

# FUNDING REQUEST APPLICATION FORM

## Full Review

SUMMARY INFORMATION			
<b>Applicant</b>	CCM, Nigeria		
<b>Component(s)</b>	TB, HIV & RSSH		
<b>Principal Recipient(s)</b>	1). National Agency for the Control of AIDS (NACA) 2). Society For Family Health (SFH) 3). Association for Reproductive and Family Health (ARFH) 4). Institute for Human Virology, Nigeria (IHVN) 5). Family Health International (FHI360)		
<b>Envisioned grant(s) start date</b>	1 <sup>st</sup> January 2018	<b>Envisioned grant(s) end date</b>	31 <sup>st</sup> December 2020
<b>Allocation funding request</b>	<i>TB: \$92,241,428</i> <i>HIV: \$293,169,900</i>	<b>Prioritized above allocation request</b>	HIV: \$ 105,390,772 TB: \$73,270,650

### **IMPORTANT:**

To complete this funding request, please:

- Refer to the accompanying ***Funding Request Instructions: Full Review***;
- Refer to the Information Note for each component as relevant to the funding request, and other guidance available, found on the [Global Fund website](#).
- Ensure that all mandatory attachments have been completed and attached. To assist with this, an application checklist is provided in the Annex of the *Instructions*;
- Ensure consistency across documentation.

**Applicants are encouraged to submit a joint funding request** for eligible disease components and resilient and sustainable systems for health (RSSH).

**Joint TB/HIV submissions are compulsory for a selected number of countries with highest rates of co-infection.** See the related [guidance](#) for more information.

**This funding request includes the following sections:**

**Section 1:** Context related to the funding request

**Section 2:** Program elements proposed for Global Fund support, including rationale

**Section 3:** Planned implementation arrangements and risk mitigation measures

**Section 4:** Funding landscape, co-financing and sustainability

**Section 5:** Prioritized above allocation request

## SECTION 1: CONTEXT

This section should capture in a concise way relevant information on the country context. Attach and refer to key contextual documentation justifying the choice of interventions proposed. To respond, refer to additional guidance provided in the *Instructions*.

### 1.1 Key reference documents on country context

List contextual documentation for key areas in the table provided below. If key information for effective programming is not available, specify this in the table ("N/A") and explain in Section 1.2 how this was dealt with within the context of the request, including plans, if any, to address such gaps.

Applicant response in table below.

Key area	Applicable reference document(s)	Relevant section(s) & pages nb.	N/A
<b>Resilient and Sustainable Systems for Health (RSSH)</b>			
Health system overview	1. NPHCDA. (2015). Report of the expert group on revitalization of primary health care in Nigeria. Abuja, Nigeria	Pgs. 18-62	□
	2. NPHCDA. (2015). Primary Health Care Under One Roof Implementation Scorecard III Report. Abuja, Nigeria	Pg. 15	
	3. USAID. (2009). Nigeria Health System Assessment 2008	Pgs. 3-14	
	4. FMOH. (January 2017). NSHDP 1 End Term Evaluation Report.	Pg. 100	
	5. FMOH. (2014). National Health Information System Policy 2014	Pgs. 8-14	
	6. FMOH. (2010). National Strategic Health Development Plan (NSHDP 2010-2015)	Pg. 42	
	7. NPHCDA. (2013). Progress Report of PHC service delivery.	Entire Document	
	8. FMOH 2014. Task-Shifting and Task-Sharing Policy for Essential Health Care Services In Nigeria. Abuja,	Pgs. 9-15	
	9. Federal Ministry of Health (2016) National Tuberculosis, Leprosy and Buruli Ulcer Control Programme 2015 Annual Report, Abuja: FMOH	Pgs. 6-29	
	10. Benjamin SC Uzochukwu, Mbachu Chinyere, Ogochukwu Ibe, Okeke Chinyere, Okwuosa Chinenye. (2016). Primary care systems profiles and	Entire Paper	

	<p>performance (PRIMASYS): Nigeria case study. The Alliance for Health Policy and Systems Research. <a href="http://www.who.int/alliance-hpsr/projects/AHPSR-Nigeria.pdf">http://www.who.int/alliance-hpsr/projects/AHPSR-Nigeria.pdf</a></p> <p>11. Daniel H. Kress, Yanfang Su &amp; Hong Wang. (2016). Assessment of Primary Health care System Performance in Nigeria: Using the Primary Health Care performance Indicator Conceptual Framework. <i>Health Systems and Reform</i>, 2:4, 302-318 DOI: 10.1080/23288604.2016.1234861</p> <p>12. Global Fund Country Team Portfolio Analysis of Nigeria Grant (2017)</p>	<p>Entire Paper</p> <p>Entire Document</p>	
Health system strategy	<p>13. FMoH. (2017). Second National Strategic Health Development Plan Framework (NSHDPf 2017-2021 draft).</p> <p>14. FMoH (September 2016). National Health Policy 2016. Promoting the Health of Nigerians to Accelerate Socio-economic Development. Abuja, Nigeria</p> <p>15. NPHCDA. (2016). Management Guideline for Primary Health Care Under One Roof. Abuja, Nigeria</p> <p>16. NPHCDA. (August 2013). Integrating Primary Health Care Governance in Nigeria (PHC Under One Roof). Draft.</p> <p>17. NPHCDA. (2012). Minimum Standards for Primary Health Care in Nigeria.</p> <p>18. FMoH (2015) National Human Resource for Health Strategic Plan 2008-2012</p> <p>19. FMoH (2016). National Supply Chain Policy for Pharmaceuticals and Other Healthcare Products</p> <p>20. Medical Laboratory Science Council of Nigeria Strategic Plan 2014-2018 attached)</p> <p>21. FMOH National Health Information System Strategic Plan 2014-2018</p> <p>22. National LMCU Performance Management Plan (2016)</p> <p>23. National Quality Assurance Policy (NQA 2015)</p>	<p>Entire Document</p> <p>Sect 2.5 (Pgs 7-16), Sect 3.1-3.3 (Pg 17);Sect 4.2 (Pgs 26-34)</p> <p>Entire Document</p> <p>Entire Document</p> <p>Entire Document</p> <p>Entire Document</p> <p>Entire Document</p> <p>Entire Document</p> <p>Entire Document</p> <p>Entire Document</p> <p>Entire Document</p>	□

	24. FMOH PSM Performance Monitoring Plan (2016)	Entire Document	
Human rights and gender considerations (cross-cutting)			<input type="checkbox"/>
<b>Disease-specific</b>			
<b>TB</b>			
Epidemiological profile (including interventions for key and vulnerable populations, as relevant)	<p>25. National Population Commission Projections: 2015 population (<a href="http://www.population.gov.ng/">http://www.population.gov.ng/</a>) Accessed May 02 2017</p> <p>26. Nigeria Demographic health Surveys (2008)</p> <p>27. Nigeria Demographic health Surveys (2013)</p> <p>28. Federal Ministry of Health. National TB Prevalence Survey 2012</p> <p>29. Nigeria: WHO statistical profile <a href="http://who.int/gho/countries/nga/en/">http://who.int/gho/countries/nga/en/</a></p> <p>30. UN data website, Slum population as percentage of urban. Accessed July 6, 2014 at: <a href="http://data.un.org/Data.aspx?d=MDG&amp;f=seriesRowID%3A710">http://data.un.org/Data.aspx?d=MDG&amp;f=seriesRowID%3A710</a></p> <p>31. World Health Organization: Global TB Report 2014</p> <p>32. World Health Organization: Global TB Report 2016</p> <p>33. UNAIDS Nutrition Factsheet – Nigeria.</p> <p>34. Pin-Hui Lee et al Diabetes and Risk of Tuberculosis Relapse: Nationwide Nested Case-Control Study. (Accessed 21st May, 2017)</p> <p>35. World Diabetes Foundation. 2014. Tuberculosis and Diabetes. The growing threat of the double burden of diabetes and tuberculosis. (Accessed 21st May, 2017)</p> <p>36. Nigeria Prison service website Accessed on 9<sup>th</sup> May 2017</p> <p>37. International Diabetes Federation website accessed on 9th May 2017</p>	<p>Web Page</p> <p>Entire Document</p> <p>Entire Document</p> <p>Pgs. 12-17, 55-59, 67-70</p> <p>Web Page</p> <p>Web Page</p> <p>Pg. 153</p> <p>Pg. 12, 13, 65, 148</p> <p>Entire Factsheet</p> <p>Pgs. 1, 4-6</p> <p>Entire Factsheet</p> <p>Web Page</p> <p>Entire Sheet</p>	

	38. Federal Ministry of Health. 2011. Directory of health facilities in Nigeria; <a href="https://knoema.com/rsjujy/health-facilities-in-nigeria-by-type-and-ownership-december-2011">https://knoema.com/rsjujy/health-facilities-in-nigeria-by-type-and-ownership-december-2011</a>	Web Page	
Disease strategy (including interventions for key and vulnerable populations, as relevant)	<p>39. Abdurrahman, S.T. et al. "Are Patients with Pulmonary Tuberculosis Who Are Identified through Active Case Finding in the Community Different than Those Identified in Healthcare Facilities?" <i>New Microbes and New Infections</i> 15 (2017): 35–39. <i>PMC</i>. Web. 28 Apr. 2017.</p> <p>40. Pepple, A.I, Minister of Lands, Housing and Urban Development. <i>Nigeria: Progress on improving the lives of slum-dwellers over the decade 2000 – 20n10</i>. Presentation at Making Slums History International Conference, Rabat, Morocco, November 2012</p> <p>Alternative: Nigeria MDGs 2013 Report</p> <p>41. The National Strategic Plan for Tuberculosis Control 2015-2020</p> <p>42. Mid- Term Evaluation of the Nigeria National Tuberculosis and Leprosy Control Strategic Plan 2010-2015</p> <p>43. Debrief: Technical Review Panel Window 1 – GF; May 2017</p> <p>44. UNICEF Nutrition Factsheet – Nigeria <a href="https://www.unicef.org/nigeria/factsheets_NUTRITION_low.pdf">https://www.unicef.org/nigeria/factsheets_NUTRITION_low.pdf</a></p> <p>45. AFDB project on Nomads</p> <p>46. Nigeria Prison service website</p>	<p>Pgs. 1-5</p> <p>Entire Paper</p> <p>Pg. 52</p> <p>Entire Document</p> <p>Entire Document</p> <p>Entire Document</p> <p>Entire Factsheet</p> <p>Pg. 1</p> <p>Web Page</p>	
Operational plan, including budgetary framework	47. Tackling Tuberculosis in Nigeria: funding gaps and fragmentation - The Economist Intelligence Unit Limited 2016	Entire Document	
Program reviews and/or evaluations	<p>48. Mid- term evaluation of the Nigeria National Tuberculosis and Leprosy Control Strategic Plan 2010-2015</p> <p>49. Challenge TB – Nigeria Year 2 Annual Report, October 1, 2015 – September 30, 2016</p> <p>50. Challenge TB – Nigeria Year 3, Quarterly Monitoring Report, October-December 2016</p> <p>51. Laboratory assessment report – GLC</p>	<p>Entire Document</p> <p>Entire Document</p> <p>Entire Document</p> <p>Pgs. 9-10</p>	

	<p>52. Tackling Tuberculosis in Nigeria: funding gaps and fragmentation - The Economist Intelligence Unit Limited 2016</p> <p>53. Improving TB case detection: A compendium of TB REACH case studies, lessons learned and a M&amp;E framework</p> <p>54. Epidemiologic Analysis of Tuberculosis in Nigeria (2017)</p> <p>55. Pepple, A.I., Minister of Lands, Housing and Urban Development. <i>Nigeria: Progress on improving the lives of slum-dwellers over the decade 2000 – 2010</i>. Presentation at Making Slums History International Conference, Rabat, Morocco, November 2012</p> <p>Alternative: Nigeria MDGs 2013 Report</p>	<p>Entire Document</p> <p>Pg. 45</p> <p>Entire Document</p> <p>Entire Paper</p> <p>Pg. 52</p>	
Human rights and gender considerations (disease-specific)	56. Technical Brief: Tuberculosis, Gender and Human Rights – 2017	Entire Document	
<b>HIV</b>			
Epidemiological profile (including interventions for key and vulnerable populations, as relevant)	<p>57. 2014 National HIV sero-prevalence sentinel survey among pregnant women attending antenatal clinics in Nigeria. Abuja, FMOH</p> <p>58. Nigeria Demographic health Surveys 2008</p> <p>59. Nigeria Demographic Health Survey 2013</p> <p>60. National HIV/AIDS and Reproductive Health Survey 2007</p> <p>61. National HIV/AIDS and Reproductive Health Survey 2012</p> <p>62. National HIV/AIDS Epidemiology &amp; Impact Analysis (NHEIA) Report, 2014</p> <p>63. National HIV/AIDS Epidemiology and Impact Analysis (NHEIA) Report, 2017</p> <p>64. Integrated Biological and Behavioral Sentinel Surveys (2007)</p> <p>65. Integrated Biological and Behavioral Sentinel Surveys (2014)</p>	<p>Pgs. 71-79</p> <p>Entire Document</p> <p>Entire Document</p> <p>Pgs. 35-47</p> <p>Pgs. 10, 390</p> <p>Pgs. 19-40</p> <p>Entire Document</p> <p>Pgs. 4-13</p> <p>Pg. 19</p> <p>Pgs. 8-9</p>	□

	<p>66. National Policy for the Control of Viral Hepatitis In Nigeria; NASCP/FMOH (2015)</p> <p>67. National Survey of Viral Hepatitis B and C Infection in Nigeria (2013)</p> <p>68. World Health Organization (WHO) Mother-to-child transmission of HIV. Available at: <a href="http://www.who.int/hiv/topics/mtct/en/">http://www.who.int/hiv/topics/mtct/en/</a> Accessed 21 April 2017</p> <p>69. Chukwuemeka IK, Fatima MI, Ovavi ZK, Olukayode O. The impact of a HIV prevention of mother to child transmission program in a Nigerian early infant diagnosis centre. Niger Med J. 2014; 55(3): 204–208. doi: 10.4103/0300-1652.132039</p> <p>70. Obafemi Awolowo University, Institute of Public Health (IPH). 2017. An Action Research to Reduce the Vulnerability of Adolescent and Young People to HIV Infection in Selected States of Nigeria: Baseline Assessment. Ile-Ife, IPH. Report and PowerPoint Presentation</p>	<p>Pgs. 4, 23</p> <p>Web Page</p> <p>Entire Paper</p> <p>Slides 40, 43-46</p>	
Disease strategy (including interventions for key and vulnerable populations, as relevant)	<p>71. National HIV and AIDS Strategic Framework (2017-2021)</p> <p>72. NACA. Ending the HIV Epidemic among children in Nigeria by 2020. An investment framework to reduce maternal and child mortality due to HIV. Sept 2015</p> <p>73. National Guidelines for HIV Prevention Treatment and Care (2016)</p> <p>74. National HIV Strategy for Adolescents and Young People 2016-2020</p> <p>75. Fast-tracking HIV treatment and PMTCT programs in Nigeria. An emergency plan of action towards achieving the 90-90-90 target by 2020</p> <p>76. UNAIDS. Global Plan Country Factsheet Nigeria.</p> <p>77. <a href="http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx">http://www.aidsinfoonline.org/devinfo/libraries/aspx/home.aspx</a></p>	<p>Pgs. 23-37</p> <p>Pgs. 5-35</p> <p>Entire Document</p> <p>Pgs. 10-39</p> <p>Pgs. 5-31</p> <p>Entire Factsheet</p> <p>Web Page</p>	<input type="checkbox"/>
Operational plan, including budgetary framework	<p>78. PEPFAR Nigeria. Nigeria Country Operational Plan (COP) 2017. Strategic Direction Summary.</p>	<p>Pgs. 4-52</p>	<input type="checkbox"/>



Program reviews and/or evaluations	79. Independent evaluation of the scope and effectiveness of intervention activities among people who inject drugs, supported by the Global Fund in Nigeria: The Assessment Report (June-August 2016)	Pg. 13	<input type="checkbox"/>
	80. National Agency for the Control of AIDS (NACA). 2015. Global AIDS Response Country. Progress Report: Nigeria (GARPR) 2015	Entire Document	
Human rights and gender considerations (disease-specific)	81. People living with HIV stigma index Survey, 2011	Pg. 14	<input type="checkbox"/>
	82. Plan of Action to remove legal and human rights barriers to HIV and AIDS response in Nigeria	Pgs. 16-19	
	83. The Act to Protect the Rights of the People living with HIV, 2014	Pgs. 4-16	
Miscellaneous (other reference documents)	84. Joint United Nations Programme on AIDS (UNAIDS). 2014. The Gaps Report. Geneva, UNAIDS	Pgs. 16-49, 191-239	
	85. Global Fund Country Team Portfolio Analysis of Nigeria Grant (2017)	Entire Document	
	86. Global Fund OIG audit report, May 2016	Pg. 8	
	87. Audit of Global Fund Grants to the Federal Republic of Nigeria (2016)	Entire Document	
	88. Annex of Figures and Tables to Nigeria GF Submissions	Entire Document	
	89. Harmonized Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund (2016)	Pg. 31	
	90. National Acceleration Plan for Paediatric HIV Treatment and Care (2016-2018)	Entire Document	
	91. 2014 National HIV Sero-Prevalence Sentinel Survey Among Pregnant Women Attending Antenatal Clinics in Nigeria (2015)	Entire Document	
Add rows as relevant, for any additional key area as relevant to the funding request			

## 1.2 Summary of country context

To complement the reference documents listed in Section 1.1 above, provide a summary of the critical elements within the context that informed the development of the funding request. The brief description of the context should cover disease-specific and RSSH components, as appropriate, as well as human rights and gender-related considerations.

**(maximum 2 pages per component)**

## INTRODUCTION

Nigeria is Africa's most populous country with 182 million<sup>1</sup> people. The country has continued to achieve a steady decline in HIV prevalence from 5.8% (2001) to 3.0% (2014) with a corresponding reduction in the annual number of new HIV infections. Nigeria also sustained drug-resistant (DR TB) and drug-susceptible (DS TB) TB treatment success rate at 77% and 87% respectively in 2013 and 2015 respectively<sup>2</sup>. Strategic investments in the health system have contributed significantly to the progress achieved. Nonetheless, Nigeria still has high HIV and TB burdens: globally, the country ranks second for HIV burden<sup>3</sup> with estimated 3.1 million people living with HIV (PLHIV)<sup>4</sup> and fourth for new TB cases with total incidence of 586,000 in 2015<sup>2</sup>.

To build on the country's achievements and address the continued challenge, Nigeria has embraced ambitious global targets for the next five years, including the goals of the End TB Strategy and the Global TB Plan, the HIV fast track 90-90-90 targets by 2020 and the elimination of Mother to Child Transmission of HIV. These goals are reflected in the National Strategic Plan for Tuberculosis (2015-2020); Implementation Plan for Accelerated TB case Finding (2017); End TB Strategy Operational Framework for Nigeria (2017); the National HIV and AIDS Strategic Framework (2017-2021); and the Fast-tracking HIV treatment and PMTCT programmes in Nigeria. The National Health Policy (2016) as well as the National Strategic Health Development Framework (2017-2021), which is being currently finalised, also support these goals and embrace further strengthening of the health system towards the realization of Sustainable Development Goal 3 within the context of universal health coverage.

This funding request provides a strategic opportunity to advance Nigeria's TB and HIV response in line with national health goals using a strategic investment approach that focuses on high impact interventions. Following extensive review and analysis of epidemiological and programme data of the two diseases, strategy review and country dialogue, this request aims to demonstrate impact through strategic prioritisation of interventions based on up-to-date evidence with a focus on population and locations which are disproportionately impacted.

The aims of this funding request are to:

1. prevent new HIV infections through strategic targeting of **key populations** with comprehensive service package, **prevention of mother-to-child**

<sup>1</sup> National population Commission (Nigeria). <http://www.population.gov.ng/>

<sup>2</sup> World Health Organisation (WHO). 2016. Global Tuberculosis Report 2016. Geneva, WHO.

