-TB patients through the incentive funding and an additional 30 XDR-TB patients through the unfunded quality demand, including those who have already been diagnosed in 2014. All the 37 States will have referral centres and over two-thirds of the LGAs will have trained CBOs to support patient follow-up and adherence to treatment.

Expected impact: Scaling up ambulatory treatment and investing in health and community systems strengthening will provide coverage for 61% of the country's MDR-TB treatment targets over the 3 year period and 60 XDR-TB patients can also be placed on treatment and adequately monitored over their 24 month treatment period.

B. Case detection and diagnosis – MDR-TB

Allocation amount requested: \$12,643,242

Target population and geographic coverage: This intervention targets all people with

TB who fall into designated DR-TB risk categories according to national policy, including symptomatic contacts to known DR-TB cases, Category I and II treatment failures, all other retreatment cases, and patients on any regimen who remain or become sputum smear positive after the intensive phase of treatment. The allocated amount includes \$6,429,475 which covers the direct cost of diagnosing 1,795 patients as DR-TB (RR-TB and/or MDR-TB), as well as follow up investigations for the twenty month period of treatment, and \$6,133,972 which covers the cost of DR-TB specific laboratory strengthening activities such as the establishment of an additional culture and DST laboratory in the South East, where there is currently none, the cost of installing line probe assay equipment in the South West reference laboratory, supporting constant supply of electricity in the reference laboratories and training additional staff. It also includes cost for the follow up investigations of 700 DR-TB patients currently on treatment. The geographic coverage is nationwide.

Implementation approach: Diagnostic support under the allocation funding will enable functionality of culture/DST laboratories in the 6 geopolitical zones of the Country, (with the installation of an additional reference laboratory in the South East). It will cover essential services such as supplies, consumables and equipment for the reference laboratories to provide culture and first- and second-line DST for diagnosing and monitoring DR-TB patients. This includes GeneXpert cartridges for screening patients in DR-TB risk categories using existing machines. Emphasis will be placed on implementing a fully functional sputum transport system using courier services to pick up specimens from collection points and deliver them to the closest GeneXpert sites. For cases with rifampicin-resistant strains according to GeneXpert, additional specimens will be transported by courier on a weekly basis to the nearest TB reference laboratory for culture and drug susceptibility testing. Local government areas will receive necessary equipment and supplies to transport specimens safely and support for a short turnaround time for retrieval of results, to ensure adequate monitoring of patients' response to treatment.

Expected impact: As a result of increased diagnostic capacity including increased use of GeneXpert, NTBLCP anticipates diagnosing and following up a total of 1,795 new DR-TB cases over the three-year period of the grant, as well as 700 existing DR-TB cases commenced on treatment by the end of 2014. This represents 12% of the country targets.

Above Allocation Funding: \$ 21,435,753

Incentive Funding: \$ 6,219,420

Unfunded Quality Demand: \$ 15,216,332

Target population & geographic scope: The incentive funding amount will provide laboratory diagnosis and follow-up for an additional 750 DR-TB (RR-TB and/or MDR-TB) and 30 XDR-TB patients nationwide. This amount includes \$2,686,410 which covers the direct cost of diagnosing 750 patients as DR-TB, as well as follow up investigations for the twenty month period of treatment, \$107,393 which covers the direct cost of additional laboratory support for XDR-TB patients and \$3,425,617 which covers the cost of MDR-TB and XDR-TB specific laboratory strengthening activities including the establishment of one additional culture and DST laboratory in the far North West, the cost of installing line probe assay equipment in the South West reference laboratory, supporting a constant supply of electricity in the reference laboratories and training additional staff.

The unfunded quality demand will provide laboratory diagnosis and follow-up for an

additional 3,150 MDR-TB and 30 XDR-TB patients nationwide. This amount includes \$11,282,922 which covers the direct cost of diagnosing 3,150 patients as MDR-TB, as well as follow up investigations for the twenty month period of treatment, \$107,393 which covers the direct cost of additional laboratory support for 30 XDR-TB patients and \$3,826,017 which covers the cost of DR-TB specific laboratory strengthening activities including the establishment of one additional culture and DST laboratory in the North Central zone, the cost of installing line probe assay equipment in the new North Central reference laboratory, supporting constant supply of electricity in the reference laboratories, training additional staff and providing additional cold boxes for sputum transportation, to cover the remaining two-thirds of the Local Government Areas in the Country. The geographic coverage is nationwide.

Implementation approach: If additional funding were made available, NTBLCP would use it to ensure diagnosis and follow-up investigations for an additional 750 MDR-TB patients through the incentive funding and 3,150 patients through the unfunded quality demand, as well as 30 XDR-TB patients through the incentive funding and an additional 30 XDR-TB patients through the unfunded quality demand, including those that have already been diagnosed in 2014. An additional TB reference laboratory will be established in Sokoto State (North West Nigeria), which will serve the population for the 3 States in the far North West, where some local government areas are currently over 13 hours' drive to the nearest next TB reference laboratory. Solar refrigerators will also be made available to the 774 local government areas to ensure adequate sample preservation when same-day transportation to the TB reference laboratory is not possible.

Expected impact: Establishing two additional laboratories would allow the processing of cultures and DST samples for 50% of the Country's MDR-TB targets over the 3 year period. 60 XDR-TB patients can also be diagnosed and their treatment adequately monitored over their 24 month treatment period.

Module 10: TB and HIV Joint Programming (TB/HIV)

Application summary for module:

Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
\$6,979,530	\$ 11,061,813	\$0.00	\$ 18,041,343

Rationale: Need for an Integrated approach to TB and HIV programs; improving efficiencies, leveraging resources and strengthening systems

Selected Interventions:

A. TB/HIV Collaborative interventions

Allocation: \$2,400,000

Target population & Geographical scope:

Six states (Kaduna, Imo, Rivers, Akwa Ibom, Oyo and Lagos) that are responsible for 41% of the National HIV burden and AIDS related mortality were prioritized for HIV interventions (e.g. ART, PMTCT). These six states were also part of the 13+1 states prioritized by the TB programme (Kaduna, Imo, Rivers, Akwa Ibom, Oyo, Lagos, Anambra, Bauchi, Borno, Jigawa, Kano, Sokoto, and FCT) based on high TB burden.

The six high HIV and high TB burden states (Kaduna, Imo, Rivers, Akwa Ibom, Oyo and Lagos) will be prioritized for accelerated and comprehensive TB/HIV interventions to demonstrate impact. The target population are the TB and HIV patients

Implementation approach:

Integrated service delivery support (joint M&E, training, Planning, supervision and mentoring. Establishment of new and support of existing TWGs at states and facility levels especially high volume facilities in the six priority states. Facilitate Policy change strategy towards integrated TB and HIV service provision in the TB and HIV clinics (one stop shop approach) through piloting of nurse led provision of TB and HIV services to increase uptake. All PLHIV in HIV care and treatment settings will be screened for TB, the TB symptomatic PLHIV patients will access GeneXpert tests in line with the National Algorithm for TB diagnosis among PLHIV. The HIV and TB programme has already prioritized the placement of GeneXpert machines in facilities providing TB/HIV services to increase access. Isoniazid Preventive Therapy (IPT) will be provided for eligible PLHIV in HIV care setting. All Patients with presumptive and diagnosed TB will be tested for HIV; the HIV positive TB patients will be promptly initiated on ART and CPT irrespective of the CD4 count. The TB/HIV services will be provided in a patient-centred manner with standard TB Infection control measures giving priority. The necessary commodities required for the delivery of TB/HIV services such as HIV test kits, INH, Co-trimoxazole and ART already covered in the respective HIV and TB modules.

Expected Impact: Integrated service delivery will be institutionalized with associated cost efficiencies. Investment in the 6 states will contribute to the screening of 41% of PLHIV in the country for TB assuming a 100% screening rate with resultant increased in TB cases detected among PLHIV. Treatment outcomes among TB/HIV co-infected patients will also be improved, Additionally, TB/HIV related morbidity and mortality will reduced.

Above Allocation: \$11,061,813

The above allocation amount is intended to expand the scope and scale of the TB/HIV integration approach to the remaining 30 states in the country, towards ensuring that TB/HIV services (e.g. TB screening among PLHIV, HCT for TB suspects and patients, IPT, CPT & ART for TB/HIV co-infected patients etc.) are offered to all in need for the achievement of the desired TB/HIV targets as envisioned in the National strategic Plan.

Expected Impact: The scope and scale of impact of the allocation amount will be increased, reduction in TB/HIV related morbidity and mortality

B. Engaging all care providers

Allocation: \$ 2,000,000

Target population and geographic scope.

TB/HIV co-infected patients and Six high HIV and TB burden states (Kaduna, Imo, Rivers, Akwa Ibom, Oyo and Lagos)

Implementation Approach: The private sector and other alternate health care providers play a huge role in the delivery of health services in the country, this sector unlike the public is not affected by industrial unrest which interrupt service provision. In view of this, the private sector will be engaged comprehensively through their organized body with a champion identified among the sector to lead this process. MoU will also be signed with

the eligible partner. Other implementation approach include advocacy engagement and capacity building for private providers, community pharmacists, traditional healers and other alternate care providers in the delivery of TB/HIV services. Match and ensure activation of ART and DOTS services in private and public facilities.

Expected Impact: Larger stakeholder involvement in service delivery as a means of ensuring uniform standards of care, and enhancing uninterrupted access. Additionally, this will also contribute to the reduction in the morbidity and mortality among TB/HIV co-infected patients in private care providers.

C. Collaborative activities with other programs and sectors

Allocation: \$: 1,500,000

Target population & Geographical scope:

TB HIV co-infected patients in other programs and sectors & six high HIV and TB burden states (states (Kaduna, Imo, Rivers, Akwa Ibom, Oyo and Lagos)

Implementation approach: Facilitate advocacy and strategy change towards integrating TB/HIV services in Maternal, Neonatal and Child health (MNCH) programme and diabetic control. TB/HIIV services will also be integrated into the PMTCT services.

Expected Impact: Larger stakeholder involvement in service delivery as a means of ensuring improved access to services and uniform standards of care.

D. Key Affected Populations

Allocation: \$1,079,530

Target population & Geographical scope:

The target population are the Key at risk populations e.g. MSM, FSW, IDU) and other high risk group such as prisoners. The interventions addressing KP will be implemented in 6 states ((Benue, FCT, Lagos, Kano, Anambra and Rivers), additionally, the prisons facilities nationwide will be part of the geographical scope.

Implementation approach:

Integration of TB/HIV services into the minimum prevention and care packages for key affected populations (e.g. MSM, FSW, and PWID) and other high risk group such as prisoners.

Expected Impact: Reduction in TB/HIV morbidity and mortality among key affected populations.

Module 11: Community Systems Strengthening

Application summary for module:

Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
\$6,000,000	\$0.00	\$0.00	\$6,000,000

Rationale for selection: Within the community health and ward health system in Nigeria, there are distinct and yet complementing roles for the WDCs and the CSOs with the overall goal of ensuring improved health outcomes for the members of the community they serve. The WDC have the primary responsibility of identifying health and social needs and plan for them; supervise the implementation of developed work plans, mobilize the community for health actions, identify local human and material resources to meet these needs, forward all health/community development plans to LGA and oversee the functioning of the Health facilities in the Wards. They are also important to liaise with government and other voluntary agencies in finding solutions to health, social and other related problems in the wards. Similarly, the CSOs play critical role in supporting the health system and are concerned with other aspects that are not universally accepted as part of the health system, such as building capacity and assuring the voice of “Right-Holders” and the accountability of “Duty Bearers”; provision of social support, human rights work and community mobilization, all of which help to improve health outcomes. The supports are aimed to enhance a scale up of community based prevention effort, community mobilization and sensitization, demand generation for ATM services, encouragement and provision of care and support to people affected as well as make referral to health facilities or other CBOs that could render services. In view of emerging human right issues including stigma, discrimination and covert exclusion/denial of services, the role of CSOs in ensuring rights-based programming finds expression, that are based on strong social analysis of underlying causes of inequities and social injustice, which if properly addressed, will over time lead toward the sustainable achievement of a common rights goal. A distinctive value of CSOs work is that their time frame is longer than that of a project, which is in itself a self-reinforcing sustainability principle. (Culled from HSS-CSS assessment report 2014).

Available evidence from the current CSS implementation, feedbacks from community dialogues in Nigeria and cross border experience support integrated community response to the control of HIV, TB and Malaria. Despite limited investment in national, state and community network institutional capacity, data from the TB/HIV community assessment report indicated increased demand for ATM services resulting from Support Group/CBO participation in demand creation. Community System Strengthening is being implemented as a cross-cutting component of the Global Fund HIV grant in Nigeria and it harmonizes the three diseases through community driven demand creation, awareness and sensitization for services uptake and utilization. (*TB/HIV/AIDS community assessment report and CSO community dialogue report, 2014*)

Prioritized interventions:

A. Social mobilization, building community linkages, collaboration and coordination:

Target population & Geographic scope:

310 CSOs working in collaboration with the WDCs in HIV and TB prioritized states (Kaduna, Akwa Ibom, Kano, Oyo, Lagos, Imo, Rivers, Sokoto, Borno, Bauchi, Katsina, Jigawa, Anambra and FCT). These states were selected on the basis of GF ATM focused states and disease burden as shown in the country's EPI-Analysis.

Allocation: \$ 2,924,193

Implementation Approach

The grant will be implemented by Civil Society Organizations (CSOs) also known as “ATM Networks”.

ATMs networks at all levels will coordinate community action, creation of networking and effective linkages with other actors and broader movements such as human rights and women’s movements. Strong informal and formal relationships between communities, facilities, community actors and other stakeholders that will result in TB/HIV program integration will be maintained.

Specific implementation arrangement is such that there will be one CBO per LGA and the activities of the CBOs will be coordinated by the state ATM network focal persons. Routine data collection, Quarterly data verification and project review coordination, and update meeting for community actors at LGA level, (CSOs, KAP groups, facilities and community Health Promoters’) will be conducted which will yield improved service quality at the facilities for ATM related services.

CBOs and CHPs selected from community structures including WDCs will actively participate in cluster site/coordination meetings where service integration issues will be discussed as well as challenges in service uptake. Major issues from the meetings such as low PMTCT, TB & HCT service uptake, drug out of stock and advocacy issues will be incorporated in CBOs periodic work plan.

310 CBOs in 310 LGAs in selected focus states will provide ATM related disease services delivering key health messages to 1,024,586, ATM disease related services such as referral to 48,000 people, data collection, case finding, carrying out community mobilization to effect demand creation for 1,550 PHCs and 36,000 mothers needing PMTCT in 310 LGAs in the focus states; 28,044 FSW; 1,952 IDUs and 5,340 MSM.

Expected Impact:

This intervention will result in effective/integrated community based demand generation and improved uptake for PMTCT services, HCT Services, TB suspect referrals and ART adherence education. The outcome will be improved delivery and uptake of the ATM services and this will ultimately reduce the mortality and morbidity among PLHIV, and key affected populations.

Also, systematic monitoring by CSOs will further strengthen decision-making processes based on the data generated on the health information system thereby resulting in evidence- based programming.

B. Institutional capacity building, planning and leadership development in the community sector

The continuous strengthening of ATM networks institutional capacity at national and state level will provide a platform to improve the quality of mentoring support for Support Groups/ CBOs and other community actors including WDCs and “Community Health Promoters” (CHP). This will act as a catalyst for scaling up sustainable community driven demand creation activities in an integrated TB, HIV and Malaria community systems framework to support the health systems. The integrated CSS framework will ensure improved capacity for community actors to deliver effective and efficient community based health care services.

Allocation Amount: \$2,351,816

Target population:

310 CSOs working in collaboration with the WDCs in focus states

Implementation Approach:

At the inception of the project, the ATM networks will map and assess community based organizations in 310 LGAs to identify credible CBOs and KAP groups to be engaged in the project.

State program officers of the ATM networks will be trained on organizational capacity development and institutional systems strengthening after which they will conduct state level orientation for all identified and assessed CBOs/KAP in each of the states. Community Health Promoters (CHPs) will be selected from the WDCs in an integrated approach. A mentoring plan for community based organizations has been developed by the ATM networks. This plan will be used throughout the project cycle to mentor CBOs on human resource planning, leadership, Community and social mobilization, ATM community services, financial management, report writing, data collection, presentation and management.

The capacity of ATM networks at the national level will be strengthened through finalization of CSS framework in the country and development/use of universal code of conduct. The networks will hold periodic governance board meetings resulting to enhanced policy and institutional capacity of the networks. The national networks will engage government on human rights and strategic advocacy issues in relation key affected population.

Expected Impact:

Through this intervention, community based organizations will fulfil their roles in service provision, social mobilization, monitoring and advocacy. CBOs, CSOs and WDC will create the needed platform for a functioning integrated health and community systems at the LGAs and grass root level. It will also result in enhanced community data generation and management system that will feed into national information management system to address ATM national disease profile.

C. Advocacy for social accountability

Allocation amount: \$723,991

Target population & Geographic scope:

CBOs, CSOs and CSS in the focus states

Implementation Approach:

The intervention will engage duty bearers at the community and in the government on gender, human rights including stigma reduction through enlightenment and strategic advocacy. This will be achieved by conducting the following activities:

- ☐ Planning of consensus, dialogue and advocacy with community actors
- ☐ Training of CBOs on stigma, legal and human right literacy for KAP
- ☐ Sensitisation of law enforcement agents on gender and human rights
- ☐ Training of CBOs and Development of RAPID presentations on Stigma, Gender and Human rights issues
- ☐ Conduct advocacy activities to different gatekeepers and stakeholders using

RAPID presentations

- ☐ Sensitisation of Communities on Stigma reduction, gender issues and human rights.

Expected Impact:

Through this intervention, an enabling policy environment will be provided to ensure zero barriers to access to ATM services as a result of human right and gender inequality issues.

Module 12: Health Management Information Systems and Monitoring & Evaluation

Application summary for module:

Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
\$ 12,000,000	\$ 7,621,676	\$0.00	\$ 19,621,677

Rationale for selection: The availability of health data and information is critical for the design implementation and monitoring of public health programs. Such data must be accurate, timely, reliable and relevant, as health information is the most fundamental step toward informed public health action. The National Health Management Information System (NHMIS) gives expression to the HIS landscape in Nigeria. HMIS makes data available for finance tracking, accountability and transparency in managing the public health resources.

Prioritized interventions:

A. Routine reporting

Allocation amount: \$: 8,846,619

Implementation approach: The Monitoring and Evaluation Division of the Federal Ministry of Health (HMIS Branch) is responsible for the coordination of technical assistance, infrastructural support, and implementation of DHIS roll out nationwide. Training for DHIS will be done at the state level by the NHMIS and disease program M&E officers, HISP shall provide technical support for DHIS roll out

The review and training on data collection tools will be coordinated centrally in collaboration with stakeholders, while the quantification and procurement of the data collection tools will be done in collaboration with stakeholders at State level. . This process will be monitored by the National Officials during the quarterly monitoring and supervisory visit.

The review of the Data collection tools will be conducted as the need arises. The States will quantify for the tools needed and procure. This will be monitored by the National Officials during the quarterly monitoring and supervisory visit.

Expected Impact: It is expected that with funds from GF and other domestic funding, not less than 80% of HMIS reporting units will be submitting timely data to the online platform DHIS monthly in facilities supported by GFATM. The platform will host Malaria, TB and HIV data and this will greatly improve data quality and completeness of associated programs (MNCH).

B. Analysis, review and transparency

Allocation amount: \$: 2,415,886

Implementation approach: The Joint ATM health sector data review meetings is an approach meant for integrating TB into HIV services and vice versa in addition to Malaria and MNCH data . The expected output is for obtaining validated country data on key Malaria, HIV & TB indicators. The joint review meetings will be held biannually at the National/ Zonal level and quarterly at the state level. Also, there will be joint review of the Mid-term Strategic plan for HIV/TB for effective implementation of the plans

Expected Impact: Joint review of HIV and TB program will correct the difference in the data reported for the same indicators by the two program and will further ensure data availability at the state and National level.

Above Allocation: \$5,702,117

Implementation Approach:

The above allocation amount will support the following key M&E related activities:

- GARP Reporting
- Joint Annual Health Data Producers Review Meeting (HDPUR) for ATM including MNCH
- M&E meetings for data collection, data analysis, review, feedback and sharing experiences in all LGAs
- State health data consultative committee meetings for state program officers and other stakeholders.

C. Surveys

Allocation amount: \$587,494

Implementation approach: Support will be provided for key population based surveys including-

- ☐ IBBSS to be conducted in 14 States among the key affected populations.
- ☐ KAP size estimation

Expected Impact: Readily availability of data for planning, resource mobilization, and policy making at all level.

Above Allocation amount: \$1,385,481

Operation researches - one operation research will be conducted for TB and HIV program respectively per year. It will be domesticated with research bodies with supervision from National program.

Other planned surveys will include:

- ☐ Support for HIV Drug resistance survey (Paediatrics)
- ☐ Support to NARHS
- ☐ Knowledge attitude and Practice survey for TB
- ☐ Operation researches relating to TB and HIV (1 TB and 1 HIV per year)

Implementation approach: NARHS field work will be conducted in all the states including FCT. It is a household survey and both Biological and behavioral data will be collected from the studied population and state-level data will be generated. With support from Government and other stakeholders, data generated will be analyzed at the national level

to produce single technical report and Fact Sheets. Further dissemination of the findings will be done at the state level.

Expected Impact: Impact and outcome level data for the two diseases will be generated to guide monitoring of progress made with control of the epidemics.

D. Other: M&E System Strengthening

Allocation amount: \$150,000

Support implementation of NHA data collection processes

Above Allocation amount: 534,077.22

Implementation approach: Quarterly quality improvement meetings will be held at the states supported by GF to review Continuous Quality Improvement (CQI) projects. There will also be mentoring visits to the HFs on CQI. This application will fund 2 cycles of the meeting per year. The biannual data collection will also be coordinated by the states and implementing partners with oversight function by the National program. The quarterly M&E TWG and Mathematical Modelling TWG will be organized by the National program with states and other stakeholders participating. This application will fund 2 cycles of the meetings per year.

Expected Impact: Improved service quality at the facilities through continuous quality improvement (CQI) projects. This will reduce mortality and morbidity among PLHIV. Coordination meetings for M&E will further strengthen decision making on health information system.

Module 13: Procurement, Supply Chain Management

Application summary for module:

Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
\$ 11,000,000	\$ 1,003,543	\$	\$ 12,003,543

Rationale: The module is a critical health systems component that is required to ensure the success of the TB and HIV control programs. It is required to ensure commodity security and quality including complementary pharmacovigilance support to programs.

Selected Interventions:

A. Operationalization of procurement and supply chain management system

Allocation: \$8,169,661

Target population:

The project is targeted at all 11,035 facilities offering TB and/or HIV services.

Implementation approach:

Strengthening Federal and State governments' coordination of supply chain management

across all programmes through the establishment of state Logistics Management Coordination Units (LMCU) domiciled in the Directorate of Pharmaceutical Services of SMOHs. The NPSCMP will be repositioned to effectively provide national PSM oversight function at all levels of the system. TB and HIV LMIS will be reviewed and harmonized; the LMCU will be established to coordinate and strengthen LMIS systems at the state and will receive support from the NPSCMP. Clear Performance Management Systems will be set up to enhance efficiency and effectiveness.

Expected Impact: Ensuring that on an annual basis, over 80% of facilities do not report stock out of key commodities.

Above allocation:\$1,003,543 (Quality assurance and Pharmacovigilance)

Target population: Same as allocation.

Implementation approach:

Strengthening Quality assurance and Rational Drug Use will be promoted through this investment.

Expected Impact: Quality assured commodities are used in service delivery points at all times. Also strong pharmacovigilance support will be institutionalized for improved quality of care.

B. PSM infrastructure and development of tools

Allocation: \$2,830,339

Target population & Geographic scope:

Warehouse and Distribution---Design and Execution

Implementation approach:

Establish zonal pharma grade warehouses. Identification and upgrading of four government owned medical stores to serve as zonal warehouses and development/implementation of efficient Public Private Partnership models for warehousing and distribution under the distribution of NPSCMP.

Module 14: Program Management

Application summary for module:

Allocation	Incentive Funding	Unfunded Quality Demand	Full Request
\$ 15,679,793	\$4,246,753.86	\$ 0.00	\$ 19,926,547

Rationale

This module focused on programme and grant management. Strengthening management of TB, HIV and HSS will be critical to the additionally contribution of the GF grant to national targets. This GF grant is especially expected to help strengthen the joint programme management aspects e.g. TB/HIV, DHIS and PSM.

On grant management, this application provides for the capacity strengthening requirements of PRs, SRs and SSRs to appropriately manage the grant as well as

address grant management risks identified for each PR.

Selected Interventions:

A. Strengthening management of HIV, TB and HSS programmes at federal, state and LGA levels (see detailed work plan attached)

Allocation: \$ 4,119,819

Target population/Geographical Scope:

This intervention is targeted at strengthening federal, state and LGA HIV, TB and HSS programme coordination and oversight.

Implementation approach:

This will be done through existing NACA, NASCP, NTBLCP and DPRS/NPSCMP structures with NACA being responsible for multisectoral HIV coordination, NASCP for health sector HIV coordination, NTBLCP for TB coordination and DPRS working together with NPSCMP being responsible for M&E and PSM.