<http://apps.who.int/iris/bitstream/10665/250441/1/9789241565394-eng.pdf?ua=1>

<sup>3</sup> Joint United Nations Programme on AIDS (UNAIDS). 2014. The Gaps Report. Geneva, UNAIDS

<sup>4</sup> Federal Ministry of Health (FMOH). 2015. 2014 National HIV sero-prevalence sentinel survey among pregnant women attending antenatal clinics in Nigeria. Abuja,

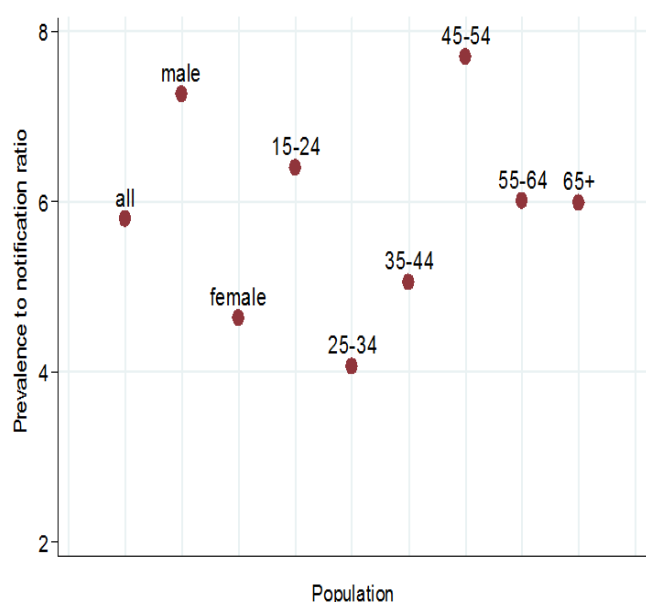
- transmission of HIV** towards the attainment of the elimination targets and reduction of HIV vulnerabilities among **adolescent girls and young women**;
2. achieve **viral suppression** among PLHIV through the use of differentiated approach across the **test-treat-retain** cascade, efficient case finding with a focus on **high burden and high unmet need** in States, acceleration of scale-up of ART coverage, linkage to quality treatment, retention in care and **leveraging efficiencies** across the continuum of care;
  3. **intensify case finding of TB cases (DSTB and DRTB)** among the general and key affected populations (KAPs) through massive TB services expansion in the public sector, engagement of private sector, optimisation of rapid molecular diagnostic tests, creation of patient support systems and strategic demand creation in the communities;
  4. **increase TB treatment success rate** for DSTB and DRTB through introduction of shorter regimens and improving treatment adherence;
  5. embed **community, rights and gender (CRG)** approaches into programming across the prevention-testing/diagnosis-treatment-care cascade; and,
  6. **addressing health systems constraints**, strengthen service linkages, decentralization, integration, and **building synergies and complementarities** with other programmes, particularly the President's Emergency Plan For AIDS Relief (PEPFAR) for HIV and USAID supported TB projects.

## I. OVERVIEW OF THE TUBERCULOSIS EPIDEMIC AND THE NATIONAL RESPONSE

### Epidemiology

Nigeria has a TB prevalence rate of 322 per 100,000 population, multidrug resistant/rifampicin-resistant (MDR/RR) TB prevalence rate of 16/100,000, and an estimated 237,000 TB deaths in 2015<sup>2</sup>. The national TB prevalence study of 2012 reported the prevalence of bacteriologically confirmed TB as 751/100,000 for males and 359/100,000 for females. The prevalence to notification rate was higher for males than females and highest in age group 45-54 years, followed by 15-24 years, and lowest in age 25-34 years (Figure 1)<sup>5</sup>.

**Figure 12: Prevalence to notification ratio by age and sex from the Nigerian TB prevalence survey**



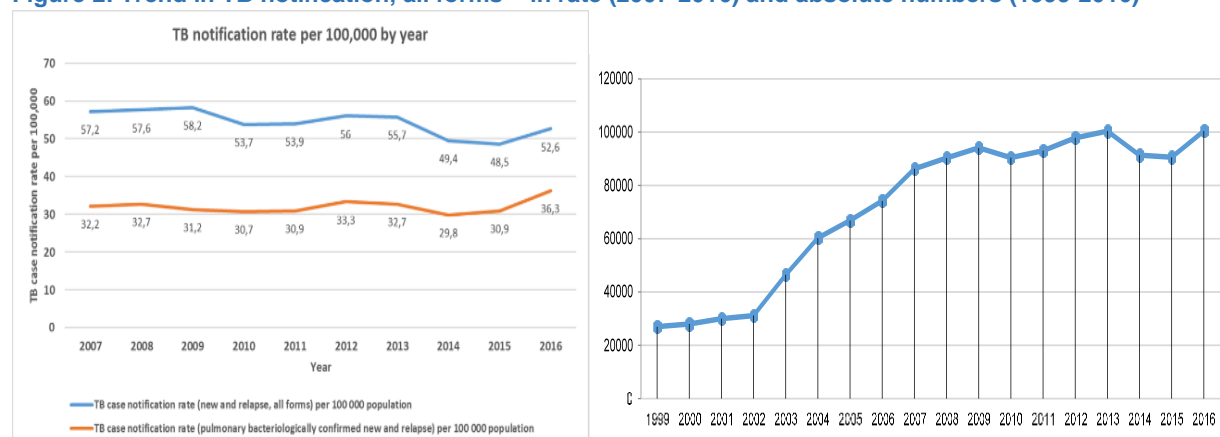
### Case notification

TB case notification rate reduced from 55.7/100,000 population in 2013 to 48.5/100,000 in 2015 but then increased to 52.6/100,000 in 2016 (Figure 2). In 2016, Nigeria adopted the use of GeneXpert machine as the primary diagnostic tool for TB, following its use in diagnosing TB among presumptive DRTB cases and

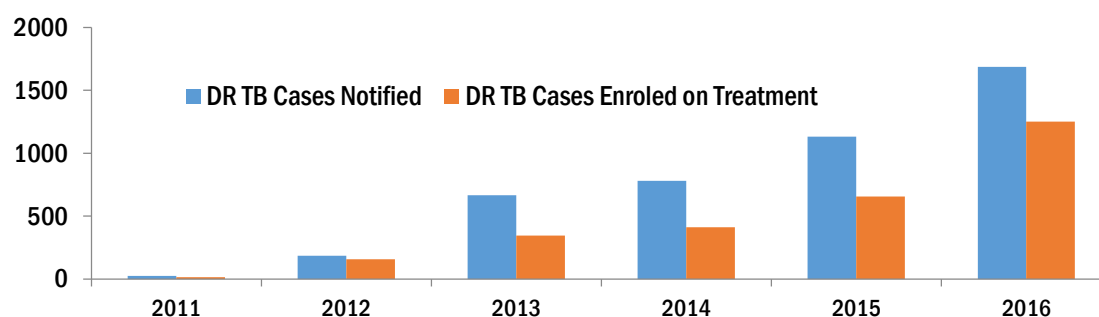
<sup>5</sup> A particularly valuable evaluation performed with the prevalence survey data is its use in conjunction with the 2012 smear-positive case-notification data to arrive at prevalence to notification ratios. These data indicate that males and those 45 to 54 age-group are not being diagnosed and/or notified sufficiently and represent an under-served groups

PLHIV since 2011. With this, DSTB case notification increased from 90,584 in 2015 to 100,433 in 2016 (Figure 2), and DRTB case notification has been increasing since 2012 (Figure 3).

**Figure 2: Trend in TB notification, all forms – in rate (2007-2016) and absolute numbers (1999-2016)**



**Figure 3: Trend of DR-TB notifications and treatment enrolment, 2011-2016**



Despite these gains, Nigeria still has one of the lowest TB case detection rates in the world with about 85% of DSTB and 96% of DRTB cases estimated to be missed<sup>2</sup>. Low awareness of TB, low TB diagnostic and treatment services coverage, limited community engagement and private sector engagement not commensurate with its scale, are some of the reasons for the missed cases. There is also a growing trend of a relatively low notification of smear-negative pulmonary TB, suggesting under-diagnosis of clinical TB which is due to a lack of awareness/inadequate skills among healthcare workers (HCWs), inadequate access to X-ray and/or poor supervisory capacity of the State and local government area (LGA) program to identify these problems and provide solutions. These challenges are targeted by appropriate interventions, including building capacity for health care workers, in this funding request.

Gaps in DOTS coverage at ART clinics limit screening, diagnosis and treatment opportunities for PLHIV. Over the years, the national TB programme has narrowed the DRTB diagnosis and treatment services gap through decentralization to the community; however, 26% of diagnosed DR-TB cases were not initiated on treatment in 2016.

## TB in key affected populations (KAP)

The 2015 – 2020 TB NSP identified a number of different sub-populations as key affected populations in Nigeria, based on a combination of modelling, globally recognized risk factors

for TB, prevalence survey data, program data and project data<sup>6</sup>. The benefits from intensified case-finding and case-holding activities are expected to be highest among these key affected populations and hence this grant application is prioritizing interventions among these KAP (Table 1) to address the challenges of the low TB case finding.

**Table 1: Key TB-affected populations and population size estimates, 2016**

Sub-population	Size estimate in 2016	Interventions initiated in the last grant in select states
PLHIV	3,165,005 <sup>7</sup>	Intensified case finding
Contacts of bacteriologically +ve pulmonary TB	1,617,936*	Active contact tracing
Urban slum dwellers	50,000,000 <sup>3, 8, 9</sup>	ACF (House to House)
Nomads	9,400,000 <sup>10</sup>	ACF
Migrants and internally displaced people	Unknown (migrants); >500,000 (IDPs)	IDP camps for ACF
Prisoners	53,000 <sup>11</sup>	Routine programme
People with diabetes	1,564,700 <sup>12</sup>	Small scale studies in Nigeria on the association between diabetes and TB and its burden undertaken.
No of incident TB cases among Children	Pop: 79,500,000 <sup>13</sup>	Active contact tracing
Health care workers, especially those in in-patient facilities, HIV & TB clinics, & IAs	400,000 (including private facilities)	None

\*Assumes average of 4 contacts per bacteriologically positive case. Bacteriologically positive cases make up approximately 69% of those diagnosed in 2016.

## Paediatric TB

In Nigeria, children under age 15 years constitute about 44% of the population<sup>2,14</sup>, but notification rates remain low among them accounting for only 6% of total TB notification in 2016. An estimated 92% of paediatric TB cases are missed contributing to the overall low TB case detection rate in the country..

## TB and co-morbidities

The HIV prevalence in incident TB cases in 2015 was 17%<sup>2</sup>. About 85.3% of the estimated HIV incident among TB cases were missed in 2016, and 20% of the registered HIV-positive TB patients did not receive ART, thereby preventing this key affected population from accessing lifesaving care and treatment. Intensification of TB case finding among PLHIV is a priority intervention in this funding request. About 10% of TB cases globally are linked to diabetes. People with diabetes have a two-to-three times higher risk of being infected with TB, compared to people without diabetes. People with TB and coexisting diabetes have a four

<sup>6</sup> NSP for TB 2015 -2020

<sup>7</sup> Nigeria Spectrum estimates 2016

<sup>8</sup> 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

<sup>9</sup> 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>

<sup>10</sup> AFDB project on Nomads

<sup>11</sup> Nigeria Prison service website

<sup>12</sup> International Diabetes Federation website accessed on 9th May 2017

<sup>13</sup> National Population Commission projections 2016

<sup>14</sup> <http://data.worldbank.org/indicator/SP.POP.0014.TO.ZS>

times higher risk of death during TB treatment and higher risk of TB relapse after treatment<sup>15,16</sup>. A large proportion of people with diabetes as well as TB remain undiagnosed or get diagnosed at a late stage. The current grant will prioritize epidemiological surveys and studies on the association between diabetes and TB and its burden in Nigeria. Pilot interventions are described in the section 2.1.

### **Burden of TB by states**

State-specific TB prevalence data are not available for Nigeria as this was not provided by the national survey conducted in 2012<sup>17</sup>. However, using a number of relevant indicators<sup>18</sup>, state ranking shows that Rivers, Kaduna, Imo, Kano, and Lagos States (Annex 6) have the highest numbers of missed cases (141,689 in total or 30% of the country total missed TB cases). Oyo, Lagos and Kaduna rank among the five states with the highest ART unmet need, and all the five states rank among the 13 high-burden states that contribute over three-fifths (62%) of unmet ART needs in Nigeria, thereby reinforcing the strategic approach of effective TB/HIV collaboration in addressing the burden of the two infections.

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<sup>15</sup> World Diabetes Foundation. 2014. Tuberculosis and Diabetes. The growing threat of the double burden of diabetes and tuberculosis. [https://www.worlddiabetesfoundation.org/sites/default/files/TB-diabetes%20co-epidemic%20fact%20sheet\\_March2014%20update.pdf](https://www.worlddiabetesfoundation.org/sites/default/files/TB-diabetes%20co-epidemic%20fact%20sheet_March2014%20update.pdf) (Accessed 21<sup>st</sup> May, 2017)

<sup>16</sup> Pin-Hui Lee *et al*. Diabetes and Risk of Tuberculosis Relapse: Nationwide Nested Case-Control Study. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3963913/> (Accessed 21<sup>st</sup> May, 2017)

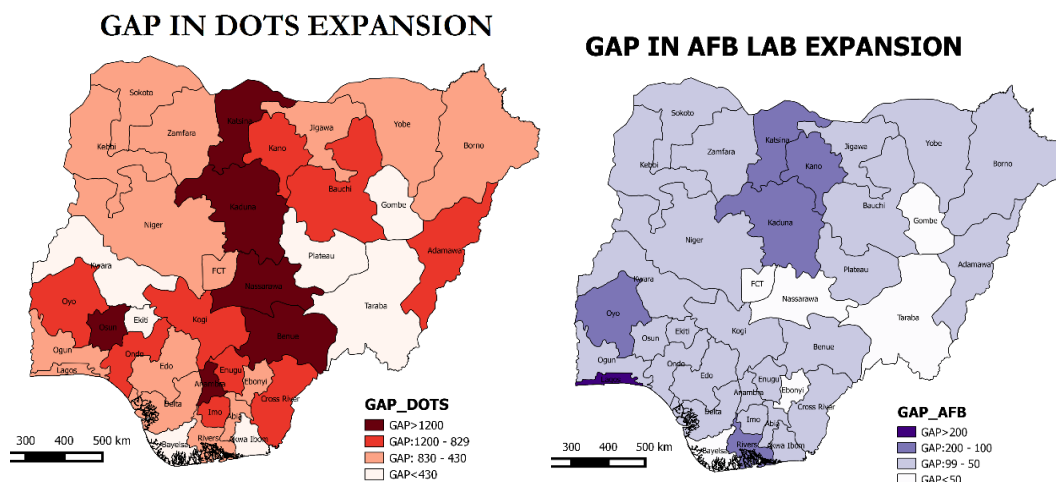
<sup>17</sup> Federal Ministry of Health. National TB Prevalence Survey. 2012.

<sup>18</sup> The estimated absolute TB population by state (calculated by applying the national prevalence rate to the state population), the estimated missed cases by state (given the state case notification numbers), the state case detection rates and the HIV prevalence rates (available from the HIV program)

## Coverage of DOTS and microscopy services as state level

There are gaps in the coverage of DOTS services, with only 5,000 of the 22,000 public sector health facilities in the Nigeria having such, covering less than 20% of the population. Gaps also exist with respect to microscopy services (**Figure 4**).

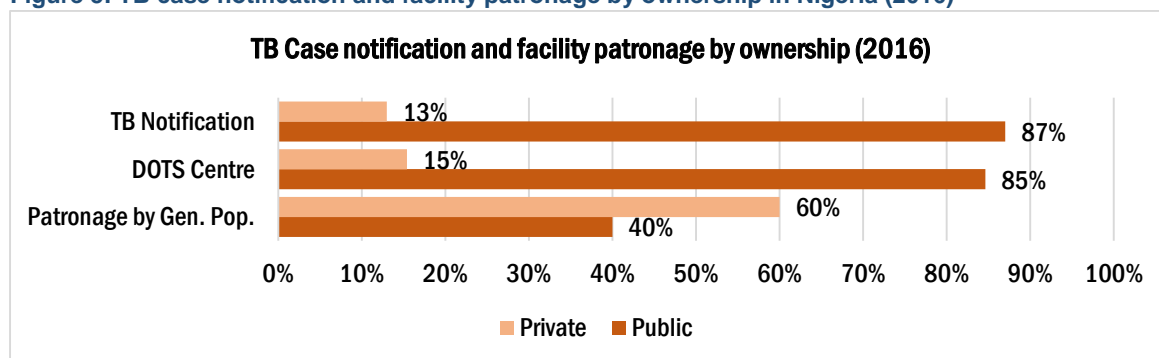
**Figure 4: Coverage of sputum microscopy and DOTS services in Nigeria**



## Private Sector Engagement

In Nigeria, the private sector accounts for about 60% of all health facility visits<sup>19</sup>. The private proprietary patent medical vendors (PPMVs) are usually the first source of care for up to 55% of under-five childhood illnesses, and provide services for 35% - 55% of adults seeking treatment especially in rural and lower income communities. Analysis of the national TB programme data shows that private facilities constitute only 15% of the DOTS centres (>6,000), and contributed 13% of case notifications in 2016 (**Figure 5**). DOTS expansion in private facilities has the potential to increase TB case notification and treatment.

**Figure 5: TB case notification and facility patronage by ownership in Nigeria (2016)**

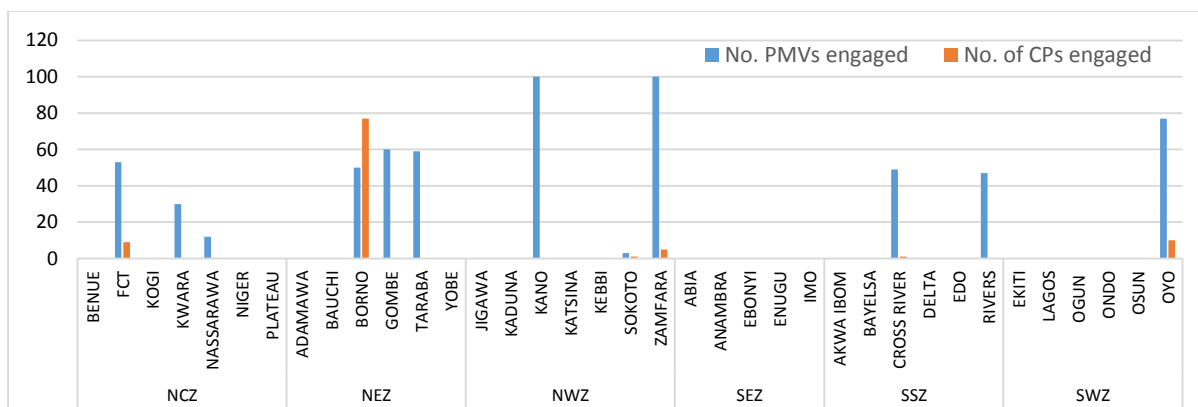


Proprietary and patent medicine vendors (PPMVs) and private pharmacies are a particularly important source of care in rural and lower income communities. States have engaged PPMVs in a number of states (**Figure 6**), however, these represent a very small fraction of total number of registered PPMVs in the states, with the exception of Zamfara where the 100 engaged PPMVs represent 50% of the registered PPMVs. Similarly, the number of Community Pharmacies (CPs) engage represent reflect a low percentage of the registered CPs in most states.

**Figure 6: Engagement of PPMVs/CPs in the TB control programme**

<sup>19</sup> Federal Ministry of Health. 2010. National Strategic Health Development Plan 2010-2015.





However, engagement of the private sector is affected, among others, by the absence of relevant national framework and programmatic guidelines for private sector engagement in the national TB programme. Engagement of the private sector is critical for improved case notification in Nigeria and a key strategy to increase TB case notification in this funding request will be private sector engagement through a structured and sustainable approach. Matching funds for the engagement of the private sector is being sought in this funding request.

### Human Rights and gender considerations

The National Health Act 2014 and the National Health Policy 2016<sup>20</sup> provides for financial risk protection of the poor and vulnerable population, and improving equitable physical and economic accessibility to care. In the last grant, TB programs were undertaken in prisons and IDP camps in the North-East (TB REACH project) as well as case finding in Qur'anic schools and guidelines for managing TB in crisis situation were developed to ensure equitable access to TB services amongst the KAPs but needs to be expanded. DOTS service are provided in 87 of the 240 prisons in Nigeria as at 2016. For prisons where DOTS services are not available, inmates who required TB services are sent to nearby DOTS centers where such services are provided free of charge. A total of 4,239 TB cases were notified from the prison facilities in 2016 representing a case notification rate of 7,998 per 100,000 population, this is far higher than the National TB notification rate of 53 Per 100,000 population in 2016. The prioritized interventions in this application will facilitate expansion of TB services to additional prison facilities, this include: pre-entrance TB screening, diagnosis, treatment, counselling and linkage to care after discharge from prison to ensure TB treatment completion Under this new funding application, more efforts will concentrate on improving the availability, accessibility, and quality of TB-related information and services targeted at KAPs.

As indicated earlier, the TB prevalence is higher among men compared with women. The national prevalence study reported the prevalence to smear-positive case notification rates for men as 7.25, and for women as 4.63. This funding request, therefore, recognises men as an underserved group; it, will, thus aim to improve men's access to diagnostic and screening services and ensure gender equity in TB care. Interventions addressing TB in male dominated settings in Lagos state (TB awareness creation in football viewing centres, Okada riders association), which were undertaken in the last grant, will be expanded further. The results from the upcoming legal environmental assessment for TB in June 2017 will further guide in improving the response to community, human rights CRG issues in TB. The TB Case Detection Rate (CDR) among Male and Female in 2016 are similar. The Programme in 2016 notified 100,433 TB cases, 62% (61,789) of these cases are Male and 38% (38,644) are female; this

<sup>20</sup> [http://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/1212\\_2016\\_National\\_Health\\_Policy\\_Draft\\_FMOH\\_1283.pdf](http://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/1212_2016_National_Health_Policy_Draft_FMOH_1283.pdf)



gives a Case Detection Rate (CDR) of 17% among both sexes. The strategic interventions for increasing TB case detection rate in this application is therefore well tailored to this gender differentials.

#### The current grant will address the following challenges:

Guided by findings from the epi-analysis, learnings from last grant implementation, GF portfolio analysis report, and multi stakeholder consultations, the NTLCP has made strategic shifts in its approach for the next grant period 2018–2020 to confront the major challenges outlined below:

1. **Low TB case detection rate** (15% for TB, and 4% for DR-TB in 2015).
  - a. **Close to half a million DS-TB and 27,789 DRTB cases missed annually.**
  - b. A trend of **very low paediatric case detection** (~8% of the estimated TB cases amongst children)
  - c. **A large burden of DR-TB** (29,000), most of whom (96%) are **undetected** and continue to transmit disease. Limited (4 of 12 facilities) second line drugs testing facilities in the country, precludes the diagnosis of XDR-TB.
  - d. **Underutilization of the GeneXpert machines:** current average of 4 tests/machine/day is way below the 12-16 tests per day norm.
  - e. **85% of the HIV incident TB cases are missed**
2. **Insufficient resources leading to the low achievement of case finding targets**
  - a. The **cost of chest X-rays** is still a significant barrier and a factor in the low case detection rate.
  - b. **Low coverage of private and public sector health facilities** with TB diagnosis and treatment services (< 20% coverage).
  - c. **Inadequate numbers and capacity of HR at LGAs** affect the last mile service delivery, limiting appropriate screening, diagnosis and treatment
3. **Health system weaknesses and financing gaps**
  - a. **Inadequate collaboration** between the **TB and HIV programs**
  - b. **Weak general health systems**, particularly in the areas of infrastructure and human resources, with **weak data systems** particularly at the state level limiting clearer understanding of state level epidemics and gaps.
  - c. Inadequate **national investment** in health/TB sector with an overreliance on donors.

## National TB Response priorities

The goal of Nigeria's national TB response, reflected in the NSP 2015-2020, is "to ensure universal access to high-quality, patient-centred TB prevention, diagnosis and treatment services for Nigerians with all forms of TB, regardless of geographic location, income, gender, age, religion, tribe or other affiliation." The programmatic priorities include: rapidly increase detection of TB in adults and children; improve treatment success; integrate TB and HIV services; build capacity for diagnosing and treating drug-resistant TB; and, create strong and sustainable systems to

support these achievements. A number of key policy changes have been effected in line with these priorities, including offering GeneXpert upfront for diagnosis of TB, adopting the "End TB strategy" and the declaration of the year 2017 as "the year of accelerated case finding". Some of the specific interventions outlined are: active case finding in 365 slums of 20 states and conducting TB outreach for IDPs and nomads; expansion of private sector coverage; and expansion of laboratory and treatment sites coverage. Others include: use of shorter regimen and new drugs – bedaquiline and delamanid for multidrug resistant TB (MDR); paediatric anti TB-drug formulations for children, including the revised guidelines to put all paediatric and pregnant women on delamanid; and, community involvement to increase accountability of the systems. The priority interventions outlined in this funding request are aligned with the national goal, and rooted in the NSP.

## II. OVERVIEW OF THE HIV EPIDEMIC AND THE NATIONAL RESPONSE

Since 2001, Nigeria's HIV prevalence rate has shown a downward trend from 5.8% to 3.0% in 2014 (Figure 7). In 2016, the country has an estimated 3.1 million PLHIV<sup>21</sup>: females constitute 54% of PLHIV, and children 7%. Nigeria has a mixed epidemic consisting of a generalized epidemic affecting the general population and a concentrated epidemic affecting key populations (KPs). Furthermore, the epidemic is geographically heterogeneous ranging from 0.9% (lowest) in Zamfara State to 15.4% (highest) in Benue State<sup>22</sup>. Between 2010 and

<sup>21</sup> Federal Ministry of Health 2013. National AIDS and Reproductive Health Survey, 2012

<sup>22</sup> National Agency for the Control of AIDS (NACA). 2015. Global AIDS Response Country. Progress Report: Nigeria (GARPR) 2015

2014, HIV prevalence increased in eight states (Table 2). The PLHIV population varies across states: five states contribute 32%; 10 states contribute 52%; and 15 states contribute 67% (Annex 7).

Figure 7: Trends in HIV sero-prevalence among pregnant women in Nigeria: 1991-2014



Source: NHSSS 2014

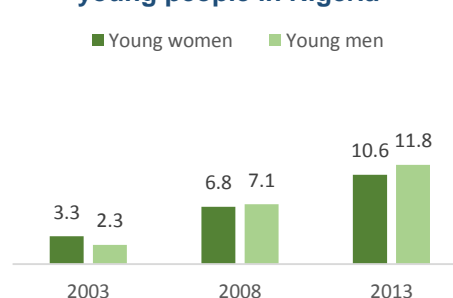
Table 2: States with increased HIV sero-prevalence between 2010 and 2014

S/N	State	HIV prevalence (2010)	HIV prevalence (2014)
1	Benue	12.7	15.4
2	Anambra	8.7	9.7
3	Imo	3.0	7.5
4	Ekiti	1.4	2.9
5	Bauchi	2.0	2.3
6	Kwara	2.2	2.3
7	Jigawa	1.5	1.9
8	Kebbi	1.0	1.4

## HIV in the adolescent and young people (AYP)

HIV prevalence among adolescents (15-19 years) is increased from 1.7% in 2007<sup>23</sup> to 2.9% in 2012<sup>24</sup>), probably due to an increase in risky behaviours (Annex 8). Females have a higher prevalence compared to males (4.5% versus 1.9% in 2007, and 3.7% versus 2.5% in 2012). HIV testing among young people (15-24 years) is still low; only 11% of sexually active young females and 12% of young males had tested for HIV in 2012-2013 (Figure 8).

Figure 8: HTS uptake among young people in Nigeria



Overall, among adolescents 15-19 years, only 9.2% of females and 4.6% of males ever tested for HIV by 2013. Furthermore, among these adolescents only 50.5% of females and 56.1% of males knew where to test for HIV. An ongoing Global Fund funded research has documented factors that increase the vulnerability of young women to HIV infection to include high level of risky sexual behaviour, gender-based violence, substance abuse, low risk perception, and being out of school<sup>25</sup>. At present, AYP-targeted HIV prevention programmes are few in Nigeria. This funding request will build on the result of the research to propose innovative interventions to reduce HIV vulnerability of adolescent girls and young women (AGYW) and other AYP.

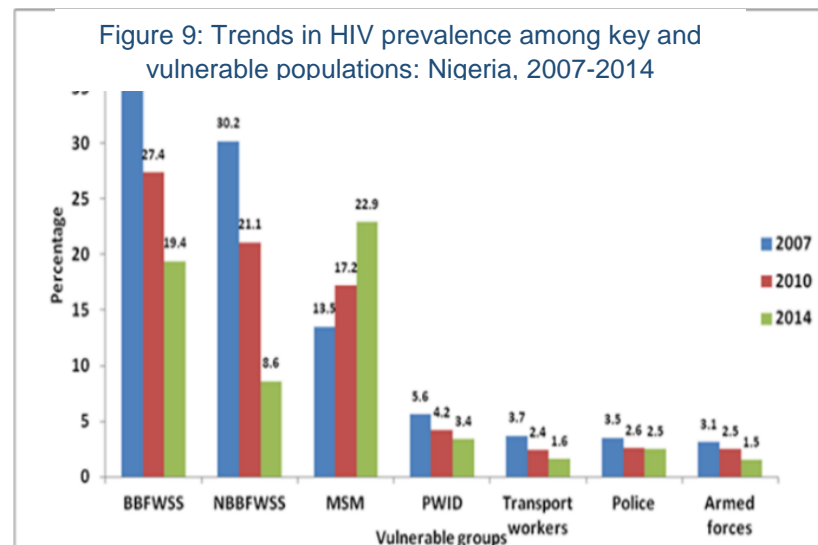
<sup>23</sup> Federal Ministry of Health. 2008. National HIV/AIDS and Reproductive Health Survey 2007. Abuja, FMOH.

<sup>24</sup> Federal Ministry of Health. 2014. National HIV/AIDS and Reproductive Health Survey 2013. Abuja, FMOH.

<sup>25</sup> Obafemi Awolowo University, Institute of Public Health (IPH). 2017. An Action Research to Reduce the Vulnerability of Adolescent and Young People to HIV Infection in Selected States of Nigeria: Preliminary Result of Baseline Assessment. Ile-Ife, IPH.

### HIV in the Key Population Groups

The HIV prevalence among men who have sex with men (MSM) is 22.9% , 19.4% for brothel-based females who sell sex (BBFWSS), 8.6% for non-brothel-based females who sell sex (NBBFWSS), and 3.4% for people who inject drugs (PWID) in 2014 (Figure 9)<sup>26</sup>. Since 2007, HIV prevalence progressively decreased among BBFWSS, NBBFWSS, and PWID, but increased by 50% among MSM<sup>26,27</sup>. This trend among MSM is associated with continued high rate of risky behaviour: for example, in 2014, less than half of MSM (48.9%) reported using condom consistently over 12 months. Even though there are no legal restriction regarding access to health services in Nigeria on the basis of sexual orientation, the country's adoption of anti-homosexuality law in January 2014 may have had an unintended negative effect on the willingness of MSM to seek HIV services in public sector facilities. Evidence from 2016 programme data shows that among the MSM, new HIV infection was highest among age 20-24 with a positivity rate of 7.5%; among FSW those aged 25-49 had highest positivity rate of 8.7%; whilst females aged 25-49 among PWID had highest positivity rate of 12.5%. The result of a local epidemic appraisal<sup>28</sup>, **Error! Bookmark not defined.** shows that the concentration of KPs varies by states and groups (Annex 9-11).



### New HIV infections

Annual number of new HIV infections decreased by 23% in children (from 43,684 to 33,422) and by 9% in adults  $\geq 15$  years (from 192,813 to 180,701) between 2010 and 2016**Error! Bookmark not defined.**. An estimated 214,123 new infections occurred in 2016; Females contributed 54% of these and children contributed 15.6%**Error! Bookmark not defined.**. Five states – Oyo, Akwa Ibom, Lagos, Taraba and Imo – contributed over a third (38%) of all new HIV infections in 2016 (Annex 12).

Figure 10: Trend in Nigeria's TB incidence, TB notified cases and HIV+TB, 2010-2015

<sup>26</sup> Federal Ministry of Health. 2014. Integrated Behavioural and Biological Surveillance Survey. Abuja, FMOH.

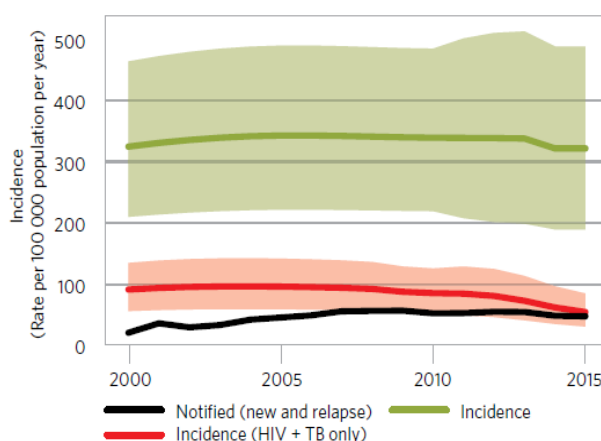
<sup>27</sup> Federal Ministry of Health. 2007. Integrated Behavioural and Biological Surveillance Survey. Abuja, FMOH.

<sup>28</sup> NACA. 2013. HIV Epidemic Appraisals in Nigeria: Evidence for Prevention Programme Planning and Implementation Data From the First Eight States

## HIV and Co-morbidities

Nigeria had an estimated incidence of 100,000 TB-HIV positive cases in 2015. The number of PLHIV screened for TB in HIV care setting increased from <500,000 in 2013 to about 1.4 million in 2016<sup>21</sup>. Notification of HIV/TB has been declining steadily over the last decade (Figure 10). PLHIV commenced on TB treatment increased from 17,102 in 2014 to 27,604 in 2016, and, those on INH prophylaxis increased from 7,973 in 2013 to 62,781 in 2016.

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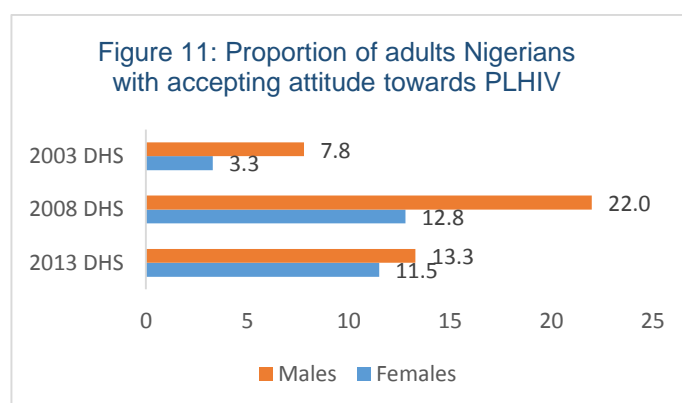
Source: WHO, 2016. Global TB report

The uptake of TB/HIV services among TB patient is also on the increase. The proportion of TB patients with documented HIV status increased from 86% in 2012 to 95% in 2016, while the proportion of HIV positive TB patients on ART increased from 57% in 2012 to 81% in 2016. The CPT uptake increased from 81% to 87%<sup>29</sup>. Lagos, Oyo and Kaduna are the highest burden states for TB-HIV, followed by the FCT, Kano, and Rivers.

Nigeria has an estimated national prevalence of 11% and 2.2% for Hepatitis B (HBV) and C (HCV) respectively<sup>30,31</sup>. The prevalence of HCV among PLHIV is reported as 2.6 - 5%, and 254,200 - 455,700 PLHIV may be co-infected with HCV. There is no routine screening or treatment for PLHIV on ART in Nigeria; this funding application proposes to integrate HBV and HCV screening into the comprehensive HIV services for some key groups.

## Human rights and gender issues

Nigeria enacted a law to protect the rights of PLHIV<sup>32</sup> in June 2014. However, HIV/AIDS-related stigmatisation remains a challenge<sup>33,34</sup>: the proportion of adult population with accepting attitude to PLHIV decreased between 2008 and 2013 (Figure 11)<sup>35,36</sup>. The activities of law enforcement agencies (LEAs) pose a challenge to programming for KPs. The same sex marriage prohibition law, criminalisation of sex work, and the unfavourable policy environment restricts harm reduction



<sup>29</sup> Federal Ministry of Health. 2016. National Tuberculosis and Leprosy Control Plan (NTBLCP) Report

<sup>30</sup> Federal Ministry of Health. 2013. Hepatitis B and Hepatitis C Prevalence Study

<sup>31</sup> National Policy for the Control of Viral Hepatitis In Nigeria; NASCP/FMOH (2015)

<sup>32</sup> Federal Government of Nigeria. 2014. The Act to Protect the Rights of the People living with HIV

<sup>33</sup> Leadership through Accountability Programme: Global Network of People Living with HIV (GNP+), Network of People Living with HIV/AIDS in Nigeria (NEPWHAN). People living with HIV stigma index Survey. 2011. Amsterdam: GNP+

<sup>34</sup> NACA. Plan of Action to remove legal and human rights barriers to HIV and AIDS response in Nigeria

<sup>35</sup> Leadership through Accountability Program: Global Network of People Living with HIV (GNP+), Network of People Living with HIV/AIDS in Nigeria (NEPWHAN). People living with HIV stigma index Survey. 2011. Amsterdam: GNP+

<sup>36</sup> NACA. Plan of Action to remove legal and human rights barriers to HIV and AIDS response in Nigeria

services for PWID<sup>37</sup>. Overall, the GoN has provided enabling environment for programming for KPs in the NSF as part of measures to reduce HIV prevalence among FSWs as a public health issue.

### National HIV Response and Progress towards 90-90-90 Targets

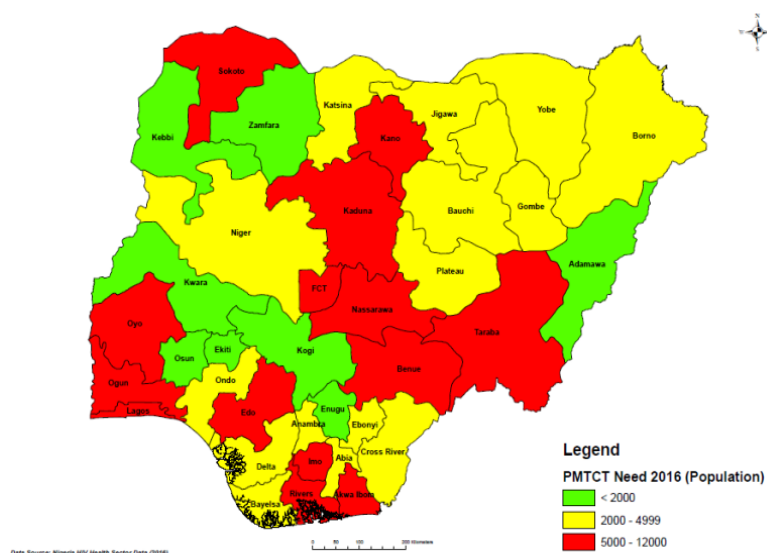
The National HIV and AIDS Strategic Framework 2017-2021 (NSF) embraces the fast-track goals of ending the AIDS epidemics by 2030 and the 90-90-90 agenda, and aims at fast-tracking the national response towards that end. **Error! Bookmark not defined..** Whereas Nigeria has made progress in access to HIV services, the level of unmet need is high and increasing. This funding request aims to close gaps in interventions that are aligned with the NSF and strategically focus on populations and locations with the greatest unmet needs to maximize impact.

In pursuant of the 90-90-90 targets, a cascade analysis of the treatment continuum conducted in 2016 showed that only 1,449,231 of the estimated 3,165,005 PLHIV in Nigeria (45.8%) knew their HIV status. Among those that knew their HIV status, 983,980 (67.9%) are on ART, but the proportion with viral load suppression is not known as this was not previously monitored.

HIV testing uptake has gradually improved, with an increase in the number of people accessing HIV Testing Services (HTS) from about 4 million in 2013 to over 11 million in 2016. The proportion of men and women (15-49 years) who tested for HIV and received their results over a recent 12-month period increased from 6.5% and 6.6% in 2008 to 9.9% respectively to 10.1% in 2013.

Following the adoption of the Option B+ policy, 56,483 women received PMTCT ARV services, while 26,896 HIV-exposed newborns received ARV prophylaxis and 18,556 had virological test (EID) before 2 months of birth by end of 2016. However, trend analysis shows that overall, PMTCT coverage decreased from 41% in 2014 to 35% in 2016. The need for PMTCT is huge in Nigeria and this need increased from 151,778 in 2013 to 159,671 in 2016. The states with high need for PMTCT include Lagos, Ogun, Oyo, Akwa Ibom, Imo, Rivers, Kaduna, and Kano States (Figure 12).

**Figure 12: Geospatial distribution of PMTCT need in Nigeria by states, 2016**



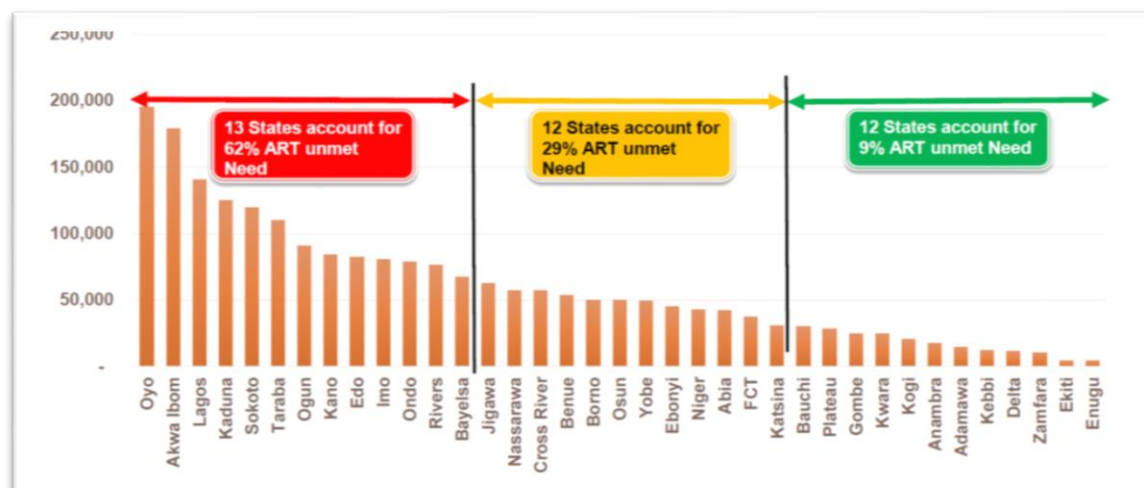
Between 2013 and 2016, the number of PLHIV on ART increased from 639,397 to 927,769, but overall ART coverage declined from 43% to 32% for adults and from 39% to 25% for children. **Error! Bookmark not defined..** The revision of ARV eligibility criterion of CD4 baseline from  $>350\text{cells/mm}^2$  in 2015 and the subsequent adoption of “test and treat all” guideline in 2016 are responsible for the observed increasing number of PLHIV on ART and

<sup>37</sup> Independent evaluation of the scope and effectiveness of intervention activities among people who inject drugs, supported by the Global Fund in Nigeria: The Assessment Report. June-August 2016.



declining ART coverage. The number of adults and children needing ART increased from 1,560,117 to 3,166,593 for adults and from 137,246 to 224,867 for children between 2014 and 2016 respectively. Thirteen states, including Oyo, Akwa Ibom, Lagos and Kaduna, account for 62% of unmet ART needs in Nigeria in 2016 (Figure 13).