Two approaches are used, involving; 1) supporting NACA, NASCP, NTBLCP and DPRS/NPSCMP in preparation of joint operational plans and strategies, conducting joint implementation plan reviews and in convening joint coordination/monitoring meetings at all the 3 levels. 2) supporting procurement of technical assistance to carry out programme assessments.

Expected Impact:

Ensuring that the Global Grant achieves its planned contribution to national impact-level targets for HIV and TB and contributes towards strengthening existing national programmes.

Above allocation:\$ 4,246,753.86 (Further strengthening of management of HIV, TB and HSS programmes at federal, state and LGA levels)

Target population: Same as allocation.

Implementation approach:

This will be done through existing NACA, NASCP, NTBLCP and DPRS structures with NACA being responsible for multisectoral HIV coordination, NASCP for health sector HIV coordination, NTBLCP for health sector TB coordination and DPRS working together with NPSCMP being responsible for M&E and PSM.

Two main approaches to be used, involving; 1) strengthening institutional capacity of NACA, NASCP, NTBLCP and DPRS/NPSCMP at federal, state and LGA levels to effectively coordinate HIV, TB, M&E and PSM with special focus on joint coordination activities. Support requested includes top up salaries for selected government staff in coordinating units, support for office operations/equipment and support for travel; 2) supporting joint programming and TA activities that are not fully covered by the within allocation funding provided.

Expected Impact:

Ensuring that the Global Grant achieves its planned contribution to national impact-level targets for HIV and TB and contributes towards strengthening existing national programmes

B. Strengthening management of TB/HIV joint concept note grant at CCM, PR, SR and SSR levels

Allocation: \$ 11,559,975

Target population/Geographical Scope:

This intervention is targeted at strengthening CCM, PRs, SRs and SSRs to manage the joint TB/HIV concept note grant.

Implementation approach:

This will be done through existing CCM and PRs as well as SRs and SSRs later to be engaged for grant implementation with CCM being responsible for grant oversight and executive decisions, PRs for grant management and SRs/SSRs for grant implementation activities management.

Three approaches will be used, including 1) strengthening institutional capacity of PRs to effectively manage GF grants. This involves salaries for selected PR staff, support for office operations/equipment and support for travel. 2) support CCM in collaboration with respective PRs to engage (potential) SRs/SSRs (including of key affected populations) to apply for and implement GF grants. This includes facilitating their participation in CCM, orientation on GF grant application, undertaking grant applications (call for proposals) and awards and orientation on GF grant management. 3) providing SR institutional strengthening (salaries, office operations and travel), undertaking SR monitoring, managing grant disbursements, undertaking grant audits and preparing grant reports. This third approach will primarily be funded from programme related allocations not reflected in this allocation.

Above allocation:\$0

There is no above allocation for grant management related activities. As indicated in the approach, grant management is expected in addition to what is indicated in the allocation to also benefit from specific programme related activities funding that each PR will be managing to cater for providing SR institutional strengthening (salaries, office operations and travel), undertaking SR monitoring, managing grant disbursements, undertaking grant audits and preparing grant reports.

3.4 Focus on Key Populations and/or Highest Impact Interventions

This question is not applicable for Low Income Countries.

For TB and HIV, describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

- If the applicant is a lower-middle income country, describe how the funding request focuses at least 50% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.
- If the applicant is an upper-middle income country, describe how the funding request focuses 100% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

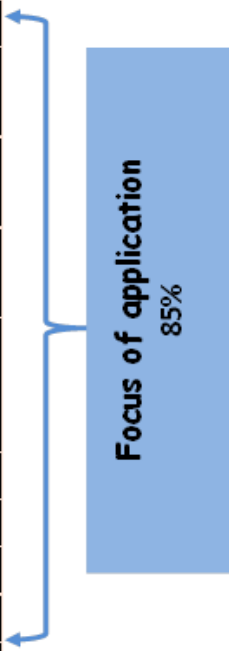
Nigeria is a lower-middle income country and as such is required to demonstrate that the funding request focuses at least 50% of the budget on underserved and most-at-risk populations and/or highest impact interventions.

Analysis of the funding request clearly demonstrates that this application meets that requirement.

Specifically, over US\$300 million (85%) of the funding request is focused on underserved populations (PLHIV, pregnant women, children, youths & adolescents), Key affected populations (FSW, MSM, PWID, AYP) and high impact interventions (ART, PMTCT, MPPI, DOTS, MDR-TB treatment, Xpert technology).

Figure 15: Focus of application mapping

Module	Allocation	%
Prevention for General Population	6,500,000	2%
Prevention programs for Vulnerable populations (MSM)	4,721,435	1%
Prevention programs for Vulnerable populations (FSWs)	6,686,487	2%
Prevention programs for Vulnerable populations (PWID)	3,592,078	1%
Prevention programs for adolescents and youth, in and out of school	2,000,000	1%
PMTCT	27,478,841	8%
Treatment , Care and support	148,453,913	42%
TB Care Prevention & Treatment	67,461,012	19%
MDR-TB	33,227,398	9%
TB/HIV	6,979,530	2%
CSS	6,000,000	2%
HMIS -M&E	12,000,000	3%
PSCM	11,000,000	3%
Program Management	15,679,793	4%
Totals	351,780,487	100%



Focus of application 85%

There are tailored interventions for key affected populations, including FSW, MSM and PWID. Allocated funding for prevention interventions for these key populations will cover over 80% of coverage gaps following the programmatic gap analysis.

Activities targeted at addressing the gender barriers to service access and removing the legal barriers to service access by especially vulnerable population groups based on the perceived illegality of their activities (MSM and sex workers) also have been prioritized.

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

This section requests information regarding the proposed implementation arrangements for this funding request. Defining the implementation arrangements for the program including the nominated Principle Recipients (PRs) and other key implementers is essential to ensure the success of the programs and service delivery. For the concept note for TB and HIV, the Country Coordinating Mechanism (CCM) can nominate one or more PRs, as appropriate given the country context.

4.1 Overview of Implementation Arrangements

For TB and HIV (including HSS if relevant), provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

- a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector PRs).
- b. If more than one PR is nominated, how co-ordination will occur between PR(s) for the same disease and across the two diseases and cross-cutting HSS as relevant.
- c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipient(s) have been identified.
- d. How coordination will occur between each nominated PR and its respective sub-recipient(s).
- e. How representatives of women's organizations, people living with the two diseases and other key populations will actively participate in the implementation of this funding request.

a) If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s)).

Nigeria will continue to use dual track implementation arrangement (Government and Non-Government Sectors), which has been adopted by the CCM before the commencement of Round 9 grants implementation. The same approach was adopted for implementing consolidated and Interim Grants currently running. Through the dual track system, PRs focus on the public and private sectors based on their competencies. Previous implementation arrangements have demonstrated the effectiveness of such a dual track arrangement in reaching the target populations, achieving additionally grant targets and in improving overall performance of current TB and HIV grants to a rating of B2 and above.

b) If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.

Coordination mechanisms already exist among TB and HIV PRs and are fully functional. They exist in the form of a PR-PR coordination platform and are implemented through quarterly meetings for experience sharing, resolution of bottlenecks and harmonization of efforts during implementation. For the joint TB/HIV grant, these existing coordination mechanisms for the two diseases will be harmonized into one. A Memorandum of Understanding (MoU) between the HIV/AIDS and Tuberculosis PRs will be developed and used to formalize the harmonization effort. This MOU is expected to clearly define roles and responsibilities of respective PR. Areas of collaboration will be revised and updated not only to address any changes in implementation resulting from this new NFM grant, but also to capture and define emerging areas not previously covered in the current implementation arrangement. The existing coordination framework of the CCM will provide guidance to the PRs, through the quarterly PR Forums. Also the interactions with the LFA will provide the CCM the opportunity to oversee grant implementation and provide oversight and stewardship. In addition the HIV/AIDS and Tuberculosis Technical Working Group (TWGs) and its sub-committees (HCT, Treatment, Care and Support, Community System Strengthen, TB/HIV Collaboration, MDR-TB, M&E, PSM, Program management) would be strengthened to carry out the coordination at the service delivery levels. The above TWGs are part of a Ministerial Task Team on AIDS, TB and Malaria including cross cutting Health System Strengthening.

c) The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.

NGO/CSO SRs for the current grants will be re-assessed to select the ones to implement this funding request along with new ones, where necessary. A transparent process will be employed with guidance from CCM, including a call for expression of interest, review of submissions, shortlisting of qualified organizations, assessment of pre-selected organizations and final selection. A Joint Program Implementation assessment has been commissioned to identify lessons learnt from the current implementation arrangements which will inform modifications to the implementation of this request.

Government departments/divisions at federal and state level responsible for coordinating the two diseases and HSS cross-cutting component areas will also be considered as SRs. For these, an assessment will be designed based on existing GF online capacity assessment; with thresholds approved by CCM built in that will be used in determining when one assumes or is disqualified from being a sub-recipient as well as other grant management decisions.

Sub-grant management arrangement will include development and signing of a Memorandum of Understanding between PRs and SRs. Existing sub-grant management documents will be updated to include relevant arrangements in the current grant. Work plans, based on the implementation arrangement, and performance frameworks will be developed with clear indicators and milestones for monitoring SR performance. Approval of disbursement requests from SRs will be based on pre-determined conditions, which will include but not limited to delivery on targets, submission of timely and accurate financial and activity reports, etc.

Other arrangements will include continuous on-the-job supervision and mentoring, PR/SR forums to review status and address challenges on grant implementation, follow up on spot checks conducted on the SRs by LFA, CCM and Internal Auditors, quarterly/periodic data quality assessments and performance based disbursements. Positioned at the State levels, these SRs will provide capacity building, supply chain management, data collection, collation and transmission. They will also undertake on-the-job mentoring, supervisory site management and carry out social mobilization activities under the grant in both the private sector and public sectors according to the PR they are affiliated to. On a regular basis, SRs financial systems will be audited and the outcome of such activities will be used to ensure prudence and

accountability. Internal controls systems of the PR will also be used to regularly conduct spot-checks on SRs as well as provides follow up on the results of LFA spot-checks on SRs.

In addition, the CCM has commenced discussion around overall review of the current implementation arrangement and the national implementation framework structure. The objective includes also the need to streamline HIV/AIDS and TB joint implementation in a manner that national structures will be strengthened for sustainability and system building. It is in this vein that it is planned that implementation of cross cutting activities will be structured to support the disease programs and delivered in an integrated manner.

d) How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.

The pre-existing sub-grant management manual that clearly describes roles and responsibilities of PRs and SRs in program implementation will be reviewed and updated in line with national implementation framework. This document will further provide guidance on program activity reporting; modalities for engagement of/or collaboration with, any third party during implementation; and accountability of funds disbursed to the SRs. The sub-grant manual will be disseminated to all participating SR staff and will form part of the grant documentation with roles and responsibilities well documented. A grant agreement will be signed between PR and SRs/SSRs across board and will outline implementation and disbursement modalities, budget and conditions precedent for the sub-grant.

The PR will use a quarterly PR-SR retreat as a coordination platform to resolve SRs' implementation challenges, provide feedback on performance, and share best practices and lessons learnt among SRs. It will also be a capacity building forum to ensure that the SRs capacity is strengthened continually for program implementation. The PRs will also regularly conduct mentoring and monitoring visits to the SRs and service providers so as to identify gaps in program implementation and proffer solutions where necessary. This will occasionally happen jointly with CCM Oversight Committee and LFA when necessary.

The internal control systems of the PR/SR will regularly conduct spot-checks to the financial systems of the SRs/SSRs to detect any anomalies as well as follow up on the issues arising from the LFA spot-checks. Issues detected will be followed up to a logical conclusion. On an annual basis, every SR will be audited by capable audit firms and reports shared with LFA and the GF secretariat. Problems arising from data management at SR levels will be logged, tracked and resolved through the joint track system. When this is not completely resolved, issues will be followed up during supervisory and monitoring visits.

e) How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.

Umbrella bodies of CSOs, FBOs, KAP and Women groups/organizations were involved in the development of this concept note and will participate actively in its implementation. It is noteworthy that some of these umbrella bodies/organizations are implementers of the current grant. These organizations will continue to coordinate implementation of community sensitization, mobilization activities and outreaches to hard to reach area focusing on key affected populations including women, children and migrant groups. The choice of states to be assigned to SRs/SSRs/CBOs/CSOs will be based on their area of strength and coverage of their network. The operation will be guided by the finalized Strategic Framework and Implementation Plan

4.2 Ensuring Implementation Efficiencies

Complete this question only if the CCM is overseeing other Global Fund grants.

From a program management perspective, describe how the funding requested links to any existing Global Fund grants, or other funding requests being submitted by the CCM at a different time. In particular, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

The current application has linkages to the existing grants for HIV and TB in Nigeria all of which shall be terminating by June 2015. The linkage is demonstrated by the due consideration given to the projected pipeline funding from the existing grants which have been factored into determining the true value of Global Fund investment across the two mechanisms and more importantly, the true funding and programmatic gap in the two disease programs. This is a purely complementary relationship between the two funding streams and duplication of costs has been avoided. Rather, a clear effort to demonstrate leverages has been adopted.

This application also has a linkage with the recently submitted Malaria concept note particularly around the areas of joint funding for Health Systems Strengthening and Community Systems strengthening. Contributions from the two applications are clearly delineated and the risks of duplication of costs have been well mitigated.

Figure 16: Overlap of the portfolio of grants in Nigeria

GRANT NUMBER	PRINCIPAL RECIPIENT (PR)	YEAR							
		2009	2010	2011	2012	2013	2014	2015	2016
NGA-H-NACA	National Agency for Control of AIDS (NACA) (HIV)				US\$ 424,916,949				
NGA-H-ARFH	Association For Reproductive And Family Health (ARFH) (HIV)				US\$ 45,105,310				
NGA-H-SFHNG	Society for Family Health (SFH) (HIV)				US\$ 49,423,343				
NGA-T-ARFH	Association For Reproductive And Family Health (ARFH) (TB)				US\$ 95,124,879				
NGA-T-IHVN	Institute of Human Virology Nigeria (IHVN) (TB)				US\$ 16,336,184				
NGA-809-G11-M	Society for Family Health (SFH) (MALARIA)				US\$ 216,708,810				
NGA-809-G14-M	National Malaria Elimination Programme (NMEP) (MALARIA)				US\$ 294,011,688				
NFM	New Funding Model (NFM) Allocation							US\$ 499,490,420	

The funding being requested for will build on the gains of the current grants in the following ways:

- In terms of trained personnel, both programs will use existing trained personnel at the Federal, Organizational, State and LGA levels to implement the activities of the grant. Refresher trainings will be used on basis of need to maintain optimal service delivery. Training documents and job aids developed from the previous grant will be used to conduct such training activities as well as improve implementation capacities at the service delivery points.
- The current grant covers 21 states for HIV, 36 states for TB and the FCT in the public sector and some private sector. However, the grant being sought for will focus on the highest burden states, which has been established to be 6 for HIV and 13 for TB respectively. Findings from the epi-analysis and other relevant reviews will guide the deployment of effective interventions to these states based on prioritization.
- The M&E Plan will be used to guide monitoring of this grant. Structures and

Systems such as the District Health Information System (DHIS), trained personnel, data tools, and data collection will be deployed in this grant to contribute to timely and quality data.

Lessons learned from the implementation of the Round 9 Consolidated grants and key findings and recommendations of programme reviews carried out will be used to inform implementation strategies for this grant.

The HSS component including capacity building, M&E, LMIS and facility upgrade under the Malaria funding request has been streamlined to ensure that there is no duplication of activities. In the case where same activities are being considered across the ATM, there is a mechanism (CCM oversight) to ensure that the services are not provided for the same group of persons in the same states or communities.

4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.

PR 1 Name	NACA	Sector	Govt
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Minimum Standards	CCM assessment		
1. The Principal Recipient demonstrates effective management structures and planning	Yes NACA has a Program Coordination Unit (PCU) led by the Director Policy and Strategy. The Director reports to the Director General. The unit is composed of members from different departments and units of NACA. Management decision processes are influenced by the source of funding. Under the Federal Government, resources allocated to NACA are managed by the Director of Finance and most decisions are made by Management. Under the World Bank project, management decisions were made by a committee made up of Directors. Resources under TGF grant are managed by the Director of Policy and strategy (the Team Coordinator) and Director of Finance with approval from the Director General		
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)	Yes NACA has technical Managers with expertise in ART, PMTCT, TBHIV, SRH, Legal, M&E, HSS, Program/Grant Management. NACA have ToRs for all		

	<p>Technical Managers and SR Portfolio Managers. NACA SRs Portfolio Managers and Technical Managers conduct regular visits to the SRs Offices and supported health facilities. During such visits, issues earlier identified are followed up to assess the status of implementation. Where there are gaps, they are brought to the notice of the SRs again for action. Management letters are also issued to SRs as appropriate. Where necessary, Heads(CEOs) of SRs are called for meetings to intimate them of the remedial actions and the need for implementation of the actions. The Mechanism for coordinating SR is that each SR sends in reports to NACA on a quarterly basis. These reports include programmatic, financial and M&E. The reports are reviewed by the technical managers, SR Portfolio Managers. Findings from the reports are shared with the SRs. Where necessary, the findings from the report can trigger initiation of meetings to provide additional guidance or clarification to improve performance.</p> <p>NACA has experience in implementation of The Global Fund (TGF) and other donor funded projects. It is a PR under the existing TGF HIV Rd9 grant together with other PRs. The NACA staff are civil servants recruited by the government. Some staff recruitment and retention is under the control of the management of NACA. Recruitment of staff goes through advertisement, shortlisting and interview process but background checks of staff recruited are not performed by the PR Staff transfers which occur frequently can have impact on the continuation of implementation of key activities. There is a need to have some level of continuity of staff</p>
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	<p>The pre- and the post- audit processes are in place to ensure accountability and transparency. Monthly and Quarterly audits and review of Financial records to assure accuracy and reliability of the financial records are undertaken. Bank reconciliations are done monthly. Identified weaknesses, if any, are addressed and corrective measures taken promptly.</p>
4. The financial management system of the Principal Recipient is effective and accurate	<p>There is an organogram for the Finance Unit of the organization. The Finance and Accounts Department is headed by the Director of Finance and Accounts (DFA), and supported by two Deputy</p>

	<p>Directors and many other experienced and qualified staff. The organization uses computerized accounting system. The organization operates computerized accounting system using the SAP. Financial reports are reviewed regularly for completeness and accuracy. Signatories to NACA's accounts include the Director General, the DFA, the Deputy Director, Finance and two other Assistant Directors. Two signatories must sign on each payment. The organization uses a Comprehensive Manual that stipulates guidelines for all functional areas, including financial management. In addition, finance operations are also guided by the Federal Government's Financial Regulation</p>
<p>5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products</p>	<p>The Federal Ministry of Health, Department of Food and Drugs manages a Federal Medical Stores in Oshodi as the central warehouse used by all Programs; the regional warehouses (Axial) are the respective states' medical stores which represent Six (6) geopolitical zones hubs warehouse for HIV/AIDS. NACA is using axial HIV/AIDS warehouses located in Awka, Calabar, Gombe, Sokoto and Abuja (only Abuja is owned presently by a private organization) as the hubs (regional stores) which are very helpful to the system. But no adequate provisions for storage of cold chain dependent items have been made in these Axial warehouses, consequently, NACA currently stores its cold chain dependent products at the Federal Medical Stores and a privately rented warehouse located in Jos, Plateau State that has the infrastructure for cold chain items. This slows down the routine re-supply process as cold chain dependent items have to be picked from these two different warehouse locations. The axial warehouses were assessed and found to meet pharma-grade standards prior to their selection, except for the absence of cold chain facilities, which needs to be addressed urgently to improve on the re-supply process. Under the PSM integration arrangement across malaria, HIV/AIDS and TB, & FPs programs commodities are centrally stored in an environment that meet the WHO minimum storage requirement. The integrity is guaranteed up to facility level. However, the facilities still require strengthening so as to maintain the</p>

	<p>integrity of the goods/commodities. Currently, a maintenance schedule with the PRs funding environmental maintenance, fuelling, utility bills settlement and security measures are in place at the central warehouse. The security arrangement uses private security guards with support from GF while Nigeria Civil defence personnel will be used at the State warehouses for security purposes. The support is expected to come from GoN. However, the need to invest more in the area of security is important through deployment of CCTV Camera and other physical approach.</p> <p>Additional expansion of the Federal Medical Stores, Lagos is ongoing, and a new warehouse is being constructed in Abuja with support from GF, USG and GoN. The two world class warehouses are expected to be completed by April, 2015.</p>
<p>6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions</p>	<p>The available distribution system is 3PLs and methodology is a combination of pull and push approaches.</p> <p>The DAs pick commodities in bulk from the Central warehouse to the regional warehouses that serve as hubs. The pick-up schedule is prepared by NACA based on facility needs per region served by the DAs. From the hubs, last mile distribution to facilities is organized by the DAs with support from NACA and Logistics Officers the host state for the warehouse.</p> <p>The re-supply system currently in use is a push-pull approach also The push approach is used for facilities with reporting challenges, while pull approach is used for facilities that report promptly and correctly. The push and pull approach is to prevent stock-out at facilities and service interruption in the midst of available commodities at the Centre. Additional measures being tried for commodity security include using the hub-and-spoke model, cluster review meetings for re-supplies, complete decentralization of warehouses to the state stores Using Central stores to deliver the products with its own vehicles, and sites collecting the products from closest state central stores after their reports have been validated and approved.. The 3 DA find the ever expanding number of facilities difficult to cover within the agreed lead-</p>

	time.
7. Data-collection capacity and tools are in place to monitor program performance	<p>One of the pre-requisites for a functioning ART site is the availability of trainable Logistics Officers (Pharmacists and Laboratory Scientists. These are trained intensively on the National Logistics Management for HIV/AIDS commodities. Their capacity is enhanced for data collection and reporting at every facility.</p> <p>LMIS tools are available in soft and hard copies. These are printed when needed by the PR and are distributed to all facilities for use. Routine monitoring and supportive supervision visits to these facilities assess the utilization of these tools and their completeness and accuracy is a HR capacity indicator, which translates also to program quality of performance.</p> <p>Human and technical capacity at NACA's Strategic & Knowledge Management (SKM) department has been boosted and there are currently 30 staff with the necessary skillset for M&E in the department. For data collection and reporting the national response core indicators as well as data collection and reporting tools were harmonized in 2011. NACA, NASCP and national level stakeholders including SRs have trained as master trainers on the data collection & reporting tools who have step this down to all the 36 states +FCT. In addition states trained health facilities in the states on the use of the harmonized tools along with its SOPs and guidelines. States and SRs have also been trained to provide mentoring and technical support to the health facilities to ensure data quality. NACA also printed and disseminated seed copies of the harmonized tools to states and facilities while also providing technical support to states to print additional quantity of tools for their facilities. Standard checklists for data quality assessment are also in place and persons at both national and state level have been trained on it. Supportive supervision guidelines are also in place</p> <p>Electronic data reporting platform DHIS 2.0 was adopted in 2012. National level DHIS team was trained on the use of DHIS. All 36 states and the FCT state teams have been trained on the use of</p>

	<p>the DHIS while as at July 2014, 24 states with technical support from the NACA have so far rolled out DHIS 2.0 to facilities and trained health facility data staff to use the DHIS2. NACA and National DHIS team provides daily technical support to state teams and health facilities on DHIS issues. NACA is also working with FMOH/DPRS and national stakeholders to strengthen NHMIS and has commenced migration of data on the NACA DHIS to the NHMIS.</p> <p>In 2013, NACA also led and concluded the process of developing national data collection and reporting tools for community based HIV interventions- Prevention for MARPs, HBC and supported the harmonization of FLHE and OVC tools. In 2014 NACA commenced the process to strengthen non health or community based electronic reporting through the customization of DHIS 2 with the community based data tools and training national level, state level and implementing level capacity to use the DHIS for reporting..</p>
<p>8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately</p>	<p>There is an LMIS manual as a guide for health workers in all facilities to effectively and efficiently manage and report on commodities. The LMIS is integrated as the national logistics management information system capturing logistics data on ARVs, RTKs and Reagents as well as on drugs for opportunistic infections. Health facilities submit the LMIS report every two months to the central level, these reports are analysed and requisitions for all facilities are pooled together to prepare distribution schedule which is shared with the FCMS as well as axial stores.</p> <p>Facility reporting rate for the LMIS is an indicator of SRs program performance in respect to the facilities they support.</p> <p>The patient management information is reported through a different MIS – DHIS. The Combined Report, Requisition, Issues and Receipt Form (CRRIRF) capturing consumption and stock status at the end of the two month review period is available at all facilities and this has been in use for effective supply plan and distribution schedule based on realities at health facilities but some assumptions on need</p>

	<p>On routine data collection and reporting, NACA in collaboration with all relevant stakeholders developed the national HIV/AIDS M&E system in 2005 known as NNRIMS operational Plan (NOP). This was reviewed and costed (NOP2 2011- 2016). The plan details core indicators for the HIV/AIDS response, data flow pathway and roles and responsibilities of the various stakeholders. In implementing the national M&E plan, indicators and data collection and reporting tools were harmonized in 2011. Electronic platform DHIS is used by health facilities and supported by the SRs to report service coverage data on a monthly basis. SRS undertake quarterly internal data quality assessment at their supported facilities. Data reported on the DHIS is accessible by all relevant levels of the national response. Quarterly, data sourced from DHIS is validated for accuracy and completeness at validation meetings at the state level in all 36 states +FCT. Following the state level validation meetings, national level validation meeting is also held to collate, cross validate and build consensus on the validated data collected from all the states. The validation meetings at the national level are held every 6 months. Following completion of the validation process the PR in collaboration with the relevant SRs undertakes semester data verification to verify data for accuracy and completeness before submission as well as provide further mentoring and technical support to states and facilities.</p>
<p>9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain</p>	<p>The PR started the process of quality control sampling and testing of pharmaceuticals (ARVs) in 2013 to meet up with the QA policy of the GF. So far the quality control sampling and testing protocol, as well as identification and selection of WHO prequalified laboratory where the testing will be conducted have been approved by GF and the process of first round of sampling and testing has started.</p> <p>With respect to pharmacovigilance (PVG), the PR have not been previously engaging in any serious adverse drug reaction (ADR) monitoring and reporting. However, in country system guideline on ADR through NAFDAC will be adopted and distributed to all facilities. The PR has started discussions with NAFDAC to activate PVG activities in all GF supported sites.</p>

4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.