**Figure 13: ART unmet need in Nigeria by states, 2016**



Source: NHEIA 2017

**Figure 18: Geospatial distribution of pediatric ART unmet need in Nigeria by states, 2016**

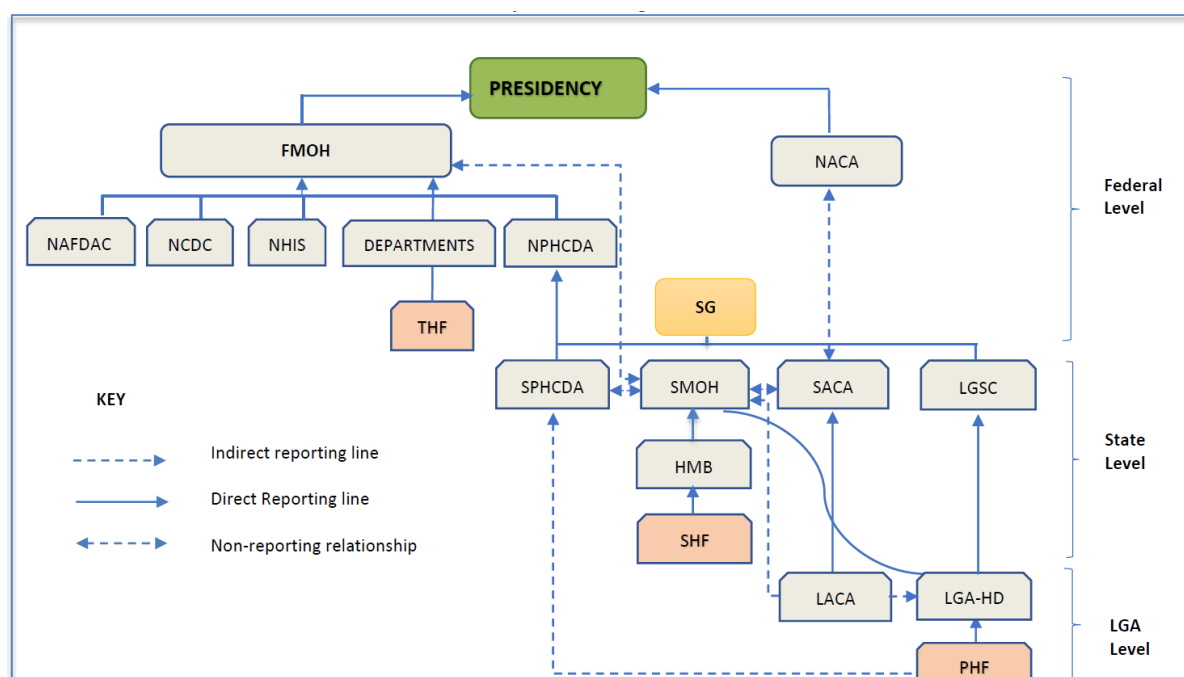
**Figure 19: Geospatial distribution of adult ART unmet need in Nigeria by states, 2016**

## Health System Governance Structure

Constitutionally, health is on the concurrent legislative list: thus, all the three tiers of government – federal, state, and LGA – have responsibilities for health, and the National Health Act (2014) defines the relationship among the three tiers. The national health system consists of: (a) The Federal Ministry of Health; (b) The Ministry of Health in every State and the Department of Health Services in the Federal Capital Territory; (c) Parastatals under the federal and state Ministries of Health; (d) all Local Government health authorities; (e) the ward health committees; (f) the village health committees; and (g) the private health care providers. As part of efforts to improve the health system, Nigeria implemented her first National Strategic Health Development Plan (NSHDP) from 2010 to 2015, and launched a new National Health Policy in 2016 (Figure 1). The End-of-Term evaluation of NSHDP (2010-2015<sup>38</sup>) has highlighted some challenges across the eight pillars of the health system outlined in the NSHDP: the findings inform critical elements of this funding request, with the aim of expanding access to services, improve quality of services, and program efficiencies.

<sup>38</sup> Federal Ministry of Health. The End-of-Term evaluation of NSHDP (2010-2015)

**Figure 14: Governance structure of the Nigerian health system**



The private sector accounts for about 60% of all health facility visits, and out-of-pocket expenditure accounts for about 72% of health spending, while 25% is by government, and 3% from other sources. Current government priority includes strengthening primary health centers (PHC), strengthening disease surveillance system, leveraging efforts of the private sector in health service delivery, and improving the quality of care.

### Procurement and Supply Chain Management (PSM)

Nigeria has achieved some strides in addressing challenges in health product management over the years. At the governance level, the FMOH established the National Products Supply Chain Management Program (NPSCMP), with the mandate for effective coordination and management of health commodities across all levels. In addition, the National Supply Chain Integrated Project (NSCIP) was established to fast-track the achievement of an integrated supply chain system that meets the needs of the 5 program areas – AIDS, TB, Malaria, Reproductive Health and Vaccines (ATMRHV). Nigeria now has, for the first time, a National Supply Chain Policy for Pharmaceuticals and Other Health Care Products<sup>35</sup> and National Supply Chain Coordination Framework to guide PSM for public health programmes at all levels. Nigeria has also successfully set up of one fully functional Warehouse-in-a-Box (in Abuja) with a second one to become operational in 2017 as well as four additional Warehouse hubs across the country to address the issues of stock-outs. These steps have enabled Nigeria to significantly reduce the challenge of weak coordination and wastages. This funding request builds on these achievements and structure. Inadequate capacity at sub-national levels in inventory and stock management; inadequate quality assurance and quality control testing of health products; and, inadequate storage capacity at some state stores and facilities are current challenges.

### Health Management Information System (HMIS)

The country has recorded progress in the HMIS structures and functions. These include the development of the Health Information System Policy (2014)<sup>39</sup> which prescribed a single

<sup>39</sup> Federal Ministry of Health. 2014. National Health Management Information System Policy

platform (DHIS 2) for health data management across the country, and the inauguration of Health Data Governance Council (HDGC). Strengthening of the data infrastructure through the review of indicator sets and national indicator reference lists; and development of an updated Master Facility List (MFL) are also ongoing. There has been progressive increase in completeness (from 56% to 71%) and marginal increase in timeliness of data reported from PHCs on DHIS2 (from 45% TO 50%) between 2014 and 2016. However, there is still some continued fragmentation and poor coordination in NHMIS as exemplified by multiple or parallel data reporting platforms such as eNNRIMS, DATIM, eTB, & DVDMT. Others challenges include: poor capacity of M&E officers; inadequate IT infrastructure at sub-national level; delay in the production and reporting of routine data; poor data quality<sup>40</sup>, and limited data reporting from the private sector.

### Leadership and Governance

Nigeria's health system has several coordination platforms, including the National Council on Health (NCH); Health Partners Coordinating Committee, Development Partners Group, and Thematic Technical Groups at the national level. These platforms have the potential to contribute to improved collaborations, outcomes and efficiencies. This funding request aims to build stronger collaboration and synergy with PEPFAR Nigeria program, and strengthen the linkages and integration of HIV, TB, and sexual, reproductive, maternal, newborn, child, and adolescent health (SRMNCAH) services; the coordination platforms become important in this wise, and need to be further strengthened.

### Human Resources in Health

Nigeria has a new National Human Resources in Health (HRH) Policy (2015-2019) to provide strategic direction on HRH issue as the country still faces considerable challenge in HRH. Inadequate number and inequitable distribution of skilled workers are major challenges. Nigeria developed the "National Task-Shifting and Task-Sharing Policy for Essential Health Care Services in Nigeria in 2014<sup>41</sup> "to meet the universal health coverage and health needs of the Nigerian population through the mobilization of available human resources, to ensure equity, accessibility, and effectiveness in the delivery of essential health care services". The Policy has significant implication for expanding services particularly at the PHC and community level.. There is the need to develop the roadmap for the implementation of this policy at federal and state levels. A dynamic human resource information systems (HRIS) linked to the DHIS2, is needed to continuously update the HRH information needed for planning and adequate resource mapping. Nigeria also needs to develop a National Technical Assistance Plan to harness international expert resources. Training and retraining is important to ensure that health workers are skilful and technically up-to-date in their practices..

### Service Delivery

The primary healthcare level has 85.5% of health facilities in Nigeria, while secondary and tertiary levels have 14% and 0.2% respectively. The National Primary Health Care Development Agency (NPHCDA) adopted the Ward Health System in 2000 for the delivery of PHC services in Nigeria.. As at 2013, 3,610 out of the 9,522 wards (38%) have been formed/reactivated in line with the PHC implementation guideline (2000), and through the support of the government and development partners. These efforts need to be continued and sustained particularly in view of the ongoing PHC revitalization agenda, which is designed to cover 10, 000 PHCs for improved quality care nationwide using a phased approach. In addition

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<sup>40</sup> Global Fund Country Team Portfolio Analysis of Nigeria Grant (2017)

<sup>41</sup> Federal Ministry of Health. 2014. Task-Shifting and Task-Sharing Policy for Essential Health Care Services In Nigeria. Abuja, FMOH



to promoting availability to, and access to health facilities, the quality of service and demand for services are also critical in Nigeria.

## Community Responses and Systems

The review and activation of community tools on DHIS2 NHMIS platform has contributed to improved community level health data reporting. Gaps that exist with regards to the community systems' response to HIV/AIDS, TB and Malaria (ATM) include: comparatively weak operational capacity; weak coordination of various community systems and structures; and, the absence of a national framework for community systems operations. The strategic objective of investing in the community systems in this grant will be to strengthen the community system and improves its linkages within the healthcare system; strengthen the health care structures including networks of PLHIV and KPs, and build the capacities of community actors across the testing-prevention-treatment care cascade, and strengthen the mechanisms for performance monitoring and accountability.

### 1.3 Past implementation and lessons-learned from Global Fund and other donor investments

- a) List recent disease-specific Global Fund grants from the 2014-16 allocation period and summarize key lessons learned from their implementation.
- b) Include lessons-learned from specific HSS grants or any HSS investments embedded in the disease-specific grant(s) from the 2014-16 allocation period as applicable.
- c) Outline lessons learned from investments by other donors as applicable.

For each of the above, explain how these lessons learned are taken into account in this funding request.

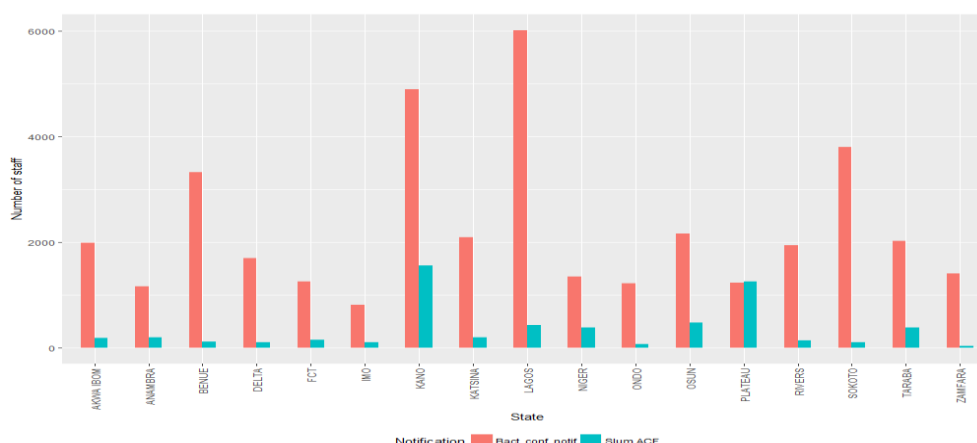
**(maximum 1 page per component)**

## I. LESSONS LEARNED FROM TB RESPONSE IN NIGERIA

1. **Prolonged grant-making process** resulted in delayed take off the grant and engagement of SRs resulting in delayed implementations of activities. All relevant documents should be worked on and made available during grant-making. SRs should be also be selected during grant-making
2. **Implementation of active case search (house to house)** for increasing TB case notification did not produce the desired results in some of the places where it was carried out. Priority geographies include high density settings including slums which were also prioritized in the last GFATM cycle focusing on active case finding in slum areas with important lessons learnt in its implementation. Overall bacteriologically confirmed TB case notification in a large part is due to ACF in slums. The contribution of the ACF approach to total state case notification ranges from 2 to 50% across States with Katsina, Sokoto and Zamfara States achieving 2% each while Plateau State achieved 50% from the intervention<sup>42</sup> Despite issues with the quality of data available, there are indications that ACF among the KAP's (among Nomads, Qur'anic schools) has a potential of improving the TB Case

<sup>42</sup> Although 22 States conducted Active TB Case Finding in Slums using the House-to-House approach, 17 States submitted data, which is analysed and presented above.

Notification. However, a more systematic evaluation of the yield from the active case finding and contract tracing initiatives are needed.



Future implementation will be tailored in areas expected to produce better results focusing on key populations at risk.

3. **Diagnostic algorithm and Paediatric Desk guide** provided to assist diagnosis of TB in children but did not produce to desired result. Training and re-training with linkage and close collaboration with RMNCAH will be the main focus in future.
4. **Irregular power supply** limited the optimisation of GeneXpert. Going forward, GeneXpert procurement (not included in this FR) must be supported with provisions for alternative power supply system.
5. **One-off sensitization of HCWs** by TB program at the GeneXpert hub and spoke sites improved service demand and utilization. Sensitization of health workers within the catchment areas should be planned while planning the optimization of GeneXpert.
6. **Sputum transportation** from peripheral clinics/communities to laboratories/GeneXpert sites needs improvement to ensure good quality sputum arrive at the processing sites.

**TA provided by WHO** in the mapping of health facilities for DOTS expansion resulted in increase in health facilities and laboratories providing DOTS services. WHO is leading teams that assess and select health facilities and laboratory for DOTS expansion plus facilitating follow up training for staff in facilities/labs earmarked for introduction of TB services. This is in addition to on-going mentorship and supervisory support that WHO NPOs undertake alongside national TB programme managers; facilitation of quarterly collation of TB programme monitoring data at state and zonal level and development of various TB normative documents and service delivery tools. These tasks are expected to remain critical in next grant hence WHO is being identified to continue.. This should be continued.

7. Use of **third party logistics** and introduction of last-mile distribution improved accessibility to drugs and other commodities for end-users.
8. **Poor PHC infrastructure** made DOTS expansion very challenging. Upgrade/refurbishment of DOTS and microscopy centres is needed to make them functional; investment in facility upgrade by Government and the Global Fund is necessary.

#### Other lessons from other projects<sup>43</sup> supporting NTLCP 2014-2016:

The KNCV is obtaining good results from strategies such as: Contact tracing and examination of index TB cases (DS-TB and DR-TB); Engagement of Patient Medicine Vendors to conduct

<sup>43</sup>USAID: (TBCARE I/CTB (KNCV); PEPFAR: SIDHAS project (FHI360), PROACT (MSH), IHVN, APIN, CRS, CIHP; CIDA (TB REACH); WB, CHAI, AGBAMI partners project (Shell, Chevron)

symptom screening and refer; and, Introduction of 'referral coordinators' at LGA and facility level have yielded encouraging results.

## II. LESSONS LEARNED FROM HIV RESPONSE IN NIGERIA

### Lessons learnt from the NFM (December 2016) which will be built upon:

1. Prioritization of interventions for the NFM grants was based on an all-inclusive consultation with stakeholders: this improved collaboration and relationships between partners.
2. Active engagement of community structures for monitoring uptake of services at the facilities reduced friction between PHCs and CBOs, and increased service coverage
3. Joint outreach sessions by Health Facility and Community actors improved linkage of HTS and ART enrolment. Integration of HTS with other services also increased coverage
4. Involvement of the government and national and state partners/stakeholders in the design, implementation and evaluation of the program enhanced the sense of ownership
5. Use of health facilities that offered integrated HIV services (Activating CBOs as One-Stop Shop) increased service uptake by key populations (KP)
6. Accompanied referral from the community-based HTS to health facilities contributed to improved linkage to treatment and care for KPs.

### What did not work/challenges and how they will be addressed:

1. **Activities of law enforcement agencies (LEAs) challenged programming for KPs:** Need to target LEAS units in programming and build strategic partnership with them
1. **Low yield of HIV positives from the general population HTS:** The mobile HTS conducted among the general population yielded positives of less than 3%. PEPFAR's experience also show that the greatest yields of HIV positives cases have resulted from facility-based testing instead of community-wide general testing. . To achieve greater yield, community HTS should be more tailored to high risk and vulnerable groups such as partners of KPs, communities around brothels, "hotspots", fishing communities, IDPs, artisans with disposable income, and transport corridors. This request will apply lessons learned from both Global Fund grant and PEPFAR to inform scale up and build synergies for impact.
2. **Excessively long procurement process by IDA** resulted in non-availability of RTKs for KP programming. The country should adopt the Pooled Procurement Mechanism, which will guarantee the availability of all commodities within a short period.
3. **Low yield of HIV positives in the prioritised 12+1 States for PMTCT intervention.** The HIV yield from PMTCT services in the 12+1 states was low. Next grant will focus on LGAs with high burden and unmet needs drawing from PEPFAR's experience to
4. **The complexity of the budgeting template** made it difficult for implementers to track and for assurance provider to also understand during reviews. The budgeting template needs to be reviewed to make it user-friendly

### Lessons learnt from investments by other donors

1. The **state of data** poses a programming challenge as positivity yield from program data does not align with spectrum estimates. Stakeholders and government agree that a National AIDS survey is required to get a better picture of the epidemic and stronger epidemiologic evidence
2. Data from PEPFAR scale up LGAs have shown that some **novel strategies** such as partner testing and index patient family testing are yielding positive results: these strategies will be adopted for this grant.
3. PEPFAR has significant investments in Nigeria and currently operating in 32 LGAs in 7 scale up States (Akwa Ibom, Lagos, Rivers, Benue, Nasarawa, Cross Rivers and FCT). The massive treatment by PEPFAR has demonstrated that focusing on the right

populations in the right geographic areas makes a difference at the sub national level. This is a **demonstration of a proof of concept** along the UNAIDS 90-90-90 goal of achieving epidemic control. This is going to be the strategic direction for treatment in this funding request application.

4. **Using evidence** of disease burden and unmet need to program at subnational level is strategic, ensuring target populations were reached and resources used efficiently and effectively
5. **Consistent and open communication between the Global Fund and PEPFAR** program resulted in ceding of sites to each other to avoid potential double counting and duplication of efforts in same geographic areas. This engagement also served as an avenue to harness other resources like RTKs when GF supply was delayed.

### III. LESSONS LEARNED FROM BUILDING A RESILIENT AND SUSTAINABLE SYSTEM FOR HEALTH IN NIGERIA

Lessons learned from the NFM (December 2016) that will be built upon:

1. **Use of electronic tools for procurement processes improved timely availability of health products:** NFM-supported the development of electronic tools for procurement process improved commodity availability. There is need to strengthen and sustain this gain through joint ATM bi-annual quantification review workshops.
2. **Enhanced quality assurance of products and drug safety monitoring improved reporting:** Robust collaboration between disease programs and regulatory agencies resulted in spontaneous pharmacovigilance reporting. There is need to sustain this effort through establishment of joint drug review mechanism and active drug safety monitoring and management. Implementation of anti-microbial resistance plan for HIV, TB and malaria through conducting of drug-resistance surveillance activities is also important.
3. **Improved collaboration and engagement of community actors increased service delivery and case detection:** Involvement of all relevant stakeholders in program design, implementation and monitoring strengthened led to reduction in the lead-time between diagnosis and enrolment in care.
4. **Decentralization of drug warehousing and logistics management reduced lead time of re-supply:** Investments in NSCIP for decentralization of national medical store into 2 central zonal stores and establishment of 4 additional zonal stores to act as regional hubs effectively reduced lead time for logistics management. This could be strengthened by establishment of emergency response system for re-distribution at State and local government levels
5. **Investment in lab infrastructure improved functionality of laboratory network to meet UHC target:** Progressive laboratory network expansion during current grant resulted in significant increase in the proportion of bacteriologically diagnosed TB patients, confirmed malaria cases, and PITC activities. More investment in laboratory infrastructure upgrade, equipment and capacity building would improve case detection and break in disease transmission cycle.
6. **Investments in NHMIS by national partners improved data management:** Significant investments were made by Global Fund, Bill & Melinda Gates Foundation (BMGF), GAVI and the World Bank in capacity building of health workers, data infrastructure (provision of laptops, mobile devices and registers) and web platform to improve data reporting to DHIS2. To enhance/sustain the gains, there is need to expand adoption of DHIS2 platform to all public and private facilities and community based health services through further investments in data infrastructure and capacity.
7. **Absence of unified national advocacy mechanism resulted in poor articulation and adoption of best practices at subnational levels:** There was fragmentation of advocacy mechanisms resulting in missed opportunities for effective engagement of policy makers towards domestic resource mobilization. This highlights the need for development of a joint ATM advocacy tool kit and plan to influence policy makers.

8. **Poor coordination has delayed integration of all reporting platforms with DHIS2:** Despite improvements made in data reporting to DHIS2, there is continued fragmentation and poor coordination as exemplified by multiple or parallel data reporting platforms such as eNNRIMS, DATIM, eTB, & DVDMT. Funding and other logistics challenges resulted in the DHIS2 lagging behind other program platforms that have achieved various levels of real-time data capture; hence, delaying adoption of NHMIS platform as national instance for data management. There is the need to support the process of integration and interoperability of all platforms with DHIS2.

Overall, the lessons from the previous Global Fund grant as well as lessons from investment by other donors with respect to the three components covered by this proposal – TB, HIV, RSSH – will be taken into cognisance, and built upon in the implementation of the new grant. The new grant and its service coverage will complement the investment already made by other development partners and PEPFAR programme.

## SECTION 2: FUNDING REQUEST (Within Allocation)

This section should describe and provide a rationale for the program elements proposed for this funding request. Attach and refer to completed **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework and Budget**, and refer to national strategy documents as applicable.

To respond, refer to additional guidance provided in the *Instructions*.

Ensure that the funding request as described in questions 2.1 and/or 2.2 meets the focus of application requirement as outlined in section 2.3.

### 2.1 Disease-specific funding request

Not applicable if the application is a standalone RSSH request.

Given the context and lessons learned outlined in Section 1,

- a) Describe the disease-specific funding request(s), the rationale for prioritizing modules and interventions, and how these choices ensure the highest possible impact with a view to ending the three diseases and removing human rights and gender-related barriers to accessing services.

For any priority modules for which gaps are difficult to quantify in the programmatic gap tables, explain here the barriers being addressed, the proposed interventions and the population or groups involved.

- b) Explain how the funding request addresses the key funding gaps reflected in the Funding Landscape Table(s) for the disease program(s) in the current allocation cycle, and specify other actions planned to cover remaining gaps.

For funding requests including both HIV and TB components:

- c) Describe the coordination of joint TB and HIV strategies, policies and interventions at different levels of the health system, including community systems, and expected impact and efficiencies from the joint programming.

Ensure the answer appropriately reflects the separate disease programs in addition to cross cutting modules where appropriate.

**(maximum 4 pages per component)**



## 1) PART A:

### I. THE OVERARCHING STRATEGY AND PROJECTED OUTCOME AND IMPACT

This funding request is based on a comprehensive epidemiology and response analysis (reports of which are attached), lessons learned from past investments, current global evidence and need to build greater synergy with PEPFAR Nigeria program for greater impact and cost-efficiency. Investment approach has been used in shaping the application. The proposed interventions fully aligned with the country's HIV NSF and TB NSP and global fast-track goals for AIDS and End TB Strategies.

Based on the investment approach used, the country seeks to maximise impact and cost-efficiencies by targeting high burden populations and geographical areas; focusing on largest coverage gaps that and efficiencies in addressing them. Intervention areas included are classified into three broad strategic approaches based on epidemiologic factors:

**1a. Scale-up States for integrated HIV interventions:** These are States with highest unmet needs for HIV services based on analysis done plus States that Nigeria earlier reached an understanding on with GF to feature as PRs (Lagos, Oyo, Imo, and Kaduna) in upcoming grant. Analysis used for selection of states is based on following criteria: (a) Potential programmatic yield (HIV sero-positivity rate, TB active case finding rate); (b) High unmet need for ART and PMTCT; (c) high TB burden and 'missed cases'. **Eight states are in this category: Lagos, Oyo, Kaduna, Imo, Ogun, Akwa Ibom, Kano and Rivers.** These States account for 38% of the burden of HIV, 45% of all new HIV infections and 44% of unmet need for ART and 36% of need for PMTCT. Therefore, these States will be the focus for new investments in ART for adults and children, PMTCT and TB/HIV interventions. Majority of the states are also among those prioritized by TB for intensified TB case finding interventions. Within these States, strategic focus will be on high burden LGAs, which have GF presence and covering geographic areas contiguous to PEPFAR LGAs which are not adequately covered. The Government of Nigeria will continue to scale up HIV interventions Abia and Taraba. In addition, the Government plans to close ART and PMTCT gaps in Benue, Nasarawa, Kaduna, FCT and Cross River States. The desire is to "saturate" selected LGAs in scale up states in terms of HIV interventions coverage, based on lessons learned, and drawing from PEPFAR experiences for complementarities and building synergies for impact.

**1b. Scale-up States for integrated TB case finding:** Prioritized states for TB case finding are in two groups. The first is that of 14 states with largest gaps in TB notification and TB services access where scaling-up of health facilities based identification and referral of presumptive TB cases is focused on. The 14 states account for 50% of missing cases and are: Lagos, Kano, Kaduna, Katsina, River, Oyo, Bauchi, Jigawa, Anambra, Imo, Borno, Delta, Niger and FCT. The second group of prioritized states for TB case finding are those to be targeted for active case finding in slums and congregate settings – Lagos, Oyo, Kano, Osun, and Kaduna: these five (5) states demonstrated significant yield in case finding as described in lessons learnt section. **Thus, 14+1 states are in the scale-up category on the whole: Lagos, Kano, Kaduna, Katsina, River, Osun Oyo, Bauchi, Jigawa, Anambra, Imo, Borno, Delta, Niger and FCT**

**2. Maintenance States:** Current GF investment for ART, PMTCT and TB covers all Nigeria's 36 states and the FCT. The application proposes to maintain current facility level services for ART, PMTCT and TB. This will include maintaining those on ART and maintaining PMTCT and TB facility-based services in all states that are not part of the "Scale up States". For HIV, 28+1 states are in this "non scale up" category. For TB, 17 states are in this "non scale up" category. 'Natural' ART scale up of 5% has been factored based on PEPFAR data and experience in PEPFAR's "non scale up" states. Hence, projection of additional PLHIV to be added to existing pool of people on ART in "non scale up" States take due cognisance of this

data. Projections for PMTCT enrolment will be made on the number on PMTCT cases that previously exist in the state in the current grant, plus a 5% increase. For TB, facility based routine case findings and treatment services will continue in these States as usual.

**3. Tailored key population intervention States:** These are States with high burden of infection among specific high burden population group – HIV KPs and TB KAPs. For the HIV component, this group consist of 10 States – the nine States that were the priority States for KP-targeted interventions under the current grant, and Kaduna that is a high burden State for MSM and FSW in the current epidemiologic analysis. **The 10 tailored intervention States for HIV component are: FCT, Anambra, Kano, Edo, Enugu, Gombe, Imo, Lagos, Oyo, Kaduna.** For TB, **slums dwellers in 5 states – Lagos, Oyo, Kano, Osun, and Kaduna States are prioritised** as the 5 States demonstrated significant yield in case finding under the current NFM grant, when similar intervention was implemented in 20 States.

## II. INVESTMENTS FOR TB FROM 2018 TO 2020

The prioritised modules for the TB component are:

- DS-TB care and prevention
- MDR case detection and diagnosis
- MDR-TB treatment
- TB-HIV collaborative interventions.

### Key outcomes

**The outcomes expected** from the investment for TB in this grant period include:

1. Doubling of the case detection rate, adding 479972 DSTB patients.
2. Establishment of additional 895 DOTS centre to increase population coverage to 1 per 25000 population and 1430 microscopic centres.
3. Treatment of more than 13809 DRTB patients by end of 2020.
4. Increase in number of private sector participation with 70% of such facilities covered with a focus on faith based facilities and PPMVs.
5. Enhanced civil society participation in TB Care and Control at all levels resulting in an expected 30% of contribution from this sector.

The strategies employed in these modules is as follows:

Finding the missing cases in Nigeria : Strategies and Interventions					
TB control in Nigeria is confronted with a diverse epidemiology, funding gaps, a fragmented health system, lack of awareness, high out of pocket expenditure on health, food insecurity and malnutrition, all of which continue to fuel the epidemic....					
<b>Intensified TB screening and diagnosis in 400 high burden health facilities of adults &amp; children</b>  1. TB screening in all health facilities and all OPDs using symptom & X Ray screening 2. Referral linkage with DOTS facility 3. Intensified TB case finding among PLHIV in HIV care settings and communities	<b>Active and systematic TB screening of the key affected population</b>  1. Active contact tracing 2. Reverse contact tracing of paediatric TB contacts 3. Rolling out point of care TB testing in HIV care settings 4. Active case finding in slums and congregate settings 5. Children in MCH including nutrition clinics, child welfare clinics, and the Orphan and Vulnerable Children (OVC) programme 6. Symptom & X Ray screening	<b>Private sector involvement</b>  1. Engagement of the professional bodies 2. TB services in the five largest faith based network of institutions covering whole country 3. Support the PPMVs and individual medical practitioners 4. Use of IT for notification 5. Mobilize resources & TB expansion from corporate partners	<b>Lab &amp; DOTS services expansion</b>  1. Expand basic TB services across 14 states with low case detection 2. Strengthen & expand sample transport mechanism 3. Optimization of GeneXpert 4. Installation of 150 solar refrigerators for sample storage 5. Increase of microscopy labs 6. identification and referral of presumptive TB cases 7. Electronic TB reporting system expanded to all GeneXpert sites 8. Expansion of TB reference labs, DRTB treatment centers and access to SLD	<b>Demand creation to enhance service utilization</b>  1. Multi media national and state level campaign 2. Community awareness and engagement of CSO's & community gate keeper 3. Use TB ambassadors for raising the profile of the prog.	<b>Create enabling environment</b>  1. Social support to TB patients: Link TB patients to existing social schemes – insurance, etc. 2. RSSH complementarity   X Ray cost

### Module 1: DS-TB care and prevention

The highest priority gaps to be addressed by this funding request are the missing TB cases. The country currently detects only 17% of the estimated incident TB cases each year, this allows for significant ongoing transmission and associated high morbidity and mortality. Most worrisome is the proportion of “missing” cases among children, where 92% of the incident TB cases among children are being “missed”<sup>44</sup>.

The interventions prioritized and detailed below ensures that the “missed” cases are brought under the ambit of the program, with more children with TB diagnosed, new infections prevented, and systems geared to support these interventions. These strategies and interventions are an assimilation of the detailed state specific gaps identified in the programmatic gaps analysis, a copy of which is presented in Annex 13.

### 1. Intensified TB screening and diagnosis in 400 high burden health facilities:

Adult and children visiting the high burden facilities will be systematically and routinely screened for TB to find all the “missing” TB cases within the health facilities. The routine TB screening will be conducted in every unit and department in the health facilities including OPD, paediatric units and special children clinics in the 400 high burden facilities across the country. The symptomatic screening tool and x-ray will be used as screening tool while GeneXpert MTB/RIF will be used for the diagnosis in line with the national algorithm. The 400 high burden facilities are majorly all the tertiary institutions and some secondary health facilities in the country. The Hospital DOTS linkage will also be strengthened.

### 2. Active and Systematic TB screening of the key affected populations:

- a. **Contact of bacteriologically positive TB patients: Active contact tracing** will be conducted for contacts of bacteriologically positive TB patients in the 400 high TB burden facilities across the country by community health workers in collaboration with DOTS staff. **Reverse contact tracing** will also be conducted for contacts of index childhood TB cases. A TB REACH project in Pakistan revealed that the smear positive TB prevalence among contacts of index smear positive cases is as high as 2,553 per 100,000 populations<sup>45</sup>. To implement this, screening algorithm used will involve symptomatic screening followed by chest X-ray and diagnosis with GeneXpert in line with the national guideline.
- b. **PLHIV:** The TB program in collaboration with the HIV program will intensify TB screening among PLHIV which is currently at low level (see TBHIV module)
- c. **Active case finding in slums and congregate settings (Slums dwellers in Lagos, Oyo, Kano, Osun, and Kaduna states).** In the current NFM grant, this intervention was implemented in 22 states, the above-mentioned five (5) states demonstrated significant yield in case finding. The 2016 TB epi-analysis also showed that the house-to-house case search conducted in selected slums in these 5 states contributed up to 20% of bacteriologically diagnosed TB cases in their respective states and was responsible for the 10% increase in TB case finding observed in the country in 2016. This is in line with a study in Nigeria, which showed that community-based activities targeted at urban slum populations identified a different TB case population than those accessing stationary services by passive case finding<sup>46</sup>. Community volunteers will be engaged to identify presumptive TB patients in selected slums and congregate settings like prisons, barracks, orphanages, Qur’anic schools and IDP’s in the 5 states. The interventions will aim to improve case finding in high-risk populations in a cost efficient way. This will be supported by a high visibility, repetitive, intensive and persuasive, national and state campaign for

<sup>44</sup> WHO Global TB Report 2016

<sup>45</sup> Improving TB case detection: A compendium of TB REACH case studies, lessons learned and a M&E framework  
[http://www.stoptb.org/assets/documents/resources/publications/technical/TB\\_Case\\_Studies.pdf](http://www.stoptb.org/assets/documents/resources/publications/technical/TB_Case_Studies.pdf)

<sup>46</sup>Abdurrahman, S.T. et al. “Are Patients with Pulmonary Tuberculosis Who Are Identified through Active Case Finding in the Community Different than Those Identified in Healthcare Facilities?” *New Microbes and New Infections* 15 (2017): 35–39. *PMC*. Web. 28 Apr. 2017.



case-finding and community commitment from the states and LGAs. The use of a mobile laboratory facility including digital X-ray and GeneXpert will also be piloted in these cities

- d. **Children in maternal and child health services including child welfare clinics and the Orphan and Vulnerable Children (OVC).** With collaboration between the family health department of the Federal Ministry of Health and the HIV program, TB screening will be integrated into maternal and child health services and other special children clinics at tertiary, secondary and primary health care facilities. Also, there will be integration of routine active TB screening into programs for orphans and vulnerable children (OVC) in collaboration with Federal Ministry of Women Affairs.

### 3. Engaging private health care providers in TB diagnosis, treatment and prevention

Currently there are 6,620 DOTS facilities out of which 780 are private DOTS facilities in the country (12%) and this also amounts to 7% of total private facility coverage in Nigeria (780 out of 11,323)<sup>47</sup>. This proportion of the private facilities contributed 13% of total TB case notification in 2016. To address the challenges of the private sector engagement, the strategic interventions proposed for this sector are:

- a. Develop relevant national framework and programmatic guidelines for private sector engagement in the national TB programme
- b. Engagement of the professional bodies (AGPMPN, Association of Private Nursing Practitioners, Association of Community Pharmacists, NMA, Association of PPMVs), to create a gateway for service provision among its member. The program will also provide continued medical education (CME)/continued professional education to encourage and attract participation of members in TB program activities.
- c. Private sector driven expansion and implementation of TB services through the engagement of major faith-based institutions, which are well structured and a hugely patronized health system in the country (Catholic, ECWA, COCIN and Ahmadiya).
- d. Well-coordinated patent and proprietary medicine vendors (PPMVs) program/interventions in states with huge private presence and with high TB burden (Lagos, Kano, Rivers, Anambra, Rivers). Dedicated PPM team will drive rapid expansion of services, supervision, monitoring and reporting of TB services in the private sector.
- e. Engagement of corporate organizations (Agbami Partners, Communication companies) for resource mobilization and expansion of TB services.
- f. Strengthening coordination and policy environment for successful PPM implementation through the current PPM steering committee whose responsibility will include advocacy and resource mobilization.

### 4. Optimizing the utilization and increasing access to GeneXpert:

The country, in 2016, adopted the use of GeneXpert as the primary TB diagnostic tool and as at end of March 2017 there are 377 GeneXpert machines installed in the country (with 195 of the machines procured with Global Fund grant). With the progressive increase in the number of Genexpert machine, the number of test conducted increased from 52,967 in 2015 to 170,416 in 2016. However, the average number of tests being conducted using these machine is presently sub-optimal due to a number of operational challenges. Under the new grant, all the GeneXpert sites will be supported to function optimally by addressing challenges identified during the National Lab assessment and gaps noted during the implementation period through: (i) demand creation activities; (ii) maintenance and change of failing modules; (iii) provision of solar inverters and solar refrigerators; (iv) renewal of warranties; (v) strengthening sample movement and result retrieval to reduce the turnaround time through engagement of vendors for integrated sample shipment for

<sup>47</sup> Federal Ministry of Health. 2011. Directory of health facilities in Nigeria; and NTBLCP DOTS data Genebase

diagnosis, baseline and follow up investigations for DS and DR-TB, (vi) and strengthening HR for service delivery and incentive for overtime; and (vii) procurement of cartridges. The optimization of these sites will be done in collaboration with the HIV programme and the USG/PEPFAR program.

With the optimization of the current 377 GeneXpert machines to perform an average of 12-16 test per day, a total of 663,520 test will be conducted in a year. However, based on the target for case finding, the estimated number of test annually for 2019 and 2020 (835,155 and 959,325 test respectively) far exceeds the capacity of the machines. The current machine are skewed in their distribution as only 250 out of the 774 LGAs in the country have at least one GeneXpert machine. Therefore, additional 168 Genexpert machine will be required to address gap in testing and access.

Additionally, the electronic TB reporting system (ETB manager) will be maximized and expanded to all GeneXpert sites to capture all presumptive TB cases tested and the outcomes. This will help to reduce the missing cases along the line of diagnosis and treatment.

- 5. Engage health facilities in identification and referral of presumptive TB cases** to address gap in TB notification and achieve universal access coverage for TB services. This intervention intends to expand basic TB services (TB identification and referral of Presumptive TB cases) to non-DOT health facilities across 14 states, which accounts for 50% of the missing cases: Lagos, Kano, Kaduna, Katsina, River, Oyo, Bauchi, Jigawa, Anambra, Imo, Borno, Delta, Niger and FCT. The health facilities will be sensitized on TB, provided with screening tool and TB service directory. Using the Hub and spoke model, identified presumptive TB cases are referred from this health facilities (spoke) to the closest DOTS centre (hub).
- 6. Expansion and enhancement of microscopic and treatment services to increase access to care.** The number of DOTS centre increased from 5863 in 2015 to 6620 in 2016. The plan is to have 7110 DOTS facility by end of 2017 with current NFM grant contributing 1655 DOTS centres. The program with the new grant will establish additional 895 of DOTS centre to increase population coverage to 1 per 25000 population. The expected number of microscopic centre by end of 2017 is 2570 with the NFM contributing 1264 centres. The program, with the new grant, will establish another 1430 microscopic centres.
- 7. Strategic demand creation to enhance service utilization:** There will be improved awareness on TB through strategic media, community awareness and engagement of community gatekeeper. The scale up of the strategy will be informed by the outcome of the planned evaluation of the current implementation. Key focus will be to ensure that people are aware of TB symptoms and how to access care.

## **Module 2: MDR case detection and diagnosis**

Nigeria has an estimated incidence of 29,000 DR-TB cases<sup>48</sup>, yet a mere 5.8 % ( 1689) of this cases were notified in 2016. The 1686 patients notified in 2016 account for 20% of the estimated country NSP target (8359). Access to DST also remains low as only 40% and 64% notified cases among new and previously treated TB cases were tested for Rifampicin resistance (RR) TB<sup>48</sup>. Similarly, case notification of XDR-TB remains very low, with only one XDR-TB case diagnosed and treated in 2015 and none in 2016. Overall, serious efforts will be made to tackle MDR and XDR-TB case detection and link patients to care.

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<sup>48</sup> Global TB report, 2016, WHO.

To address the gaps and challenges (reasons explained in section 1.2 and 1.3), Nigeria intends to reinforce quality DR-TB diagnosis and treatment through the following measures.

- **Optimization of GeneXpert and strengthening specimen referrals for all cases to be tested for TB** (see DS-TB section) will lead to an increase in RR TB case detection as described in module 1 above. All cost relating to Genexpert and sample movement will be under this module.
- **Expansion of TB reference labs.** There has been significant progress since the last joint international laboratory assessment in March 2016<sup>49</sup>. Currently there are 8 functional reference laboratories with the capacity for first line DST, however only 4 have the capacity for second line DST. By the end of 2017, the remaining 4 reference laboratories will be upgraded to have capacity for second line DST. In this grant application, therefore, there will be upgrade of 4 new TB reference laboratories to improve access to second line DST.
- **Improve access to quality diagnostic care.** There is an existing EQA for all laboratory services. This will be strengthened to improve quality of service. Areas with low human resource will be supported with adequate HR.
- **Strengthened surveillance for DR-TB** at all levels will improve DR-TB case notification which requires sensitization of service providers and strengthening of electronic data management systems.