PR 2 Name	ARFH-HIV	Sector	NGO
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?	X Yes <input type="checkbox"/> No		
Minimum Standards	CCM assessment		
1. The Principal Recipient demonstrates effective management structures and planning	<p>ARFH is a leading, indigenous nonprofit and a national NGO established in 1989. ARFH has demonstrated over 24 years effective management, quality improvement structure and planning by rendering evidenced based interventions in various health fields including child survival, malaria prevention and treatment, HIV and AIDS prevention and Sexual & Reproductive health targeting high risk, vulnerable and disadvantaged group groups. ARFH operates through 2 offices located in Abuja, Federal Capital Territory (FCT) and Ibadan, Oyo State where the headquarters is located with established linkages across the 36 +1 states. The PR has sufficient staff to implement the grant. These employees are experienced and possess requisite expertise to properly implement the grant. The PR has 3 Directorates namely; Programs, Finance and Administration and Evaluation & Operations Research which are appropriately staff with qualified staff and mentored by the President/CEO who is a Professor of O&G. The Program staff have the required qualifications including medical qualifications including a medical degree, Nursing and Pharmacy as well as Masters in Public Health and MSc in relevant fields. There are 11 Chartered Accountants in the Finance and Internal Audit Units. The organization also has a legal officer who handles legal matters whenever they arise. ARFH partners with several international donors including DFID, USAID, UNFPA amongst others. ARFH has insurance cover for assets including project vehicles, laptops and other office equipment.</p>		
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)	<p>ARFH is experienced in implementation of GF and other donor funded projects. ARFH has been implementing GF grant since 2007 and is currently a PR under the existing GF HIV and TB and SR under the GF Malaria. ARFH has the required capacity and system for effective programmes management for example under the current grants, specific targets earmarked for ARFH and the performance is regularly assessed. ARFH's HIV was rated A2 during the July – December 2013 reporting period. Generally, the PR submits report to TGF on time. The implementation, monitoring and reporting under the grant is headed by a Director of Programmes (oversees all GFATM programmes) and a HIV project coordinator and program managers dedicated for managing, tracking and responding to each of the SR's needs. ARFH holds regular oversight visits, management meetings and quarterly PR/SR review meeting to review programmatic and financial results before submission to TGF. ARFH works with the various ATM networks, Network of people living with HIV, with coverage in all the states and LGAs hence able to support the community demand generation, adherence and facilities uptake. ARFH has signed MoU with SRs with which program implementation is governed. The PR also participates in TWG and TWG sub-committee meetings. The PR generally has the relevant experience to implement the grant with strong partnership networks. SR management procedures are documented in the SR management Manual. The PR supports and mentors the SRs guided by the SR management manual and ensures engagement and competent staff to provide programmatic and oversight of Sub Recipients and SSRs across</p>		

	board. This is usually done through regular tracking of implementation of quality program, quarterly review of SRs programmatic and financial records as well as supportive supervision and oversight visits.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	ARFH has separate bank accounts for different projects including the Global Fund grant. Two signatories are required for all cheque payments. Appropriate controls have been built around banking arrangements, these controls include but not limited to proper authorization and approval of disbursements, cheques and transfers signed by two signatories and bank reconciliation statements are prepared on monthly basis. The PR does not co-mingle funds. Separate bank accounts and accounting records are maintained for each grant managed by the PR. Bank accounts can only be opened or closed with the approval of the Board of Trustees. Signatories to the bank accounts are grouped into two levels designated as "A" and "B" signatories and cheques are only honoured when they are signed by two signatories of which at least one should be an "A" signatory. Bank accounts are held in the name of the PR and the project being implemented. The PR has implemented proper segregation of duties to ensure that roles and responsibilities are properly spelt out and executed. The PR has an Internal Audit unit that reports directly to the Board. The organisation has an internal audit charter that provides a framework for the conduct of the organisation's internal audit.
4. The financial management system of the Principal Recipient is effective and accurate	The system is functional and effective. The PR's accounting records are maintained on computer systems with required level of security and access to physical accounting records by non-finance staff is restricted. The organization has an IT unit that manages regular back-ups and implements recovery strategies. ARFH uses modified cash accounting and also has a written chart of accounts that guides the recording of transactions and retrieval of information. The chart of accounts is flexible enough to accommodate for new codes. Payment vouchers are used and there is adequate segregation of duties in the payment process. The finance policy manual also contains documented process for journal entries. All journal entries are checked and approved by the Director of Finance and Admin. External audits are conducted for the PR and its SRs annually. Audited financial statements usually include at least an income statement and a balance
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	The PR under this grant has not been handling commodities. logistics However, the national Central storage system will be aligned with anytime the need arise.
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions	Same as item 14
7. Data-collection capacity and tools are in place to monitor program performance	Although there is a national M&E Plan, each PR has grant specific plans which is being implemented, currently efforts are in place to ensure the alignment of the non-health sector/community component to be standardised across the country. The data collection mechanism is also being improved to address the low M&E capacity of service providers as well as inadequate monitoring and supervision at the state level.

<p>8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately</p>	<p>The PR has a robust M&E plan and detailed data flow system agreed upon by all the implementing entities. The detailed workplan helps in monitoring the performance of the SRs and SSRs on the conduct of various activities they are assigned and ensures timely reporting using standardized national data collection and reporting tools across the SDAs (Home based care/adherence support, OVC and Community system strengthening). On a quarterly basis, the PR and SRs conduct regular onsite data verification for reported data as well as jointly conduct data quality assurance exercise in collaboration with other PRs (NACA and SFH) and USAID IPs to the states, health facilities and CBOs/Support groups to cross-check the quality of data. The indicators and targets contained within the approved performance framework are used to assess the performance of the grant on a semester and annual basis. Recently, the OVC and HBC data collection and reporting tools have been incorporated into the national DHIS 2.0 for reporting and ease of data alignment and harmonization with the national HIV database. The PR has experience and qualified M&E technical staff to effectively manage the grant. The PR will ensure adequate technical support and capacity strengthening to the SRs, states and SSRs. Intensified effort are in place to strengthen and address the identified gaps and weaknesses at the state and SSR (CBOs and Support groups) levels to ensure improved monitoring and accuracy of data. The PR will also ensure that the SR have state technical structures with adequate capacity to provide day-to-day oversight on grant implementation, ensure continuous quality improvement and respond to identified and emerging challenges promptly.</p>
<p>9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain</p>	<p>The PR presently is not handling products that deserves quality monitoring and therefore have no system. However, the national product quality monitoring procedure will abide accordingly.</p>

4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery			
For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.			
PR 3 Name	Society for family Health (SFH-HIV)	Sector	NGO
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?		X Yes <input type="checkbox"/> No	
Minimum Standards		CCM assessment	
1. The Principal Recipient demonstrates effective management structures and planning		Society for Family Health (SFH) is an indigenous non-profit, non-political, non-governmental organization in Nigeria which has interventions in various health fields, including child survival, malaria prevention and treatment, HIV and AIDS prevention, and reproductive health. SFH implements her life saving programmes in partnership with the public working primarily through the private sector and provides health products, clinical services and behaviour change communications to Nigerians in both urban and rural areas, especially among the most vulnerable. It has robust governance structures including an internal control system that is well set up and effectively functioning in the day-to-day running of projects	

<p>2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)</p>	<p>SFH works through 21state (Territorial offices) spread across the 36 states and the Federal Capital Territory - where the headquarters is located. SFH is affiliated with PSI and partners with several international donors. SFH has insurance over assets including project vehicles, laptops and other office equipment. It has membership on various technical committees in the country that work on regulatory and policy changes. SFH has experience in implementation of TGF and other donor funded projects. It is a PR under the existing TGF HIV and malaria grants in Nigeria. The PR's grant TGF HIV grant was rated B1 during the July – December 2013 reporting period. Generally, the PR submits report to TGF on time following the reporting cycle. There has been security unrest in the northern part of the Country. The PR relatively was able to implement activities in the affected areas under its current programmes through the use of indigenous and locally based LGA focal persons in the affected areas. PR have a mechanism for monitoring and supervising the SR which is an avenue effective oversight on relevant SR and SSR.</p>
<p>3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud</p>	<p>SFH has documented procedures in the identification and management of system. The PR has an organogram for its Finance & Accounts Directorate which clearly defines the responsibilities between the various levels and positions. The Directorate comprises four units namely Finance & accounts, Internal Control, Financial reporting & Audit, and Corporate & Treasury units. The Finance & Accounts Directorate is headed by the Chief Finance Officer (CFO) while every unit within the directorate is headed by a director or a deputy director. The PR outlines authorized signatories on bank accounts and official documents where the MD C-level Officers are "A" signatories.</p> <p>The internal audit unit has segregation of duties and report to Management Board. There is an internal control unit that monitors the financial activities of the SRs of SFH and also help in their capacity building. The unit conducts regular financial review of the SRs and field offices of the PR. In addition, they are responsible to ensure that GF recommendations from PUDR reviews and SR spot check reviews are implemented by the PR and the SRs.</p>
<p>4. The financial management system of the Principal Recipient is effective and accurate</p>	<p>The PR has a finance policy manual which guides its financial activities. The manual contains information on accounting policies, project codes and chart of accounts, and standard procedures on invoicing, bank & cash management, payroll, advances & retirements, fixed assets, financial reporting, among others. The last update of the finance policy manual was done in April 2012. Prior to 2013, the organisation used Quick Books to account for its transactions. In 2013, the PR migrated its transactions from Quick Books to a new SAP accounting system. Annual performance appraisal is carried out and merit increment and promotions are based on the appraisal. Poor performances from the appraisal attracts some remedial actions including reduction in merit increment, placing the poor performing staff on performance improvement plan and also appointing a mentor as the case may be and other punitive measures as management deem fit. The PR has strong strengths in accounting system, unqualified yearly external audit opinions, proper and timely supervisory actions e.g. journal reviews and meeting donor reporting deadlines.</p>
<p>5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products</p>	<p>SFH HIV commodities are centrally warehoused in SFH warehouse Otta. The storage of products at the SFH central warehouse have greatly improved since the completion of Otta Warehouse and has built synergy with the Malaria and other donor funded programmes including USAID, DFID and Bill and Melinda Gates Foundation. This synergy allows for overall cost efficiencies and maximal impact. Furthermore, at regional levels it utilizes 11 Manufacturer Delivery Services (MDS) storage facilities across the country which serves as hub for storage of commodities for the 21 implementing states. However, further storage will be done at the SFH state offices and subsequently distributed to the CSO partners. The procurement manual has been revised and updated in line with Global Fund comments.</p>