### Module 3: MDR-TB treatment

In 2015 and 2016, 52% and 74% of diagnosed DR-TB patients were initiated on treatment respectively<sup>50,51</sup>. The program will continue to expand the treatment service.

To address existing gaps, Nigeria intends to prioritize the modules on MDR-TB treatment by:

- **Ensuring access to high quality second line TB drugs.** The program will continue to expand the treatment of patient using the shorter regimen, individualized regimen and new drugs (bedaquiline and Delamanid). The program will also strengthen the existing treatment services at the community and facility level. DRTB treatment centres will be expanded to 11 states within this period while XDRTB treatment centres will be established in 5 zones (North West, South East, South South, North East and North Central). Expansion of community DRTB services to remaining 599 LGAs will take place. Improve linkages to care through CBOs will be ensured. The program will also decentralize enrolment of diagnosed cases to outpatient (OPD) sites

### Module 4: TB-HIV collaborative interventions (TB patients with known HIV status; HIV positive TB patients on ART)

A huge proportion of HIV positive incident TB cases are missed annually. In 2016, 85% of the incident TB cases were not diagnosed and notified<sup>52</sup>. The ART uptake among HIV positive TB patients is below the national target of 100% and less than 10% of eligible PLHIV in care are accessing IPT. The **key issue** of low TB case finding among PLHIV (overview presented in section 1.2) can be mainly attributed to a sub-optimal TB screening among PLHIV in HIV care setting and poor access or referral to GeneXpert testing for TB symptomatic cases. Approximately 20% (259) of the country's 1,292 ART centers still do not provide TB services, and those who implement are not maximally optimizing available TB-HIV services due to poor knowledge and resources.

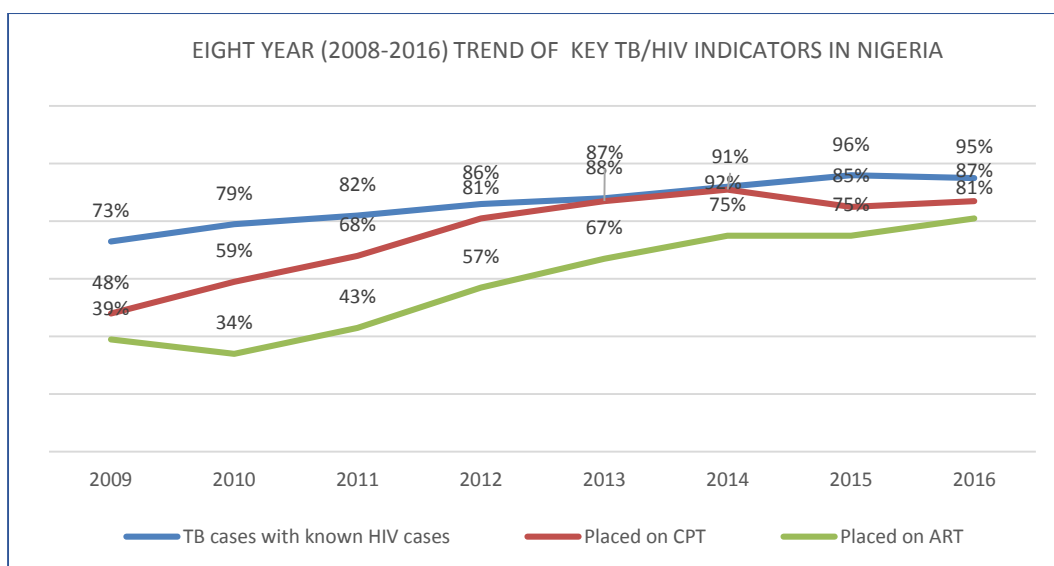
**Figure 15: Trend of key HIV/TB indicators in Nigeria, 2008-2016**

<sup>49</sup> Laboratory assessment progress report.

<sup>50</sup> Global TB report, 2016, WHO.

<sup>51</sup> NTBLCP 2016 report

<sup>52</sup> NTBLCP Annual TB report, 2016.



To **address these challenges**, this funding application prioritizes the following interventions in the TB-HIV module

- **Intensified TB case finding among PLHIV in HIV care settings and communities:** All PLHIV will be screened for TB at every visits using the symptomatic screening tool. The use of chest X-ray will be incorporated to strengthen the sensitivity of the screening tool. In addition, all TB symptomatic PLHIV will have access to GeneXpert testing. The cascade from screening to diagnosis and treatment will be monitored to ensure no clients are missed in the process.
- **Rolling out point-of-care TB testing in HIV care settings:** HIV service delivery centers will be prioritized for the introduction of point of care testing (GeneXpert Omni). Until the Ultra GeneXpert cartridge is introduced, the diagnostic algorithm will be reviewed to ensure further assessment and monitoring of all GeneXpert negative cases to rule out any potential false negative diagnosis.
- **Prompt and appropriate TB treatment and early initiation of ART for co-infected patients:** TB/HIV co-infected patients will be placed on appropriate TB treatment including Rifabutin containing regimen when necessary, efforts will also be put in place to ensure early initiation of ART in line with the national guidelines.
- **Scale up Integrated TB/HIV services: Expansion of TB and HIV services will be implemented to enhance provision of integrated TBHIV services.** The TB program in its expansion effort will ensure that the 20 ART centres without DOTS services are prioritized.

#### Expected Results/Impact:

The implementation of this intervention will result in:

- 1) Increased TB case finding among PLHIV and TB-HIV co-infected patients will have improved access to life-saving anti-TB treatment and ART;
- 2) 15% (48,552 TB cases) contribution by HIV-positive incident cases to the number of TB cases (323,677 TB cases) to be detected within allocated amount; and
- 3) Reduced morbidity and mortality among TB-HIV co-infected patients.

#### TA support during implementation

WHO NPOs have been providing TA to the national programme since October 2016 in the implementation of key areas in the current NFM grant. The TA within few months of implementation has led to rapid scale up of services (documented in the lessons learnt section). The WHO NPOs will continue to provide TA support in the implementation of the

strategies identified in this funding application. In addition, the WHO NPOs will support states and LGAs in the areas of planning, implementation, monitoring and evaluation. International TAs will be obtained from organizations such as USAID, KNCV, CDC, WHO HQ/AFRO, Stop TB Partnership and other partners especially in the areas of scaling up of shorter regimen, implementation of new drugs, End TB strategy interventions, PPM and other key thematic areas.

### III. INVESTMENTS FOR HIV FROM 2018 TO 2020

The modules prioritised for the HIV component are the following:

- Differentiated ART Service Delivery for Adults
- Differentiated ART Service Delivery for Children
- Prevention of Mother-to-Child Transmission (PMTCT)
- TB-HIV collaborative interventions -TB screening among HIV patients
- Prevention programs for sex workers and their partners
- Prevention programs for men who have sex with men
- Prevention programs for PWID and their partners
- Prevention programs for adolescents and youth

#### Module 1: Differentiated ART Service Delivery for Adults

Nigeria adopted a new treatment guideline to "Test and Treat" all who test positive to HIV on 1<sup>st</sup> December 2016. Nigeria has also adopted components of the New Service Delivery model (NSDM) which allows differentiated models of ART service delivery to align with the goals and targets of her NSF towards the realization of the 90-90-90 treatment goals. This module will support the implementation of the differentiated models, which will optimize delivery of HIV treatment and support services, reduce unnecessary burdens on the health system and cost to the patients, as well as improve efficiencies, health outcomes and impacts. This module will also strengthen the test-treat-retain cascade to improve continuum of care. The task-shifting and task-sharing policy, which Nigeria has already embraced, provides a platform for the implementation of the differentiated care model.

Differentiated approaches have been successfully piloted in some PEPFAR supported treatment scale-up sites in Nigeria<sup>53</sup>, with the application of different treatment and care schedules for stable and unstable PLHIV<sup>54</sup>. PEPFAR's successful experience will inform the implementation of this module, and operations research and implementation research will be incorporated to understand the performance of the models, identify new approaches, and guide more precise articulation and refinement of the models and the implementation process.

The estimated number of adult PLHIV needing ART in Nigeria will increase from 3,051,081 in 2018 to 3,179,147 in 2020, and the NSF set the target of meeting 51% of the needs in 2017 (1,556,051 PLHIV), and 71% (2,257,194) by 2020. Currently, the Government of Nigeria (GoN) supports Abia and Taraba States HIV response fully from domestic resources: this amounts to 6% of national ART coverage in 2016. By December 2016, PEPFAR has placed 687,130 adults on treatment and plan to add 168,119 in 2017 and 241,703 in 2018. By the

<sup>53</sup> PEPFAR Nigeria. Nigeria Country Operational Plan (COP) 2017. Strategic Direction Summary. 30 March 2017.

<sup>54</sup> Stable patients are defined as "those who have received ART for at least one year and: have no adverse drug reactions that require regular monitoring; have no current illnesses or pregnancy; are not currently breastfeeding; and, have good understanding of lifelong adherence and evidence of treatment success (two consecutive viral load measurements below 1000 copies/mm<sup>3</sup>). Patients who do not meet the criteria outlined above are classified as unstable, for example those with poor adherence to medication and those who experience treatment failure. Whereas stable patients receive multi-month scripting (three [3] month drug refills) and biannual doctors' visits, patients classified as unstable are scheduled for more frequent visits for clinical consultation, laboratory investigations, adherence support and drug refills.

end of December 2017, Global Fund will have 200,330 PLHIV on treatment and these people will be supported under the new investment through 2018-2020. New 69,764 PLHIV will be placed on ART through the new grant over three years: 16,001 in 2018, 22,401 in 2019, and 31,362 in 2020. Seventy percent (70%) of the newly enrolled will be from the 8 scale up – Lagos, Oyo, Kaduna, Imo, Ogun, Akwa Ibom, Kano, Rivers, and prioritising 38 high-burden LGAs – while 30% will be from the maintenance states. Based on the state specific HIV positivity rates for the 8 scale up, and an average positivity rate for the maintenance states, a total of 2,536,446 adults will require testing over the next 3 years; 78% of these numbers will be concentrated in high burden LGAs in the 8 scale up states. Thus, a total of 270,094 PLHIV will be on ART by 2020 through the new Global Fund grant.

### *Key Interventions:*

#### ***I. Reaching the “first 90”:***

Expand access to HCT services: through a combination of facility-based and targeted community-based approaches, and use of multiple testing streams. Evidence-based approach will be used to optimise testing yield by strategically targeting TB patients and their contacts, partners and family members of PLHIV, KPs with HTS. Self-testing and use of experiential community-based approaches such as assisted partner notification and home-based index testing, social network testing, and mobile HTS will be vigorously promoted. Integration of HTS into SRMNCAs platforms will be strengthened at all levels of health care, particularly maternal health care services, sexually transmitted infections (STI) clinics, and adolescent and youth friendly health services (AYFHS). Recognising that most Nigerians patronise private sector health facilities, a major focus under this module will be the expansion of HTS within the private sector. Provider-initiated testing and counselling (PITC) will be the main strategy to be used in facility based HTS with a strategic focus on units and departments to produce high yields (in-patients, STI clinics, DOTS points etc); this is to ensure that a more universal coverage of the target population is achieved. Within this context, a special focus will be devoted to targeting men for HIV testing to breach the gender gap on men accessing treatment after testing. Identified health system bottlenecks to HTS, including PSM challenges, will be addressed during this grant and community systems and structure strengthened as detailed in the RSSH component of this funding request.

Create demands for HTS and facilitate enabling environment for HTS uptake: Demand creation activities will be undertaken at facility and community levels to improve knowledge of, and attitude to HTC, and facilitate uptake. Enabling environment will be facilitated for HTS at community level mounting activities that will address inhibiting social factors such as HIV-related stigma and discrimination especially within-health settings. PLHIV networks will be actively engaged to facilitate demand creation and addressing of stigma and discrimination.

#### ***I. Reaching the “second 90”:***

Build capacity for differentiated ART service delivery: PEPFAR’s experience of differentiated care will be reviewed to inform alternative models of differentiated care, which shall be piloted in the context of implementation research in selected LGAs backed with rigorous documentation to facilitate the adoption of a national package of differentiated care. Capacity of health workers will then be built to implement the differentiated service delivery models. In this regard, lessons shall be drawn from the efforts of PEPFAR Nigeria to pilot virtual clinical mentoring using an information, communications technology (ICT)-based platform to build the capacity of healthcare workers in secondary health facilities to improve quality of care and patient outcomes. PEPFAR’s plan is to set up “hubs at tertiary health facilities with highly skilled medical professionals that will serve as resources persons with several peripheral sites (secondary health facilities) as spokes connecting virtually to the hub”. This approach is reckoned to be cost-efficient, and will thus be adapted under this grant. The capacity of the community systems and structures will also be developed in tandem for the delivery of quality differentiated ART service delivery and referral systems will be effectively strengthened



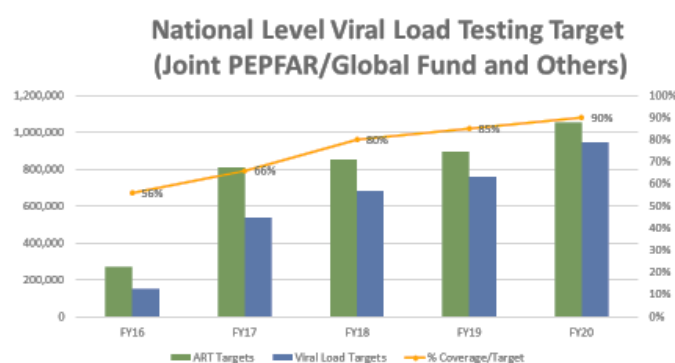
especially in contiguous LGAs without ART facilities. Treatment of opportunistic infections and TB prophylaxis will be integrated into ART service, alongside screening for HBV and HCV. All patients who have tested positive in care and not yet on ART will be prioritized for treatment.

Strengthen treatment monitoring and quality of care: Focus under this module will include monitoring of treatment processes and outcomes for PLHIV on ART, including the monitoring of toxicity and Early Warning Systems for HIV drug resistance, monitoring the quality of care and institutionalisation of quality assurance mechanisms including periodic monitoring and supervision, and conducting relevant operations and implementation research. Efforts with PLHIV peer-networks will be intensified to ensure that lost-to-follow up are low and retention in care is optimized and adherence strengthened intensively. Innovative approaches will be explored with PLHIV peer networks to facilitate regular drug pick-ups and to avoid long waiting times at the clinics and strengthening adherence support. Healthcare workers and PLHIV peer networks will be trained on mental health issues to help address burnout and also assist in early identification and treatment of patients with mental health needs which can potentially affect adherence or their retention in care. There will be a linkage with mental health experts and mental health facilities to support the national program in this direction.

## ***II. Reaching the “third 90”:***

The viral load testing coverage in Nigeria is very low. Available program data from PEPFAR/Nigeria indicates that only 22% (150,000) of the 700,265 patients eligible for viral load testing by the end of 2016 were tested. There is, thus, the urgent need to expand viral load testing facilities and adequately monitor viral suppression as part of the 90-90-90 goal. Under this new grant, the GF program will coordinate closely with the PEPFAR program to jointly address the key health systems and laboratory services delivery specific barriers to increasing access to viral load testing through: . These issues include: very low demand/up-take of viral load test; limited access to PCR laboratories, especially in ART/PMTCT sites that are remotely located from the PCR labs; and low optimization of the PCR equipment installed capacity in the country – which is about 1,500,000 viral load tests/year (PEPFAR COP17 Data). To achieve this, the Global Fund and PEPFAR programs will jointly implement high-impact systems and focus on interventions that would ensure total country coverage for viral load testing and that at least 85% of eligible patients received viral load testing by end of 2019, and at least 90% by end of 2021 (See projections in Figure 24).

**Figure 16: National level Viral load testing target, Nigeria, 2016-2020**



The following systems intervention will be implemented:

- 1- **Strengthened PCR Laboratory Network:** Global Fund and PEPFAR will jointly support the maintenance and quality management implementation in all the 26 PCR laboratories in Nigeria. Global Fund will directly support 3 of these labs from 2018 onward. Global Fund-supported program will further work with PEPFAR to ensure that all ART and PMTCT sites in the country are fully mapped (using their geo-coordinate data) and linked to designated PCR laboratories as part of the National Lab network. Global Fund will also jointly support the overall coordination and oversight provision to the lab network through the National Laboratory Technical Working Group, the NCDC, and the FMOH.
- 2- **Implementation of Integrated Sample Referral System:** as part of strategy to fully optimize the PCR Labs, Global Fund, PEPFAR, and the GoN will implement an integrated sample referral system across the country. This intervention would ensure that viral load, EID, TB, and other clinical samples are appropriately processed and shipped to PCR and other clinical labs as necessary, as well as pick-up viral load and other lab results and return to the appropriate clinics within the network. This activity will be funded through a cost-sharing arrangement with the PEPFAR program, based on the unit cost of shipping each specimen, and volume contributed by each supported sites
- 3- **Pooled Procurement of Viral Load reagents and commodities:** the Global Fund will sustain its current partnership with the PEPFAR program in the implementation of pooled procurement of viral load reagents and commodities and use the established National and regional warehousing, distribution, and last mile delivery system to ensure that the PCR network are consistently supplied with the required products for viral load testing. The Global Fund will also collaborate with PEPFAR in the implementation of Logistics information systems (LIS) for the country.
- 4- **Increased Demand and Viral Load Service Uptake in the clinics and Communities:** The Global Fund will support sustained increase in demand and viral load testing services uptake in all supported sites, through mentorship programs for clinicians and care givers. Health care workers especially physicians will be sensitized on the need to always request viral load for monitoring patients on ART and will be trained on utilization of the results to manage the patients including management of PLHIV not achieving viral suppression. Similar awareness campaigns and education program on the utility of viral load, will be targeted towards PLHIV so that they can demand viral load for monitoring their response to treatment
- 5- **Strengthening and Expansion of Laboratory Information Management System (LIMS) for PCR laboratories:** The CHAI/PEPFAR program has rolled-out a LIMS system for all PCR labs in the country. The Global Fund will join in this partnership and support the smooth function of this system in its supported PCR labs, as well as ensure that the LIMS systems are linked and uploading viral load testing data into the National Viral Load and EID Dashboard. Global Fund will further support the linkages and interfacing of existing LIMS to the electronic medical records (EMRs) of linked supported sites ART/PMTCT. This will reduce the Turn-Around-Time (TAT) of viral load testing by delivering results to clinics electronically.
- 6- **Implementation of DBS for viral load Testing:** To expand access to viral load, the PEPFAR program is currently piloting the use of DBS samples for viral load testing. The Global Fund will key into this effort and support the roll-out of DBS samples for viral load in supported ART/PMTCT facilities that are remotely/distally located away from the PCR labs, or where plasma processing and handling is difficult to achieve. It is estimated that DBS samples will contribute about 40% of viral load test samples by 2019.
- 7- **Strengthening Clinic/Laboratory Interface for increased viral load utilization:** Global Fund will work in collaboration with PEPFAR, WHO and other key stakeholders to sustain the current efforts aimed at strengthening clinic-laboratory interface for



increased viral load utilization; longitudinal monitoring of patients who fail to achieve viral suppression, and the community viral suppression tracking.

- 8- **Prioritization of Infants, Pregnant women, and Key population for viral load:** as part of its strategy moving forward the Global Fund will prioritize viral load testing for infants, pregnant women, and key populations through the one-stop-shop (OSS) strategy, and ensure that these are being adequately monitored for viral suppression.
- 9- **Increased Capacity Utilization in supported PCR Labs:** to increase the capacity utilization of PCR lab network, Global Fund will jointly work with the PEPFAR program to support increased work hours for laboratory scientists in the PCR labs beyond 8hrs, to at least 16 to 24hrs testing. The program will leverage the viral load ancillary equipment (such as Biosafety cabinet, micro-pipettes, and centrifuge) maintenance certification/calibration program initiated by the PEPFAR program, to ensure uninterrupted viral load services within the network.
- 10- **Viral load scale-up implementation monitoring:** Global Fund will work with PEPFAR, WHO, CHAI, FMOH, and the Treatment and Laboratory TWGs to provide ensure the needed routine oversight and implementation monitoring is provided and that routine testing data is made available and utilized for quality improvement and program management decision making.

#### ***Expected results/Impact:***

The GF investment will enable the provision of ART to 270,094 PLHIV in the 2018-2020 period, and increase the national coverage from 48% to 52%.