<p>6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions</p>	<p>SFH has a robust distribution system with electronic and manual based inventory system at each point of the supply chain. Commodities are moved from the central warehouse and transported to the regional hubs at the state level. SFH Focal Staff in the states upon receipt of commodities will give out the commodities i.e. condoms and lubricant etc. to CBO facilitators or KOLs as the case maybe that will in turn distribute them to Peers during sessions. The CBOs /KOLs are expected to maintain a register of all collected and distributed items to target population within their communities. , SFH focal person will fill the combined request and requisition form (LMIS) and send to the HQ bi monthly. This tool will provide information on the quantities used for the month and requisition for resupply. Attached is the procurement and distribution plan for SFH.</p>
<p>7. Data-collection capacity and tools are in place to monitor program performance</p>	<p>SFH maintains an Enterprise Resource Planning (ERP) soft-ware with a module for commodity logistic management at the central warehouse and the regional MDS offices. This is in addition to the DHIS2 Software which is recommended for use by the FMOH and NACA. All SFH offices at the regional level are linked to DHIS2 which allows for real time inventory management. It uses the National data collection tool for LMIS which the Combine Request and Requisition Form (CRRIF).</p>
<p>8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately</p>	<p>Although there is a national M&E Plan, each PR has grant specific plans which is being implemented. However, the combined report/requisition issue and receipt form (CRRIF) has been modified for condoms and test kits. This will be used to maintain an inventory of commodities. Although there is a national M&E Plan, each PR has developed a grant specific M&E plan which describes structures and systems for programme monitoring and evaluation. It also discusses the data management, reporting flow and transmission at the various levels. There also exist standardised national indicators and tools for routine data collection i.e. HCT registers, Referral Forms, Peer Education Tracking Tools and Monthly Summary Forms. Furthermore, in strengthening the national system both at the state and central, SFH reports programme activities at the community and facility level to the State for onward transmission to the National level which includes NACA and the FMOH. Find attached the M&E plan for SFH HIV Grant.</p>
<p>9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain</p>	<p>The organization has in place Procurement, Sales, Distribution and Warehousing Divisions with dedicated staff members. These units work in conjunction with the Programme units to ensure adherence to quality standards. In addition national other documents SFH has an internal SOP for Quality Assurance and a detailed distribution plan which describes the procedure for Internal and external QA as follows:</p> <p>Good lab practices with set standards of practice for performing condom and HIV tests</p> <p>Systems for management of condom and HIV test results (confidential or coded lab books that are stored in a lock cabinet).</p> <p>Records on available condom and test kits, batch numbers and expiry dates</p> <p>Periodic inclusion of previously characterized samples in order to identify problems with competency of the personnel performing the HIV tests and also identifying problems with the test kits.</p> <p>External QA will include the following:</p> <p>Proficiency testing: All Mobile teams providing CT would receive HIV proficiency sample panels from the NRL at least 1/year in accordance with national and international guidelines</p> <p>All Mobile Teams with consistently unreliable QA tests will receive additional</p>

	<p>technical supervision and support.</p> <p>Samples of procured condoms will be taken to federal ministry of health condom laboratory.</p>
--	---

4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery			
For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.			
PR 4	IHVN-TB	Sector	NGO
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?		X Yes <input type="checkbox"/> No	
Minimum Standards		CCM assessment	
1. The Principal Recipient demonstrates effective management and planning structures		<p>IHVN has implemented projects of a similar scale across some states in Nigeria. The entity is currently the Principal Recipient to the GF under the MDR-TB Grant. Also IHVN is implementing the 'HIV/AIDS care and treatment in Nigeria' program (ACTION PLUS UP). The management and organization practices of IHVN are sufficient to receive and implement funds as the entity does not only engage extensively with relevant partners and stakeholders. IHVN has cognate experience in managing donor funds from different partners. Furthermore, IHVN receives technical assistance and implements capacity building plans from other institutes with similar experience and has developed a capacity building plan to strengthen financial practices. IHVN jointly support CCM and others at political engagements. The organization is also a member of MDR-TB and Technical Advisory Committee for TB.</p>	
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)		<p>The PR has operational procedures and plans for managing SRs. The PR has adequate and competent staff to provide programmatic and oversight of sub recipients. This is usually done through quarterly review of SRs programmatic and financial records as well as supportive supervision visits.</p> <p>The PR has the capacity to provide technical training such as SR's orientation on TGF requirements. The PR has adequate resources and capacity to effectively oversee sub-recipients as demonstrated under the current TB grant. IHVN conducts quarterly oversight visits and provides supportive supervision to SRs on the improvement of their grant implementation.</p> <p>The PR has a formal system of identifying risks at the SR level through review of the SR reports, spot checks, through data verification visits and PR/SR review meetings</p>	
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud		<p>There are different bank accounts for different grants and programs (each bank account is held in the name of the PR and the project), and there are strict signature mandates on the operations of the bank accounts. Hence, grant funds are not co-mingled with other funds.</p> <p>Petty cash does not constitute a significant portion of the PR's cash due to the limits placed on it. Evidence obtained showed that cash-counts and bank reconciliations are carried out regularly and filed appropriately providing evidence of proper cash management by the PR.</p>	

	<p>Relevant supporting documents e.g. invoices and purchase orders, are attached to payment vouchers and are reviewed by authorized signatories before cheques are issued and signed. The PR has implemented proper segregation of duties to ensure that roles and responsibilities are properly spelt out and executed – the initiator of a transaction is different from the approver.</p>
<p>4. The financial management system of the Principal Recipient is effective and accurate</p>	<p>The PR is currently managing a GF TB grant and has necessary procedures and systems in place to ensure effective and accurate management of the . The procedure and system also safeguarding the funds held by sub-recipients. IHVN insures assets purchased and given to SRs and requires the SRs to insure assets purchased themselves. The PR's financial and management information system enables adequate tracking of sub-recipient expenditures by reviewing SR's quarterly budget tracking, bookkeeping reports, bank reconciliation statements and GF specific bank statements before disbursements are made to SRs.</p>
<p>5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products</p>	<p>The availability of central warehouse with sufficient infrastructure, human resource and capacity to manage commodities was noted. However the near perfect situation at the central level is not replicated in health facilities. Discussions between IHVN and NTBLCP on revised approach for storage and distribution of MDR commodities and revised roles and responsibilities are still ongoing and implications of these proposed changes could not yet be fully assessed. In the revised proposed approach MDR drugs for in patients will continue to be supplied directly from Central Warehouse to treatment sites, while MDR drugs for patients in the community are assumed to be supplied through State Medical Stores. Detailed principles and procedures of how this will be working had not been defined at time of assessment. An assessment of this will be reviewed in detail and proposed changes will be discussed in September 2014.</p>
<p>6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions</p>	<p>The distribution of commodities from the central warehouse to the Health facilities stores and state stores for clients in ambulatory phase is through a 3PL arrangement which affords the opportunity of adherence to appropriate logistics SOPs ensuring commodities security and quality was noted.</p> <p>What appear inadequately addressed is how flexible is the contract of the 3PL to accommodate requests for commodities at times outside predetermined periodic distribution cycle especially for clients in the communities in ambulatory phase of treatment.</p> <p>We also note that 3PL from the PR only delivers drugs for ambulatory patients to the state TB Control manager, for onward transfer to the client through the LGA supervisors through the health facility closest to the client. This has created a gap in the supply chain as the PR do not have control over adherence to storage and distribution standards as well as timelines between the period the commodity is handed to the State TB Control manager and when the patient eventually gets the drug</p>
<p>7. Data-collection capacity and tools are in place to monitor program performance</p>	<p>The country currently operates a harmonized national instance that is in transition from multiple donor driven instances. The HMIS harmonization efforts provides a single point for accountability in data gathering and dissemination, reduction of duplication of efforts and streamlining communication across the national and sub-national levels.</p> <p>Specifically, the District Health Information System (DHIS) was introduced in 2010 by the DPRS-FMOH</p>

8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	<p>The M&E staffs have adequate skills for collecting, analyzing and interpreting programmatic data for program planning and M&E. They hold degrees in medicine, pharmacy, statistics and epidemiology, up to Masters Level. They all have over 3 years, experience in monitoring and evaluating public health projects and processes, and data management. They are highly skilled in planning and implementing public health interventions to prevent and manage TB and other infectious diseases, and all have an understanding of the health system structure. They are highly proficient in the use of Microsoft Office package and statistical packages (including SAS, SPSS, Epi info and Stata) relevant for analysing, organizing and presenting programmatic data with excellent oral and written communication skills.</p>
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	<p>National QA policy is yet to be developed, by the National Product Supply Chain Management Program (NPSCMP) which is at the vanguard of this activity and this will form the basis of the QA/QC protocol to be adopted by the PR. This poses a risk to the Quality Assurance policy of GF as commodities quality assurance cannot be verified after it have arrived in country.</p> <p>The PR have adequate record of PVG using a register to capture detail of this information and sharing with appropriate authority (NAFDAC).</p> <p>However, the PR in collaboration with ARFH will implement sampling and testing of first and second line TB drugs in the QC laboratory already identified and selected by ARFH</p>

4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery			
For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.			
PR 5 Name	ARFH-TB	Sector	NGO
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?	<input type="checkbox"/> XYes <input type="checkbox"/> No		
Minimum Standards	CCM assessment		
1. The Principal Recipient demonstrates effective management structures and planning	<p>ARFH demonstrated effective management structure and planning by rendering interventions in various health fields including child survival, malaria prevention and treatment, HIV and AIDS prevention and reproductive health. ARFH operates through 2 offices located in Abuja, Federal Capital Territory (FCT) and Ibadan, Oyo State where the headquarters is located. The PR has sufficient staff to implement the grant. These employees are experienced and possess requisite expertise to properly implement the grant. The PR has 3 Directorates namely; Programs, Finance and Administration and Evaluation & Operations Research which are appropriately staff with qualified staff. The Program staff have medical qualifications including a medical degree, Nursing and Pharmacy as well as Masters in Public Health and MSc in relevant fields. There are 11 Chartered Accountants in the Finance and</p>		

	<p>Internal Audit Units. The organization also has a legal officer who handles legal matters whenever they arise. ARFH partners with several international donors including DFID, USAID, UNFPA amongst others. ARFH has insurance cover for assets including project vehicles, laptops and other office equipment.</p>
<p>2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)</p>	<p>ARFH is experienced in implementation of GF and other donor funded projects. ARFH has been implementing GF grant since 2007 and is currently a PR under the existing GF HIV and TB and SR under the GF Malaria Community TB scale-up services, TB prevention, treatment, drug adherence and patient monitoring as well as capacity building for community health workers. The grant is implemented in all 36+1 (community TB activities under the GF are implemented in 10 LGAs in 24 States) States of the federation.</p> <p>The organization has capacity and system for effective programmes management for example under the current grants, specific targets earmarked for ARFH and the performance is regularly assessed. ARFH's TB grant was rated B1 during the July – December 2013 reporting period. Generally, the PR submits report to TGF on time. The implementation, monitoring and reporting under the grant is headed by a Director of Programmes (oversees all programmes) and a TB project coordinator which holds regular management meetings and quarterly PR/SR review meeting to review programmatic and financial results before submission to TGF. The PR has a nationwide coverage and is represented in all the 36+1 States and also implement GF supported community TB activities in 10 LGAs in 24 States. ARFH has signed MoU with SRs with which program implementation is governed. The PR also participates in TWG and TWG sub-committee meetings. The PR generally has the relevant experience to implement the grant with strong partnership networks. SR management procedures are documented in the SR management Manual. The PR has adequate and competent staff to provide programmatic and financial oversight of Sub Recipients. This is usually done through quarterly review of SRs programmatic and financial records as well as supportive supervision visits.</p>
<p>3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud</p>	<p>The PR ARFH has a comprehensive organizational structure which clearly defines lines of authority. ARFH has a separate bank accounts for different projects including the Global Fund grant. Two signatories are required for all cheque payments. Appropriate controls have been built around banking arrangements, these controls include but not limited to proper authorization and approval of disbursements, cheques and transfers signed by two signatories and bank reconciliation statements are prepared on monthly basis. The PR does not co-mingle funds. Separate bank accounts and accounting records are maintained for each grant managed by the PR. Bank accounts can only be opened or closed with the approval of the Board of Trustees. Signatories to the bank accounts are grouped into two levels designated as "A" and "B" signatories and cheques are only honoured when they are signed by two signatories of which at least one should be an "A" signatory. Bank accounts are held in the name of the PR and the project being implemented. The PR has implemented proper segregation of duties to ensure that roles and responsibilities are properly spelt out and executed. The PR has an Internal Audit unit that reports directly to the Board. The organisation has an internal audit charter that provides a framework for the conduct of the organisation's internal audit. Resources under TGF grant are managed by the Director, Finance and Administration with project specific Finance and Accounts Units with experienced senior qualified accountants managing the accounting functions.</p>