The investment is expected to achieve the following impact results over the funding period:

- Based on AIM and GOALS modelling for impact, this investment in Nigeria will result in **reduction of new HIV infections** by 57% in 2020 from the base year of 2016.
- Overall, **reduction in AIDS mortality** will increase from 23% in 2018 to 42% in 2020 (against 2016 base year)
- ART scale up will **avert 221,429 AIDS deaths** by end of 2020
- Improve **Life years gained** by 76% by end of 2020 (Life years gained increased from 671,216 in 2016 to 1,181,360 by end of 2020)

#### **Module 2: Differentiated ART Service Delivery for Children and adolescents**

Children and adolescents (less than 15 years of age) living with HIV will benefit from models of devolved care tailored to meet their needs for improved adherence and retention in care. The number of children with need for ART in Nigeria is estimated as 186, 493 for 2018. The NSF targets meeting 41% of the paediatrics ART needs in 2018 (76,591 children) and 59% (92,727 children) by 2020. This module will focus on the selected 38 high-burden LGAs within the 8 scale up States (Lagos, Oyo, Kaduna, Imo, Ogun, Akwa Ibom, Kano, Rivers). Currently, GoN supports Abia and Taraba States HIV response fully from domestic resources, and plans to expand its coverage between 2017 and 2021 with the intention of increasing coverage by additional 15% by end of 2020. PEPFAR placed 35,927 children on ART by 2016, and intends to put additional 18,155 children between 2017 and 2018, giving a total of 54,082 children living with HIV. It is anticipated that PEPFAR will maintain this number between 2018 and 2020. GF's investment has resulted in placing 10,804 children on treatment in 2016 with the intention to add 1,983 children more on treatment in 2017 to reach 12,787. In the new allocation, this module embraces the continuation of ART for these children on ART between 2018 and 2020, and to add 17,873 children more between 2018 and 2020: 2,553 by 2018, 5,107 by 2019, and 10,213 by 2020. Seventy per cent (70%) of the new enrollees are expected to come from the scale up States. A total of 649,831 children will be targeted for HIV testing in the process: 92,833 in 2018, 185,666 in 2019, and 371,332 in 2020. Based on 2016 National validated data, the proportion of EID to the number of positive pregnant women placed on ARVs is 33% from a growth of 17% in 2013, 21% in 2014 and 30% in 2015. It is expected that

this proportion for EID will grow from 33% to 50% by the end of 2020 increasing EID test from 4,066 in 2018 to 6,056 in 2020.

**Key Interventions:**

Based on the National Acceleration Plan for Paediatric HIV Treatment and Care (2016-2018), the following interventions will be prioritised:

- Expand access of children to HIV testing and treatment (including early infant diagnosis (EID) services for HIV-exposed infants, HIV serological test at 18 months) through increased service delivery points and linkages with child health services and platforms within both public and private sectors (e.g. vaccination and child welfare clinics and child nutrition services), and strengthen partnership with community structure and systems for maternal and child health care. Also building on PEPFAR experience on the intensified paediatrics HIV case finding in selected high volume ART sites, which revealed that family index cases, in-patients and outpatients are the most efficient testing streams, this strategy will be implemented and the identified HIV infected children promptly commenced on ART.
- Prioritisation of children receiving ART for viral load monitoring and thus improve viral suppression in this age group, which is currently poor based on program data.
- Development and implementation of differentiated service delivery models for ART at facility and community levels
- Strengthening community systems and structures for effective differentiated care
- Improving adherence counselling and tracking mechanisms for paediatric PLHIV at facility and community levels
- Promotion of linkages and referrals to treatment, care and support

**Expected results/Impact:** 17,873 new paediatric PLHIV enrollees and a total of 30,660 children living with HIV will be on Paediatric ART from the new GF grant. The GF contribution will cover 19.6% of the children that needs ART by 2020. The investment is expected to **avert 1,661 AIDS deaths among children 0-4 years** with the ART scale up by 2020.

### Module 3: Prevention of Mother-to-Child Transmission (PMTCT) ARV

An estimated 168,887 HIV-positive pregnant women are estimated to need ART in Nigeria in 2018, and 182,789 women by 2020. The NSF sets a target of meeting 65% of PMTCT ART (110,114 pregnant women) and 95% by 2020 (173,650 pregnant women) in line with elimination target. The GoN is supporting PMTCT program across the states through the “Save One Million Lives” initiative, and fully funding the HIV response in Abia and Taraba States from domestic sources. PEPFAR plans to put 56,680 pregnant women on PMTCT ART in 2018. This funding request proposes to put 39,310 HIV-positive pregnant women on ARV in the context of PMTCT between 2008 and 2020: 12,231 in 2018; 13,107 in 2019, and 13,881 in 2020. The grant also proposes to provide EID at 2 months for the same number of HIV exposed infants delivered to HIV positive pregnant in addition to the 56,680 planned by PEPFAR in the same period. Sixty percent (60%) of the women are expected to come from the 8 scale-up states (Lagos, Oyo, Kaduna, Imo, Ogun, Akwa Ibom, Kano, Rivers). To achieve the PMTCT ARV target, 3,791,888 pregnant women are expected to be tested.

**Key Interventions:**

- **Prong 1: Expand the access of young girls and women to HIV Minimum Prevention Package Intervention (combination prevention) and HCT by leveraging on the SRMNCAH platforms, including adolescent-friendly health services and pre-conceptual health programs, and maternal health services. Partner testing will be encouraged as well as condom promotion and use.**

- **Prong 2:** Facilitate the access of HIV-positive girls and women to family planning services to unwanted pregnancy through linkage and integration with family planning and other SRMNAH services at facility and community levels.
- **Prong 3:** Expand access of HIV positive pregnant and breastfeeding mothers to ART services through sustainable supply of antiretrovirals and strengthened linkages with RMNCAH platforms, private and public health service providers, and community-based maternal care services including traditional birth attendants..
- **Prong 4:** Family-centered approaches will be adopted based on the country experiences of PEPFAR as part of Treatment, care and support to mothers living with HIV, their children and their families. Access to HIV-exposed infants to early infant diagnosis (EID) services, ART prophylaxis and co-trimoxazole prophylaxis and the access of HIV exposed babies to HIV serological test will be expanded through: increased service points; linkages with child health services and RMNCAH platforms within both public and private sectors (including vaccination, child welfare clinics and child nutrition services); and, strengthened partnership with community structure and systems for maternal and child health care. Other strategies to be adopted for Prong 4 will include:
  - Fostering an enabling environment for HIV positive pregnant and breastfeeding mothers and HIV-exposed infants to access ARVs by addressing bottlenecks at facility and community levels, and providing supportive services and structures at the community level
  - Strengthen demand generation programs for PMTCT
  - Promote stronger linkages between and/or integration of HIV testing services for pregnant women and antenatal care and treatment services and post-natal follow-up
  - Strengthen community systems to support care for HIV-positive mothers and HIV-exposed infant via the use of mentor mothers (mother to mother groups).
  - Design, develop and implement strategies aimed at supporting retention of the mother-baby pair in PMTCT services including the use of cohort monitoring tools for PMTCT monitoring, both at the programmatic/facility level and at the community level
  - Promote WHO recommended enhanced ARV for the high-risk HIV exposed infants
  - Design, develop and implement innovative viral load access by HIV positive pregnant and breast feeding women
  - Modules for training of health care workers on mental health services to support patient adherence and for educating all HIV positive patients will be developed to improve retention in care and to facilitate early identification of mental health related issues and how they can be managed appropriately.

**Expected results/Impact:** *The GF grant will provide ARV to 39,310 HIV-positive pregnant women. This investment will increase PMTCT coverage from 50% in 2018 to 73% in 2020. The GF contribution will cover 7% of the national need for pregnant women receiving ARV. Overall, **PMTCT will avert 66,683 new HIV infections** by end of 2020 and will **avert 27, 763 deaths among 0-4 years** old children.*

#### **Module 4: TB-HIV collaborative interventions -TB screening among HIV patients**

TB-HIV collaborative interventions will increase synergy between the disease programs, enhance cost-efficiencies, and improve treatment outcomes. This module prioritises key interventions to ensure intensified TB case finding (ICF) among PLHIV; TB treatment completion; scale up of TB Preventive Therapy (TPT)/ Infection Control; and, sustained joint TB/HIV programming and monitoring. A total of 157,000 PLHIV (enrolled in adult ART, paediatric ART or PMTCT from 2018 - 2020 with investment from Global Fund) will be

appropriately screened for TB in HIV care settings, receive TB preventive drugs in line with the national guidelines and be referred as appropriate for further TB care.

**Key Interventions:**

- Chest X-ray for TB screening in the PLHIV: Enhanced TB screening in the PLHIV population at HIV diagnosis/treatment initiation using chest X-ray to increase sensitivity of symptom screening and appropriate referral for follow-up TB treatment
- Scale up of GeneXpert services: Improve access to GeneXpert services by prioritization of GeneXpert deployment to ART sites (only about 70 ART sites currently has GeneXpert out of the 437 PEPFAR supported ART sites in the country). GeneXpert Omni to be procured and deployed to peripheral DOTS sites to enhance TB diagnosis. Support to be provided for GeneXpert maintenance and cartridge.
- TB/HIV referral coordination initiative: To improve TB/HIV referral services within and across sites, support should be provided to engage TB/HIV referral coordinators/volunteers. These volunteers ensure best referral practices including referral facilitations/ documentation, facilitation of sputum transport from supported facilities to proximal GeneXpert sites, maintenance of an up-to-date facility-based presumptive TB/HIV diagnostic and treatment register, and follow up and documentation of the PLHIV TB diagnostic evaluation results in the register as well as keeping track and documentation of TB treatment outcome for all TB/HIV co-infected patients within a given facility.
- Scale up of TB Infection control implementation: Streamlined TB infection control implementation through proven strategies, such as TB BASICS. Support to be provided to ensure continued scale up of TBIC services across sites especially those with co-located DOTS and ART services.
- TB Preventive Therapy (TPT): Progress to be sustained, and TPT implementation tied to TB ICF with the use of Chest X-ray for TB screening. Integrated logistics for INH and HIV drugs and other commodities to be supported.

**Expected results/impact:**

The Global Fund investment will enable the provision of relevant TB care to 157,000 in the 2018-2020 period.

## **Module 5: Prevention programs for sex workers and their partners**

Female sex workers (FSWs) have higher HIV sero-prevalence rate compared to the general population. Spectrum analysis estimates the population of FSWs in Nigeria officially as 185,513 in 2015<sup>55</sup>, but PEPFAR estimates FSW population as 256,282 in its 2017 COP.

The NSF target is to meet the prevention need of 90% of FSWs (166,962 FSWs) by 2018, and throughout the 2018-2020 period. Currently, through Global Fund support, FSWs are being reached with MPPI (inc in FCT, Anambra, Kano, Edo, Enugu, Gombe, Imo, Lagos, and Oyo State. FSW-targeted interventions will continue in the same states under the new grant, and with Kaduna added as an additional intervention state. Also, PEPFAR Program is reaching FSWs in Lagos, FCT, Nasarawa, Benue, Rivers, Cross Rivers and Akwa Ibom; PEPFAR proposed to reach 205,025 FSWs in 2018. In Lagos and FCT where the PEPFAR program and the Global Fund investment currently co-exist, implementation has been delineated by LGA between the two programs to prevent overlap and enhance complementarities: this arrangement will be maintained under the new grant.

Through Global Fund support, 23,652 FSWs will be reached with MPPI (including HTS and condoms) at the end of 2017, and will be continued on behaviour maintenance prevention

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<sup>55</sup> <http://www.aidsinfoonline.org/devinfo/libraries.aspx/home.aspx>

services from 2018 to 2020. In terms of new investments, 30,000 FSW (15,000 in 2019 and 15,000 in 2020) will be added; no new FSW is added in 2018 as no programmatic gap exists that year because of PEPFAR's investment. The new grant will have MPPI as its core strategy, and the One-Stop-Shop (OSS) as the fulcrum for reaching FSWs (and other KP) with integrated HIV services. The OSS is safe space and "community clinic" for the delivery of a complete cascade of KP-focused prevention, treatment, care and support service, and also constitute a hub for community based ART delivery using peer-led networks and community outreach workers. OSS has been used successfully under the current Global Fund grant and also by PEPFAR program: the new Global Fund grant will further coordinate strategy with the PEPFAR program on OSS.

### Key Interventions:

- Minimum Prevention Package of Interventions:
  - Individual Level: These will include communication interventions delivered through innovative approaches at brothels and other convenient locations to improve HIV-related knowledge, attitude, self risk-perception, and risk reduction skills of FSWs; provision of male and female condoms, lubricants, STI management service, pre-exposure prophylaxis (PrEP) and referral services (including PMTCT) using appropriate national guidelines. Provisions have been made to place 9,447 FSW over the three-year grant period (1,185 in 2018, 2,899 in 2019, and 5,365 in 2020). Supportive mental health services will also be provided to sex workers. The OSS will be the fulcrum of these service delivery activities, and will have the active participation of KP peer support groups. Targeting of young FSW will be particularly important using both peer and mentoring approaches. More CBOs will be activated as OSS as necessary.
  - Community Level: including strengthening and supporting organisations and networks of and those working with sex workers; and, fostering programs led by sex workers to enhance prevention-testing-treatment-care cascade activities for FSW.
  - Structural Level: including advocacy for legal and policy reforms, legal support and legal literacy, human rights services, engagement of law enforcement agencies to reduce stigma and discrimination, legal harassment and implementation of unfavourable policies.
- First 90 (Intensive Case Finding):
  - Community Testing: Testing of FSW will be incentivized as necessary based on individual risk profiles (e.g. recency and STI history). Moonlight testing, mobile HTS, and other community-based approaches will be used in this process, and HIV-positive FSWs linked to care
  - Self-testing: The option of self-testing will be made available to FSWs who are able to afford them
  - Partner testing: Positive FSWs will have access to partner testing services. Client tracing and Home tracking for ARV delivery will be carried out.
- Second 90 (Community Based Anti-Retroviral Treatment):
  - Outreach Approach to Initiation/Continuation: While the OSS serves as the hub for treatment, clinical teams will be able to provide offsite ART services to FSWs that are still in denial or experiencing social or legal barriers.
  - Differentiated Care Model: ARVs will be made available to stable FSWs using existing social non-clinical (e.g. support groups, community workers etc) means and will include multi-month scripting.
- Third 90 (Viral Load Suppression):



- Viral Load Testing and tracking of viral suppression: All supported OSS will be mapped to reference PCR laboratories, as part of the viral load network, and viral load testing will be provided through sample referral.
- Innovative Viral Load Testing: DBS samples will be used for viral load testing in OSS or in KPs' settings that are remotely located from PCR labs, or where it is difficult/challenging to collect and transport samples for viral load testing.

**Expected results/Impact:** 30,000 FSWs will be newly reached with MPPI between 2018 and 2020, in addition to 23,652 FSWs who will be on behaviour maintenance prevention through the new GF grant. Overall, together with other high-impact interventions, this investment will result in the **reduction of new HIV infections by 57% in 2020** from the base year of 2016.

## Module 6: Prevention programs for men who have sex with men

HIV prevalence has been increasing consistently among MSM in Nigeria: hence, effort to reach the group with prevention services is crucial. While the legal environment poses a challenge to programming for MSM, the GoN has prioritised HIV programming for MSM and other KP as a public health issue within the context of the national HIV response as reflected by the NSF. Programming under the current legal environment necessitates innovative approaches and meaningful engagement of the MSM community in developing and implementing effective prevention programs, as well as strategic engagements with law enforcement agencies based on the lessons learned from the current grant.

The population of MSM in Nigeria is reported as 29,470 for 2015<sup>56</sup>, and a spectrum analysis gives the figure of 46,628 for 2018<sup>Error! Bookmark not defined.</sup>. It is possible that this figure is an underestimate as the methodology used in the Local Epidemiologic Analysis<sup>28</sup> focused on MSM frequenting hot spots, and the reluctance of some MSM to disclose their status (especially those engaged in bisexual practices). Nevertheless, the reported figure provides a basis for pragmatic planning in the context of this grant, while attention will be given to new study with more robust methodological to generate new estimates that will inform future programming. Already, The Office of Global ADS Affairs is providing funds to PEPFAR Nigeria for a study on KPs.

Currently, through Global Fund support, MSM are being reached with MPPI (including HTS and condoms) in FCT, Anambra, Kano, Edo, Enugu, Gombe, Imo, Lagos, and Oyo State. MSM-targeted interventions will continue in the same states under the new grant, and with Kaduna added as an additional intervention state. Also, PEPFAR Program is reaching MSM in Lagos, FCT, Nasarawa, Benue, Rivers, Cross Rivers and Akwa Ibom; PEPFAR has proposed to reach 5,586 MSM with prevention services in 2018. This number will increase by 1.25% of the male population using additional funding to be received. In Lagos and FCT where the PEPFAR program and the Global Fund investment currently co-exist, implementation has been delineated by LGA between the two programs: this arrangement will be maintained under the new grant.

Through Global Fund support, 26,089 MSM are to be reached at the end of 2017 and would be provided with behaviour maintenance prevention services inclusive of HTS, STI and ART from 2018 to 2020. In terms of new investments, 6,762 MSM will be targeted: 3,381 in 2019, and 3,381 in 2020; no new MSM is added in 2018 as no programmatic gap exists that year because of PEPFAR's investment. The new grant will have MPPI as its core strategy, and the OSS as the fulcrum for reaching MSM with integrated HIV services and the hub for community based ART delivery using peer-led networks and community outreach workers. The new grant will further coordinate strategy with the PEPFAR program in respect of OSS.

<sup>56</sup> <http://www.aidsinfoonline.org/devinfo/libraries.aspx/home.aspx>

*Intervention approaches:*

- Minimum Prevention Package of Interventions targeted at individual, community and structural levels.  
First 90: Intensive case finding using community-testing, self-testing and partner testing.
- Second 90: Community-based anti-retroviral treatment using outreach approach to initiation/continuation, and differentiated care model.
- Third 90: Viral load suppression using viral load testing and tracking of viral suppression.
  -

**Expected results/Impact:** 6,762 MSM will be newly reached with MPPI between 2018 and 2020, in addition to 26,089 MSM who will be on behaviour maintenance prevention through the new Global Fund grant.

Overall, together with other high impact interventions, this investment will result in the **reduction of new HIV infections by 57% in 2020** from the base year of 2016.

### **Module 7: Prevention programs for people who inject drugs and their partners**

Drug injection is one of the most efficient ways of HIV transmission, and the HIV prevalence among PWID (and their partners) is higher than that of the general population. An independent Global Fund-supported evaluation of PWID program in Nigeria reported the following, among others: the scale of HIV related work among PWIDs is somewhat underestimated; there is limited acknowledgement of the importance of working with sexual partners of PWID; the essential core elements of HIV prevention and care (harm reduction) work among PWIDs have not been introduced in Nigeria; and, certain aspects of the policy environment in Nigeria restrict the development of harm reduction. The report also noted that “a solid foundation for harm reduction development has been laid by non-governmental organisations working with PWID” and that “there is significant room for increase in coverage, which would require strengthening of outreach and service delivery models”. This funding request responds to these findings, and build on existing foundation to expand the scale of PWID-targeted HIV response.

The population of PWID in Nigeria is reported as 18,801 for 2015<sup>57</sup>. Currently, through Global Fund support, PWID are being reached with MPPI in FCT, Anambra, Kano, Edo, Enugu, Gombe, Imo, Lagos, and Oyo State. PWID-targeted interventions will continue in the same states under the new grant, and with Kaduna added as an additional intervention state. Also, PEPFAR Program is reaching PWID with services in Lagos, FCT, Nasarawa, Benue, Rivers, Cross Rivers and Akwa Ibom. In states where the PEPFAR program and the Global Fund investment currently co-exist (i.e. Lagos and FCT), implementation has been delineated by LGA between the two programs to prevent overlap and enhance complementarity: this arrangement will be maintained under the new

Through Global Fund support, 16,572 PWID are to be reached at the end of 2017 and would be provided with behaviour maintenance prevention services from 2018 to 2020. In terms of new investments, 450 PWID will be targeted: 150 in 2018, 150 in 2019, and 150 in 2020. The new grant will have MPPI as its core strategy, and the One-Stop-Shop (OSS) as the fulcrum for reaching PWID with comprehensive HIV services and the hub for community based ART delivery using peer-led networks and community outreach workers. The interventions will be targeted to both PWID and their sexual partners, and the new grant will target advocacy efforts

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<sup>57</sup> <http://www.aidsinfoonline.org/devinfo/libraries.aspx/home.aspx>



towards promoting dialogue on harm reduction approaches as well as integrate screening and treatment for HBV and HVC.

*Intervention approaches:*

- Minimum Prevention Package of Interventions targeted at individual, community and structural levels.
- First 90: Intensive case finding using community-testing, self-testing and partner testing.
- Second 90: Community-based anti-retroviral treatment using outreach approach to initiation/continuation, and differentiated care model.
- Third 90: Viral load suppression using viral load testing and tracking of viral suppression.

**Expected results/Impact:** 450 PWID will be newly reached with MPPI between 2018 and 2020, in addition to 16,572 PWID who will be on behaviour maintenance prevention through the new Global Fund grant.

Overall, together with other high impact interventions, this investment will result in the **reduction of new HIV infections by 57% in 2020** from the base year of 2016.

### **Module 8: Prevention programs for adolescents and youth, in and out of school**

AYP, especially adolescent girls and women (AGYW), in Nigeria have increased vulnerability to HIV. An ongoing Global Fund-funded action research in Kaduna, FCT, Akwa Ibom, and Oyo has highlighted some of the vulnerability factors among AGYW. This module priorities prevention programs for AYP, especially AGYW, in view of this epidemiological picture and the fact that such investment brings triple dividend of benefits – “now, into future adult life, and for the next generation of children”.