<p>4. The financial management system of the Principal Recipient is effective and accurate</p>	<p>The PR has adequate policies and procedures in place to guide activities and ensure accountability at the PR. Some of the policies include GF approved Financial Management Procedures Manual, Travel Policy Manual, Staff Compensation Plan, Harmonized Accounting Manual for SR, Procurement procedures, Asset Capitalization and Disposal Plan, Fraud and Dishonesty Policy and Audit Committee Charter. The PR introduced annual confirmation of conflict of interest by staff members and directors in April 2014 to strengthen existing corporate governance structure. The PR uses QuickBooks accounting software while the payroll is managed by Cowrie Payroll software. This ensures accuracy, completeness and reliability of reports.</p>
<p>5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products</p>	<p>Deliveries move from the Ports to the Federal Central Medical Stores and to the 6 Zonal Stores; then to the 37 state stores; The last mile distribution is done to about 5,700 DOTS and 1,400 Microscopy Sites. First line TB drugs procured by GDF are stored in FCMS, Oshodi. The storage conditions of the warehouses in Oshodi have remarkably improved, at least, based on 2013 country profile assessment/supply review. Indeed, the warehouses were found to be neat, air conditioned, with good racking and temperature control systems (thermometer and temperature chart). However, inventory records are manually kept at all level except at state level using Pick 'n' Pack excel based for analysis of stock.</p> <p>Over the past year, the PRs have taken up the operational cost of maintenance of FCMS, Oshodi..</p> <p>There is however, no insurance coverage for FCMS, Oshodi, as well as, the health commodities stores in the medical stores. This has been brought to the attention of GoN at several meetings for GoN to implement.</p>
<p>6. The distributionsystems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions</p>	<p>The distribution of first line TB products from central FCMS to zonal stores is outsourced to Third Party Logistics (3PLs) namely: Zenith Carex International, and Red Star, with whom MOUs have been signed. As part of the MOU, the 3PLs responsible for transport from FCMS to Zones were required to have insurance coverage of not less than N5 million for products on transit. In addition, they were required to have adequate security measure against theft, diversion and damage for goods on transit. The distribution from Zones to States and from States to Health facilities is being executed by ILEP partners. ARFH has initiated but not yet concluded selection process of 3PLs to also outsource transport from Zones to States and subsequent distribution to the facilities.</p>
<p>7. Data-collection capacity and tools are in place to monitor program performance</p>	<p>The required capacity and systems are in place and being utilized adequately. the NTBLCP R & R system is organized through a paper based system and reported from the DOTS centers to the LGA, then to the State TBL Control office and reviewed at the zonal level by the WHO NPO before transmission to the central unit, NTBLCP. The NHMIS under the Department of Planning, Research and Statistics, FMOH captures facility data and transmitted through the DHIS 2.0 Also the use of electronic LMIS System (PicknPack) to track commodities annual consumption data report, including Quarterly (and monthly)</p>

	Stock Status reports/reviews is in existence.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	<p>The 2013-2015 M&E plan for the GF R9 grant was culled from the National M&E Plan 2010-2015 and adapted accordingly. The PR has been supporting and strengthening the data management processes of the NTBLCP by ensuring timely production and printing of nationally standardized R&R tools, distribution and availability of the tools at the DOTS facilities while ensuring that the SRs provide ongoing capacity building and on-the job mentorship for the appropriate use of the tools. The PR has adequate human and technical capacity to manage the implementation of the M&E plan and the approved workplan to ensure that the SRs including NTBLCP report timely. There are clearly defined reporting mechanisms at all levels and adequate mechanisms are in place during quarterly state review meetings where Local Government Supervisors present their data for state auditing and then state presentation of data at Zonal review meetings before forwarding them for collation at the national level. Strategies and mechanisms to integrate the paper based data reporting system of the national TB programme into an electronic platform e.g. DHIS 2.0 as this will further facilitate improved data quality. The PR and SR conduct regular (quarterly) onsite data verification exercises to cross-check and validate the reported data from the states while a semester basis a joint data quality assessment is being carried out to further ascertain the quality of data from the states and DOTS facilities in selected sites across the country. The performance of each SR is measured based on the targets set in the approved performance framework and feedback provided during the PR-SR review meetings and oversight visits. Reporting on the health-related indicators is received from the NTBLCP whereas non-health related indicators (mainly training) are reported directly to PR from its ILEP Partners and SR.</p>
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	<p>The PR has engaged a Singapore QA laboratory to conduct the quality assurance of health products annually. The first set of samples of TB Commodities will be collected for Quality Assurance in the last week of August-2014 in 4 selected States (Niger, Bauchi, Enugu and Oyo states) & four facilities per state, as well as FCMS Oshodi. The QA results of TB Commodities are expected in Q4, 2014 which will confirm the impact of the vigorous activities geared towards protecting the integrity of TB Medicines. The PR is also using the LMIS/Pharmacovigilance training that is on-going to further build the capacity of Health facilities on Good Storage Practices which will ensure product quality. Continuous mentoring and supervision are on-going to ensure that Good storage practices (GPP) are maintained in all Zonal, State and facility stores so as to maintain the integrity of the drugs e.g. routine measurement/charting of temperature in all zonal stores, quarterly storage maintenance support provided for maintenance of stores i.e. fuel for generator & cleaning of the stores. All these are structures put in place by the PR to ensure adequate QA.</p>

4.4 Current or Anticipated Risks to Program Delivery and PR(s) Performance

- With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, PR(s) and key implementers' capacity, past and current performance issues.
- Describe the proposed risk mitigation measures (including technical assistance) included in the funding request.

All the existing PRS have had to do a risk assessment. The findings informed the development of a risk mitigation plan for each PR. These plans are attached for reference to this application. Below is a summary of some of the major findings for each PR.

PR Name	SFH	
Domain	Current and anticipated Risk	Mitigation measures
Program Management & Governance	Delay in disbursement and implementation of activities which can be triggered by delay in reviews and approval/signing of grants documents, reprogramming activities.	<ul style="list-style-type: none"> • Follow up on timely review and approval of grant documents by the GF country team • Timely submission of quarterly PUDR by SRs for review and approval by PR • Timely submission of reprogramming requests by PR to GF • Ensure timely completion of necessary documentation and implementation of CPs and SPs
	Weak national framework (Governance structure) for Health Community Systems Strengthening (CSS) activities at all levels which affects the selection of right CSOs triggered by Absence of a national framework for community systems strengthening	<ul style="list-style-type: none"> • Develop a national framework for community systems strengthening • Timely assessment of CSOs/CBOs before grant inception
	Inability to meet targets triggered by delay in commencement of implementation, delay in disbursement of fund, transient nature of target population, inability to implement programs in crisis prone communities, unfavorable Government legislations/policies, industrial actions/civil unrest and weak capacity of SRs and SSRs.	<ul style="list-style-type: none"> • Intensify mapping of beneficiary locations • Use of evidence for continuous advocacy to government and other relevant stakeholders for a robust programme success as contained in NSF. • Timely submission of disbursement request for approval
	High risk of double dipping due to multiple partners triggered by weak co-ordination at the national level and also between PRs, SRs and other partners.	<ul style="list-style-type: none"> • Develop a unified operational plan at the national level • Increased participation in partners coordination platforms for cross learning, clear delineation of areas of funding and implementation among PRs, SRs and partners.
	The criminal and penal law on same sex marriage has resulted in MSM going into hiding and living closeted lives. This makes it difficult to locate, mobilize and organize programs	<ul style="list-style-type: none"> • Continuous engagement with the Key Affected Population as facilitators to lead community programs. • Holding more of interpersonal sessions • Using weekends and breaking the cohorts into smaller groups of 3 to 5 for effective reach.
Financial Management	Challenges with SAP accounting system such as difficulties in generating relevant reports such as GL and trial balance from the system, Differences between descriptions of transactions in the general ledger extracted from the system and the printed copies i.e. transaction numbers.	<ul style="list-style-type: none"> • Introduction of Rapid Marts to SAP has made it possible to generate a number of reports including trial balance, income and expenditure, balance sheet, bank reconciliation, advance aging analysis in a consolidated form for all projects. • All reversals are approved based on the authorized workflow on the system and reporting line. The hard copy document is equally approved. Henceforth, the document will clearly state the reasons for the reversal. • Work is still ongoing by the SAP/IT team to resolve the issue of inconsistent transaction

		<p>description in the GL and on the printed payment voucher.</p> <ul style="list-style-type: none"> The finance team will take utmost care to ensure timely and accurate posting through monthly reconciliation of postings as well as ensure adherence to SFH cut-off date for posting on monthly basis.
	Inability to verify assets location this can be triggered by physical verification of assets not possible, assets not properly documented, assets register not regularly updated.	<ul style="list-style-type: none"> New improved tags pasted on all assets Assets register updated quarterly to reflect location, funding projects and custodian
	High Budget and Expenditure Variance which can be triggered by Grant activities not implemented according to plan (i.e. Training plans approval, PIP approvals, etc., Delay in retirement of advances (Both Staff and Project), Delay in procurement Improper costing of budgeted items and Low Burn Rate.	<ul style="list-style-type: none"> PR will adhere to timelines in work plan and budget during program implementation Early assessment and signing of agreements between the PR & SRs Punitive measure for defaulting staff Quarterly burn rate analysis
Monitoring & Evaluation	Inability to meet documentation and reporting deadlines which can be triggered by complicated MIS tools ,inadequate capacity at SR and SSR levels and low capacity of CSOs and CBO members in documenting and reporting	<ul style="list-style-type: none"> Harmonize MIS tools for use by all stakeholders Provide visual job aids at service delivery points and provide frequent on the job supervision and mentoring.
	High rate of attrition of skilled and trained staff at CBO level and low output from volunteers/Corpers at community level triggered by Poor incentives, motivation and government policy.	<ul style="list-style-type: none"> PR and implementing SRs will encourage step down training Provide frequent on the job supervision and mentoring
	Tracking and reporting of FLHE program is currently regarded as an add-on to the teachers work load thus we noted several gaps in documenting and reporting of incidence and data.	<ul style="list-style-type: none"> The current reporting processes and procedures for all HIV & AIDS interventions supported by this grant, including FLHE are fully aligned to the national M & E system and national guideline. However, aligning FLHE reporting to the school system is a long term measure as it has some policy and programmatic implications. It is also important to note that there are mechanisms put in place for checking the quality of data, e.g. the quarterly data review by the SR & SSR and DQA and field support visit by the PR. SFH and the FME would work hand in hand with the states to identify outstanding gaps in the FLHE reporting system and put appropriate measures in place to address such gaps and forestall future occurrences of data management gaps. This would include sensitization of teachers and school authorities, frequent monitoring and supervision at the school level, program ownership and sustainability by the states.

PSM	Lack of access to commodities (condoms and lubricants) by target beneficiaries and inadequate supply of commodities which can be triggered by delays in contracting Procurement Agents (PA) and disbursement.	<ul style="list-style-type: none"> •Development and submission of procurement plan at the beginning of the year •Putting in place monitoring mechanisms to ensure strict adherence to procurement plans, i.e. routine follow up and quarterly review of plans •Timely payment for procurements in line with SFH procurement policy
	Delays in procurement triggered by delayed approval of procurement and distribution plans, delays in waiver processing and clearing from the port, long procurement processes and delayed feedback on procurement related issues.	<ul style="list-style-type: none"> • Meeting timely Condition precedence •Early commencement of procurement processes •Advocacy to Ministry of Finance and other relevant authorities to prevent delays in waiver processing •Timely feedback on procurement related issues from GF and PA.
	Procurement of sub-standard products and commodities triggered by lack of adherence to standards.	The PR will adhere to procurements policy on quality issues and Correct specification of commodities.
	Storage and Distribution conditions and costs triggered by High cost of warehousing and distribution, rigid supply chain system and third party logistics and warehousing agents.	<ul style="list-style-type: none"> • The PR operates an integrated distribution of commodities by different projects which reduce the cost of warehousing. • Adherence by PR to the developed warehouse policy • Bi-monthly distribution plan and progress reporting on distribution at PR level •
	Expiry of HCT test kits due to weak monitoring of commodities within supply chain and late procurement and arrival of test kits in country.	<ul style="list-style-type: none"> • Implement a robust LMIS System, with ability to track batches • Develop and implement SOPs for inventory management and enforce them • Ensure timely procurement and delivery of test kits

PR Name	NACA	
Domain	Current and anticipated Risk	Mitigation measures
Program Management	The state of emergency in 3 States and occasional terror attacks in some States impacts negatively on program implementation	A different mechanism (working more with the state structures) of implementing the grant may be needed at some point should there be significant disruption in service delivery. The current SSRs status given to the 12+1 states will be studied for possible replication
	Delay in grant signing between the PR and SRs has been a major issue in the past	NACA intends to commence SRs assessments and negotiations earlier to forestall a recurrence.
	Inadequate Coordination with State Level stakeholders and gatekeepers;	NACA intends to strengthen State Level actors' ownership of program
	Limited ownership by States of program resulting in inadequate oversight of SRs by State regulators	Develop a comprehensive oversight plan that will be used to track and monitor oversight and mentoring of SRs
	Inadequate safeguards and application of sanctions on erring SRs	Strengthen grant provisions and safeguards and enforce compliance amongst of SRs
	Increase in the number of SRs and having states	<ul style="list-style-type: none"> • Ensuring there are qualified and

	SASCPs as SSRs are issues identified as major risks to the program implementation.	<p>experienced team with appropriate expertise to manage the grant/coordinate the SRs at the PR level</p> <ul style="list-style-type: none"> • Strengthening the capacity and systems of SRs
	Delay in Site Selection is another risk identified	Learning from the implementation of the current grant where SRs in the States worked directly with the States while NASCP and NACA provided oversight, we now have a better and faster approach to site selection. This will be sustained moving forward.
	Inadequate community engagement is a major risk affecting service delivery including service utilization	NACA intends to strengthen its engagement with PRs primarily in the communities to ensure better interface between the community and the facilities. Lessons learnt from implementation of current grant will be used to guide implementation
Financial Management	Low absorptive Capacity	<p>Timely, complete and realistic reprogramming requests; - PR should adhere to timelines in work plan and budget during program implementation;</p> <p>- early assessment and signing of agreements between the PR & SRs to reduce the time-lag between grant signing between the PR and GF and implementation by the SRs;</p> <p>- Monthly budget variance analysis by the PR and SRs.</p>
	Fraud, Corruption, or Theft of GF Funds	<p>Ensuring good corporate governance structure as mandated within PRs and SRs operations by the Global Fund; Increase in over-sight and development of monitoring plans; increase in the number of staff; Ensuring dissemination of GF's policies and procedures; Developing standardized tools/templates for PR&SRs; Use pre-numbered payment vouchers; - Regular spot checks on the SR/SSRs by the PR;</p> <p>Regular oversight by PR financial staff/Internal Auditors; Enforce retirement of outstanding funds with adequate supporting documents before further funds are disbursed to SRs/SSRs; Resource and build the capacity of internal audit team; Internal audit unit should be made to report to the Board instead of the Director General of NACA; Regular procurement review of non health procurements transactions by the PR's internal auditors.</p>
	Poor financial reporting	<p>Some of the mitigating measures include</p> <ol style="list-style-type: none"> 1. Alignment of accounting systems and

		<p>packages;</p> <p>Where it is impossible to streamline accounting software, ensure standardised reporting templates are used for reporting purposes; Provide TA on the application and proficient usage of the accounting software; Increased budget to build financial capacity at the SR/SSR levels (finance staff, systems, etc.); Active project management of timetable and deadlines to SRs and SSRs.</p> <p>Implementation of provisions in the financial manuals and procedures at the SR /SSR levels; Train and build the capacity of the finance team of the SRs and SSRs (SASCP) on GF procedures and reporting; Strengthen financial management system of the PR and SRs including linking all transactions to the budget on PVs; Improve monitoring and financial oversight of SRs and SSRs.</p>
Monitoring & Evaluation	<p>Delay in the roll out, use and integration of the national DHIS (eNNRIMS and NHMIS instances); Weak M&E Capacity to collate and analyze data for reporting.</p>	<p>NACA is working with the DPRS to expedite the roll out of mobile DHIS to PHCs; Advocacy on the use of DHIS in health facilities will continue. Other actions include 1. Procure and distribute necessary infrastructure such as laptops and modems to SHFs to ensure real time data transmission</p> <p>2. Engagement of data clerks in some facilities to expedite data transmission, ownership and sustainability, engagement with state level authorities to prioritise data transmission and ownership.</p> <p>3. Fully support and operationalize the National M & E infrastructures.</p>
	<p>Delays in validating national data (both health and non-health sector)</p>	<p>NACA working with the DPRS and NASCP has commenced the decentralisation of the health and non-health sector data validation to states. NACA has also put together a committee for the planning of the process comprising of stakeholders from the line Ministries e.g. FMOH, FMOH and FMOWA, other partners. Other examples are USAID- CDC- Implementing partners committees. Sustaining the above will no doubt significantly reduce the delays usually experienced.</p>
PSM	<p>Breakdown of Laboratory Equipment is another major risk that the PR is currently responding to</p>	<p>The tracking of equipment status is now more frequent. NACA is also exploring the option of engaging its SRs who have the capacity to maintain the equipment and are currently doing so with their PEPFAR sites, to be given the responsibility to manage the maintenance of equipment in the GF</p>

		supported sites.
	Stock-out of required commodities	Advance preparation of procurement matrix/plan with methods and timelines for various procurements. Strict adherence to procurement timelines. Prompt startup of procurements and strict adherence to procurement timelines

PR Name	ARFH- HIV	
Domain	Current and anticipated Risk	Mitigation measures
Program Management & Governance	Weak engagement of state ATM focal persons in project implementation due to low performance of the state ATM focal persons in previous implementation and most ATM focal persons are engaged in other primary activities which did not allow majority of them to give adequate attention to project implementation.	<ul style="list-style-type: none"> The state focal persons will be included to participate in the ATM monthly coordination meetings under the New Funding Model. The focal persons will also form part of the M & E critical mass to monitor project activities to ensure effective implementation
	Weak skills/capacity of CBOs/SGs in project implementation especially at the community levels associated with inadequate number of days allotted for CBO training at project start-up.	<ul style="list-style-type: none"> Refresher training to strengthen CBO capacity which will be tailored on identified gaps Capacity building and technical supports to state M & E and Zonal programme Officers (ZPOs) to be able to provide more effective mentorship to CBOs. More frequent supportive supervision will also be provided to CBOs especially from the state M & E and ZPOs More implementation guidelines and Standard Operational Procedure will be developed and shared with implementers for guidance.
	Weak community - facility interface due to lack of orientation of facility staff and weak coordination at the state and service delivery points.	<ul style="list-style-type: none"> Provision of incentives for facility staff The PR is currently adopting a remodelling system. All the low-yielding CBOs are to be disengaged and high yielding CBOs will be realigned to the approved GF facilities within their localities in line with the LGA/Cluster system.
	Attrition of trained CBOs / staff due to use of volunteers that results in attrition of trained staff and poor budgetary allocation to hire skilled staff	<ul style="list-style-type: none"> Adequate budgetary provision for key positions to give room for hiring of skilled manpower Reduced volunteerism through the recruitment of dedicated staff. Increased institutional supports to the CBOs to enlist their support
Financial Management	Poor Financial Reporting which manifests in various forms such as falsification of receipts, late retirement, breach of financial procedures etc. These are attributed to (i) Culture of impunity that has been imbibed by some CBOs (ii) low capacity of Finance staff to understand the retirement process (iii) retirement process is also cumbersome to meet by some of the CBOs/SGs and (iv) demand for receipts for all financial spending at the community level is difficult to meet in most situation	<ul style="list-style-type: none"> Proper follow-up on CBOs to routinely track CBOs' financial records Appropriate sanctions to deter CBOs from further falsification of records More capacity for CBOs finance staff for improved financial management Recruitment of qualified finance officers for CBOs Regular spot checks on SRs and SSRs
Monitoring & Evaluation		
PSM	Irregular service(s) availability at some GF selected facilities due to (i) frequent stock out of	<ul style="list-style-type: none"> Provision of incentives for facility staff The PR should consider including

	essential commodities (ii) poor attitude of some health facility staff (iii) frequent industrial unrest by facility staff (iv) faulty diagnostic equipment	strengthening community confidence in accessing services by referring to functional listed sites in the mitigating measures.
--	--	--

PR Name	IHVN	
Domain	Current and anticipated Risk	Mitigation measures
Program Management & Governance	Limited program relevance due to inadequate quantity of drugs to meet the Country needs	Clear identification of Country targets and contributing institutions in the concept note,
	sub-optimal access to treatment and diagnostic services	Increased advocacy to State Governments and the private sector to ensure investment in MDR-TB, scale-up of MDR-TB services to cover underserved areas, ,
	gap in the number of States with capacity to manage MDR-TB patients	Systematic capacity building for State DR-TB teams and community systems to manage DR-TB patients and ensure decentralization of services
	Multi-tasking by PR staff	Revision of the roles and responsibilities of the staff on projects with a view to reducing the amount of multi-tasking of staff thereby increasing focus on the efficient use of GF resources in the next phase of implementation.
	Few SRs involved in implementation	Partnership with the ILEP partners to expand the number of Sub-recipients in the Program
	Disruption of program implementation due to industrial strike actions or insecurity.	Not within PR control
Financial Management	Low absorptive capacity, poor financial efficiency, poor financial reporting due to inadequate capacity of staff in operating the accounting software and low capacity of SRs and facilities in financial reporting.	<ul style="list-style-type: none"> • Ensure adequate human resources to provide program and financial oversight for SRs and other implementing entities such as treatment centres • Ensure adequate capacity building of PR internal auditors in international best practices, as well as other staff in technical and grant management skills, conduct periodic specific capacity building activities for staffs of PRs, SRs and other implementing entities in financial management and reporting • Engage technical assistant to improve-on or change accounting software.
Monitoring & Evaluation	Weak M&E systems and poor data quality due to inadequate monitoring and evaluation activities	Capacity building for States, LGA and facility staff on monitoring and evaluation and quality reporting, ,
	Inadequate State and site visits to provide required technical assistance, sub-optimal capacity at State, LGA and facility levels to provide quality reports, conduct DQAs for the treatment centres and laboratories and use data	<ul style="list-style-type: none"> • Adequate planning and budgetary provision for monitoring and supervision activities • Ensure adequate staff for M&E at state level
	Inadequate budgetary provision for EQA activities in view of scale-up of MDR-TB services and weak engagement and participation of community systems in the program	<ul style="list-style-type: none"> • Advocacy for increased resource allocation • Strengthening the integration of MDR-TB reporting into routine TB data management processes at all levels., DQA and EQA to accommodate the scale-up of the Program,
PSM	Disruptions in drugs supply, stock outs and expiries due to non-clarity of roles and responsibilities between PR and NTBLCP in the modified SCM model	Finalization and dissemination of modified SCM roles, with well-defined tasks and terms of reference after GF LFA review, ensure adequate staff for PSM, ,
	Lack of access of PR to key modules of the E-TB Manager	Access to the Web based electronic TB Manager (ETB Manager) needs to be extended to include the PR PSM for ease of visibility of all team members involved in client management.
	Sub-optimal LMIS system for MDR-TB	Ensure adequate staff for LMIS monitoring, supervision and capacity building of State

		and facility level staff, install robust LMIS software for treatment centers, laboratories and State TB Programs.
	Lack of flexibility of 3PL contracts to address emerging realities	modify 3PL agreement to ensure their ability to respond to the scale-up of MDR-TB services

PR Name	ARFH- TB	
Domain	Current and anticipated Risk	Mitigation measures
Program Management & Governance	Not Achieving Grant Outcome & Impact Targets due to low TB Case detection/notification rate and limited information on availability of free TB services in the community	The active case finding initiative and engagement of PMVs in referral of presumptive TB cases is expected to improve case detection and notification. The number of centres providing DOTS services will be increased for greater accessibility particularly in the slums and amongst hard to reach populations via DOTS expansion and training of DOTS providers in public and private facilities. GeneXpert technology will be used to improve diagnosis on a wider scale (PLHIVs; other MARPs) including TB-HIV programmatic integration. Also, structured inclusion of the Private sector and the CBOs in implementing TB Control at all levels of the health system will be harnessed.
	Poor Government commitment to the TB program at all levels.	Advocacy to government
	Inadequate SR Governance & Oversight due to inadequate funding to support the SR supportive supervisions to states.	Adequate provision for quarterly supportive supervision by SRs to states has been incorporated in the Concept note.
Financial Management	Financial Non – compliance due to limited administrative control of PR or SR over Governmental SR or SSR	The PR will ensure proper orientation of the SRs and SSRs on compliance with budgetary provisions on GF policies and procedures during zonal review meetings, monitoring, mentoring and supportive supervisory visits, all grant expenditure should be supported with receipts and regular PR oversight over SR financial reporting and internal controls implementation. In addition, referral of non compliance issues to the highest government authority to which the institution reports.
Monitoring & Evaluation	Inadequate M&E & Poor Data Quality at facility and LGA levels	The M&E data management and reporting system will be strengthened including the design and set up of an access based database or similar software that is linked to the DHIS2 platform. This will enhance data quality, access to information use and sharing. Also, facility level aggregation of data and use to promote ownership and quality will be initiated and strengthened. This will ensure use of data by the TBL supervisor at LGA level, sharing lessons learnt and best practices, regular DQAs and improved feedback mechanism for follow up actions.
PSM	Poor Quality of Health Services & Use of Health Products due to lack of quality assurance infrastructure in-country and low level of logistic management capacity at the facility level	The PR has engaged Singapore QA laboratory to conduct the quality assurance of health products. The QA results of TB Commodities are expected in Q4, 2014 which will confirm the impact of the vigorous activities geared towards the

		integrity of TB Medicines. The PR is also using the LMIS training and capacity building of facility and state staff in good inventory management practices. This has been completed in 7 states while the remaining states will be completed before the end of the semester. The PR has strengthened the states on Good Storage Practice over the quarters during the Zonal and State Review Meeting through direct information dissemination on the need for good storage condition. Also, the STBLCOs and Logistics/Store officers have all been mentored through several Mentoring and supervisory visits to the states.
--	--	---

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

<input checked="" type="checkbox"/>	Table 1: Financial Gap Analysis and Counterpart Financing Table
<input checked="" type="checkbox"/>	Table 2: Programmatic Gap Table(s)
<input checked="" type="checkbox"/>	Table 3: Modular Template
<input checked="" type="checkbox"/>	Table 4: List of Abbreviations and Attachments
<input checked="" type="checkbox"/>	CCM Eligibility Requirements
<input checked="" type="checkbox"/>	CCM Endorsement of Concept Note