Conscious of the potential benefits, Nigeria has explicitly prioritized investments in AYP in her NSF, National HIV Strategy for Adolescents and Young People (2016-2020), National HIV and AIDS Strategic Framework (2017-2021), and Integrated National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy (2017-2021), among others. Nigeria has also increasingly prioritised adolescent and youth friendly services (AYFHS) <sup>58</sup>.

The core strategy of this module is to reach AGYW (and other AYP) with Minimum Prevention Package Intervention (MPPI)<sup>59</sup> using a combination of delivery platforms, which can involve schools, community, the electronic media, social media, and information, and communication technology platform. It is expected to embrace innovative approaches such as the piloting of self-testing for HIV and mobile-technology driven and interactive communication interventions with links to AYFHS services. The specific MPPI interventions and the delivery channels will be selected through a “Youth HIV Prevention Challenge” that will be modelled after the successful DREAMS Innovation Challenge. The DREAMS innovation challenge was utilised by PEPFAR and partners as part of the highly acclaimed DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women) project targeted at AGYW in 10 sub-Saharan African countries to competitively select the most promising interventions for HIV prevention among AGYW. The approach is expected to generate “multiple innovative

<sup>58</sup> Over the last 5 years, Nigeria has developed the National Guidelines for the Integration of AYFS into PHC; the National Guidelines on Promoting the Access of Young people to AYFHS in PHC Facilities; AYFHS training manual; AYFHS clinical protocols; and AYFHS job aids for health workers.

<sup>59</sup> MPPI is defined as “the strategic, simultaneous use of different classes of prevention activities (biomedical, behavioural, structural) that operate on multiple levels (individual, community, and societal/structural), to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritizing, partnership, and engagement of affected communities.”

solutions” to the challenge of AGYW HIV vulnerability in Nigeria with multiple implementer selected through an open and competitive process as described below. The innovative approaches will align with the combination prevention approach espoused in the MPPI, which incorporates Behavioural change interventions, Biomedical interventions, and Structural interventions (Table 3).

- *Behavioural change interventions*, including; school-based comprehensive sexuality education, media-based approached (enter-educative and mobile technology-based programs), community-based programs targeting HIV, sexual and gender-based violence and human rights, and parent-targeted programs, and condom and lubricant programming.
- *Biomedical interventions*, including: expanded HTS access, tailored comprehensive condom programming, and sexual and reproductive health services for young people and AYFHS to meet the need for condom and dual protection methods, treatment of sexually transmitted infection, among others.
- *Structural interventions*, including: advocacy and community-level interventions aimed at addressing stigma and discriminations as well as non-supportive community norms, promoting supportive social and legal environment for AYP programming, and facilitating the empowerment of AGYW and other young people.

**Table 3: MPPI level of operationalization and expected outcome**

Programme component	Level targeted	Outcome
Behavioural interventions	Individual, Community	Reduced individual risk
Biomedical interventions	Individual	Reduced exposure, transmission and/or infection
Structural interventions	Community (norms, culture, practices, values, behaviours etc.) Structural levels (policy, legal etc.)	Reduced individual vulnerability

Source: National HIV Strategy for Adolescents and Young People (2016-2020)

### *Key interventions*

The core strategy of this module is to reach AGYW and AYP with effective and innovative evidence-informed prevention interventions that are impactful in the immediate period, and can be further scaled up in the future. The interventions will be selected through an open and competitive process tagged “Youth HIV Prevention Challenge”. In this regard, advertisements for proposals on innovative ways to address one or more of the AGYW HIV vulnerability factors identified in the ongoing action research will be made nationally and beyond for various types of organisations (academic and research institutions, NGOs, CSOs, private firms etc) to apply. A selected number of organisations with required capacity and innovative approaches will be competitively selected and funded to implement a 30-month AYPG-targeted prevention interventions informed by implementation science. The interventions will be rigorously evaluated in terms of impact and cost-effectiveness, and the result considered for further future funding as well as shared with other development partners that are interested in effective HIV interventions for AGYW. An estimated 99,000 adolescents are expected to be innovatively reached through this approach in three years.

**Expected result/Impact:** The Global Fund allocation is expected to reach a total of 199,000 AGYW with effective prevention intervention.

Overall, together with other high impact interventions, this investment will result in the **reduction of new HIV infections by 57% in 2020** from the base year of 2016.

### **TA support during implementation**

WHO NPOs have been providing TA to the national programme since October 2016 in the implementation of key areas in the current NFM grant. The WHO NPOs will continue to provide TA support in the implementation of the strategies identified in this funding application. In addition, the WHO NPOs will support states and LGAs in the areas of planning, implementation, monitoring and evaluation. International TAs will be obtained from other relevant international development agencies as may be necessary in the course of implementation.

The National office of UNAIDS has also been provided technical support and will continue to do so under this grant. The UNAIDS Technical Support Facility for West and Central Africa has continuously provided short term technical assistance to grant application and grant implementation for Nigeria and other countries. This TA will be leveraged based on specific gaps in implementation as well as the generation of strategic information for program quality improvement and efficiency. Technical staff of UNAIDS and other technical agencies (UNICEF, UNFPA etc) will provide continuous demand-driven TA to ensure that the grant in Nigeria achieves its desired impact.

## **2) PART B:**

In view of the inadequate government allocation for HIV and TB, this funding request focuses on key and high-impact interventions and the use of investment approach, targeting essentially the high-burden areas to achieve maximum impact and cost-efficiencies. The case of Abia and Taraba States where government is fully funding the HIV response from domestic resources illustrates the potential of GoN to increase its funding support to the health sector and TB/HIV programs. Thus, intensive and evidence-driven advocacy shall be pursued over the next few years to influence greater government's commitment to, and increased funding for the health sector and the TB/HIV program to close the existing funding gap.

## **3) PART C:**

Nigeria has established TB-HIV Technical Working Group at national and state levels, and is strengthening the coordination between the two diseases. Coordination/collaboration shall be further enhanced by sustaining the joint planning, advocacy and coordination initiatives at all levels to integrate the delivery of TB and HIV services. ,

The National Guidelines stipulate the implementation of key TB-HIV interventions at various levels of health care delivery in line with the WHO recommendations.

In this intervention the scope of work for staff at DOTS centres and HIV service delivery sites has been expanded to include provision of integrated TB/HIV services.

The implementation of the joint TB-HIV interventions has enhanced access of TB and HIV patients to TB-HIV services in a patient centred manner as evidenced by the followings:

- **HTS for TB patients:** Access to HIV services for TB patients has increased rapidly since 2007. In 2016, 95% of all TB patients notified in 2016 had documented HIV status. Out of these, 14.7% HIV-positive TB patients were notified.
- **CPT and ART for HIV positive TB patients:** In 2016, the percentage of HIV-positive TB patients on co-trimoxazole preventive therapy (CPT) and anti-retroviral therapy (ART) during TB treatment was 87% and 81% respectively. **IPT:** In 2016, 62,761 PLHIV were

placed on IPT at the HIV service delivery centre, this represent 6% of eligible PLHIV without active TB who are in need of the services in HIV care setting. Though there was 35% increase in uptake of IPT in 2016 when compared to 2015 (40,855 PLHIV were placed on IPT in 2015), a lot still need to be done to remove barriers that prevent eligible PLHIV from accessing IPT services. Challenges to IPT uptake include logistic for INH supply and distribution, unwillingness of some health providers and implementing partners to rapidly expand access to IPT. In order to address the challenges, the programme will be leveraging on the current 3PL to ensure uninterrupted availability of INH at facility level, capacity for reporting and requisition will also be strengthened. In addition, advocacy will be further conducted through the National ART committee to expand access to all eligible PLHIV.

The implementation of this joint interventions has led to reduced morbidity and mortality among TB-HIV co-infected patients, it has also led to efficient sharing and use of resources between the TB and HIV program. For example, the HIV program with their line of funding through Global Fund facilitated the installation of 185 GeneXpert machines to support efforts at finding missing TB cases among PLHIV in HIV care setting; the joint TB-HIV forum at national and state level has also provided opportunities to address challenges facing the implementation of the program in a joint manner, thereby preventing duplication of efforts.

#### **Grant Management and Coordination**

A lump sum of 10% has been allocated for grant management and coordination across the funding splits. Previous experience show that actual amount required would be well above this proportion, hence the proposal is to use savings during grant implementation to cover part of the funding gap for this module. This allocation covers PR/SR cross-cutting grant management costs, national programme coordination activities and technical assistance.

## 2.2 RSSH funding request

The Global Fund strongly encourages funding requests for RSSH investments to be submitted within a **single** application, and preferably to be requested in the first submission.

**Does this funding request include an RSSH component?**

☒ Yes

☐ No

**If yes**, describe the request below and how it is strategically targeted.

Referring to the national health strategy, gaps and lessons learned outlined in the previous section, describe the funding request for RSSH and how the investment is strategically targeted to strengthen systems for health and achieve greater impact on the diseases. In your explanation, refer to the Funding Landscape Table on 'government health spending', Performance Framework and Budget as appropriate. Note that it is optional to complete a Programmatic Gap Table for RSSH.

**(maximum 3 pages)**

The following issues have been prioritised for the RSSH component based on rigorous analysis of the country situation, relevant national policy and strategic plan documents, as well as grant review experience and OIG reports across the three disease areas (HIV/AIDS, TB, and malaria):

- Procurement and Supply Chain Management (PSM)
- Health Information and Data System
- Governance and Leadership
- Service Delivery
- Community Response and Systems

### PROCUREMENT AND SUPPLY CHAIN MANAGEMENT (PSM)

The strategies proposed aims to sustain the gains made so far with the National Supply Chain Integrated Project (NSCIP). The investment will focus on the following areas:

- Upgrading the Logistics management information system (LMIS): this will focus on strengthening of systems for continuous data quality improvement and ensuring availability of quality logistics information for decision-making through automation to transform the LMIS to a national e-LMIS that will be linked to the DHIS2.
- Strengthening Logistics Management Coordinating Units (LMCUs): LMCU structures have been established in the 36 states and the FCT, of which 14 states have fully functional structures with trained personnel and working infrastructure. Funding commitment is available to make the structures in the remaining 23 states functional (infrastructure, personnel and capacity building) through the NSCIP by the end of 2017. This request will support the efforts of the national LMCU Task Team in mentoring, monitoring and providing supportive supervision to the state LMCUs with the aim of ensuring sustained capacity for proper forecasting, procurement, distribution and monitoring at state level.
- Improving warehousing and distribution systems to ensure accountability and efficiency: The national plan aims to establish at least one warehouse per geo-political zone, i.e. a total 6 zonal warehouses. Four zonal warehouses will be fully operational by the end of 2017 through the NSCIP, there is need to invest in the remaining 2 zonal warehouses to make them fully operational.
- The country has a National Quality Assurance Policy for medicines and other health products (2015) with manuals and SOPs developed to guide its implementation, but these documents are not readily available at the point of use. Guidelines will be

produced and widely disseminated for optimal implementation of QA/QC. Also, mechanism to improve current bio-safety and institution of quality assurance program for all laboratory commodities and other relevant health commodities (e.g. RDTs, drug provision) using integrated data and service quality management hand-held devices.

- Advocacy by NPSCMP at national and state levels for improved funding of PSM activities.

## HEALTH INFORMATION AND DATA SYSTEM

The Department of Health Planning, Research and Statistics is currently implementing a one-year (2017) Global Fund supported project titled “Strengthening the National Health Management Information System (NHMIS) for Effective National Health Response and Coordination in Nigeria”. This project is designed to fast-track progress towards the goal of the NHMIS. The strategic interventions to be supported through this grant will consolidate and further the gains made through the current grant through the following strategies:

- Strengthening and supporting the functionality of data governance structures at national (HDGC), state (HDCC) and LGA levels.
- Strengthening routine data generation and flow from service delivery points (public, private facilities and communities) through provision of mobile devices for integrated HMIS-LMIS real time data collection and reporting linked to DHIS2.0 (with additional capability for quality assurance of RDTs for HIV and Malaria programmes). The interventions will include provision of infrastructure, training, mentoring, monitoring, supervision and technical support.
- Support the harmonization of health data indicators and production of a national reference list of health indicators with a data dictionary
- Review and ensure availability of the NHMIS/ATM tools, including community tools, to ensure adequacy for ATM programs within the DHIS2 platform
- Operationalization of the enterprise architecture to foster interoperability and data integration among various funding streams; this will focus on the expansion of the capacity of the NHMIS DHIS2 to accommodate data from other platforms and to ensure their inter-operability.
- Coordination of the Integration of data quality review at local government, state and federal levels and provide prompt feedback for policy action
- Support the production of information products from periodic data quality reviews
- Support population based national HIV sero-prevalence survey to determine the prevalence of HIV among the general population to inform evidence-based programming and policy development.
- Strengthening coordination, partnership, and integrated M&E supportive supervision to address governance and monitoring and evaluation processes and to use data for improving program quality and to generate efficiencies across the continuum of care. Capacity will be built at the federal, State and LGA levels to ensure that program intelligence from data is used for quality assurance and quality improvement in health service delivery for ATM. This capacity building process will be mainstreamed into regular monitoring and supportive visit to facilities as part of a continuous QA/QI process nationwide.
- Support ATM implementation research and result dissemination as well as periodic epidemiological analysis and program response: and
- Strengthen data demand and use for decision making at all levels.



## GOVERNANCE AND LEADERSHIP

The following strategies will be used to facilitate an enabling policy environment that ensures adequate oversight and accountability for the delivery of quality health care and sustainable development of the National Health System:

- Promotion of evidence-informed planning and decision-making at all levels via data analytics linked to real-time quality assured data from DHIS platform
- Strengthen PHC governance structures at State and LGA levels to effectively operationalize the PHC under One Roof (PHCUR) policy and implementation guideline
- Strengthen and ensure inter- and multi-sectoral collaborations and linkages for strategic partnership and effective coordination
- Strengthen management and coordination structures in the LGA health systems to improve accountability in the context of the PHC revitalization policy.
- Support states and LGAs to develop/adapt and operationalize HRH policy and plans taking into cognisance the national task shifting policy, and public-private partnership for HRH.
- Development and periodic review of policies and plans to ensure better alignment in their implementation and improved outcomes.
- Development of a unified national advocacy strategy for resource mobilization and policy buy-in at State and LGA levels.

## SERVICE DELIVERY

Investment in this building block of health system prioritizes building stronger linkages between TB, HIV, and SRMNCAH services to facilitate rapid expansion of TB and HIV responses using an integrated approach. Strategic interventions to be supported, with the overall objective of increasing PMTCT service coverage and TB case finding among the vulnerable group especially children in an efficient manner, include:

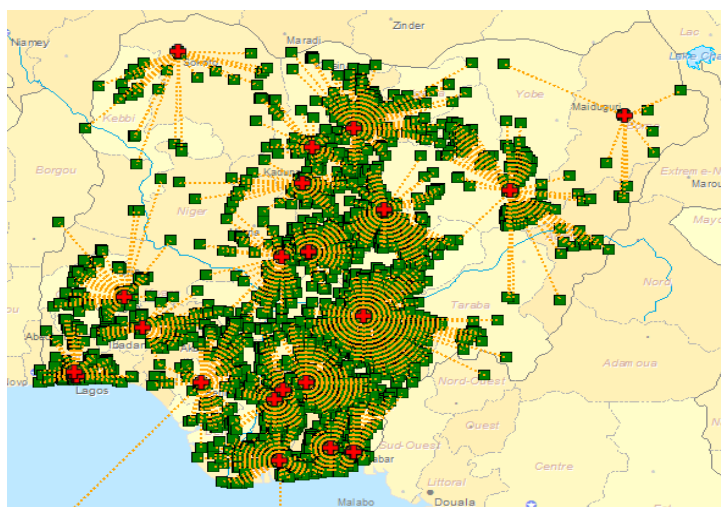
- Mapping of all facilities implementing SRMNCAH with the aim of determining those not currently implementing PMTCT and DOTS services, and exploring the opportunity of integrating PMTCT and DOTS services into them;
- Development of minimum package of SRMNCAH care in health facilities as well as a training curriculum for service integration and train facility staff; Integrated Supportive Supervision (ISS) for quality improvements
- Development of regulatory framework to facilitate the engagement of the private sector to support service delivery across the three diseases (AIDS/TB/Malaria).  
Leveraging sim-enabled mobile devices to support data management, service delivery, decision-making and capacity building at PHC level.

## LABORATORY SYSTEMS STRENGTHENING FOR IMPROVED QUALITY OF HIV, TB, MALARIA

- Upgrading of laboratories to meet ISO standards and increasing capacity to include relevant ATM lab investigations through NAFDAC.
- Strengthening of the national laboratory technical working group to produce a national framework for sample logistics across the three levels of care and facilitate more efficient laboratory services across disease programmes consistent with the National Medical Laboratory Strategic Plan (2015-2019). This framework will be founded on geo-spatial mapping of tertiary laboratories and linkage to facilities-cluster for easy sample transportation and result retrieval. It will draw from existing arrangements being implemented by other partners such as PEPFAR.
- Leverage on Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA) and Strengthening Laboratory Management Toward Accreditation (SLMTA) frameworks to strengthen capacity for quality laboratory services..



Figure 17: Mapping of health facilities linked to referral PCR Laboratories



Equipment Management System; and sustained use of the established pooled procurement and distribution system for all major laboratory reagents/consumables logistics.

- During this funding cycle, Global Fund investments will be utilized to support the joint implementation of Continuous Quality Improvement (CQI) approaches that is appropriate for each level of care in all laboratories within the network. It will leverage on PEPFAR supported Lot-to-lot Testing/Post Market validation (PMV) of HIV Rapid Test Kits to jointly support PMV for procured Rapid Test Kits/Cartridges, consistent with WHO guideline and international best practices, strategies/models to expand access to care through the private sector.
- Sim-enabled mobile devices will be used for data collection and promotion of adherence to service protocols at the facility.

## COMMUNITY RESPONSES AND SYSTEMS

The strategic objective of investing in the community systems in this grant will be to build capacity of the community system and structure to support ATM response. Under the current grant, the programme management capacity of 107 CBOs has been strengthened. Eighty of these CBOs (10 per state) will be selected in eight HIV and TB scale-up states for further capacity strengthening by the national ATM CSOs networks to engage with different community actors to conduct community-based monitoring as basis for accountability and advocacy at the LGAs with particular focus on issues of barriers to service uptake and CGR. The capacity of engaged CBOs will also be strengthened to provide community-based HTS, treatment adherence for TB/HIV, and TB case finding through innovative strategies.

Strategies to achieve these are:

1. Strengthen the capacities of 80 CBOs to coordinate community actors to conduct community-led monitoring for health interventions using citizens' charter and community scorecard approaches.
2. Promote community-led advocacy for social accountability based on emerging issues from community monitoring activities and advocacy for enabling environment for health interventions through strategic town hall meetings and dialogue sessions to build the confidence of the locals and get feedbacks.
3. Mentorship/coordination of engaged community actors across Global Fund project LGAs for the purposes of peer learning, accountability and work plan tracking
4. Strengthen capacities of 80 community based organizations through structured training for community actors to improve their skills on innovative approaches such as

index contact tracing, partners' notification, moonlight testing, reaching KPs during special events, targeted active case search for TB, increasing demand for available ATM services and health seeking behaviours.

5. Strengthening community linkages and collaborations to foster integrated service delivery and improve response between community and public health systems for accountability. Strategically, the referral linkages between the community and service providers will be developed and/or strengthened.
6. Support will be required for the finalization of the national CSS framework for the purpose of standardization of community intervention

**If no:**

- a) Indicate when the RSSH funding request was/will be submitted; and,
- b) **If the RSSH funding request has not yet been submitted**, highlight below the elements of the planned RSSH investment that will directly support the disease program in this funding request.

**(maximum ½ page)**

*[Applicant response]:*

### 2.3 Focus of application requirement <sup>60</sup>

This question is required for Lower-Middle Income (LMI) and Upper-Middle Income (UMI) countries. It is not applicable for Low-Income (LI) countries.

To respond, refer to guidance provided in the *Instructions*.

#### For LMI countries:

- Does the funding request focus at least 50% of the budget on: disease-specific interventions for key and vulnerable populations; programs that address human rights and gender-related barriers and vulnerabilities; and/or highest impact interventions?
- For RSSH, does the funding request primarily focus on improving overall program outcomes for key and vulnerable populations in two or more of the diseases, and is it targeted to support scale-up, efficiency and alignment of interventions?

☐ Yes      ☒ No

☐ Yes      ☒ No

#### For UMI countries:

- Does the funding request focus 100% of the budget on interventions that maintain or scale-up evidence-based approaches for key and vulnerable populations, including programs that address human rights and gender-related barriers and vulnerabilities?

☐ Yes      ☐ No

**Ensure that the funding request as described in questions 2.1 and/or 2.2 meets this focus of application requirement.**

<sup>60</sup> Refer to the [Global Fund 2017 Eligibility List](#) for income level. LMI and UMI countries have specific requirements in terms of the focus of applications as set forth in the Global Fund [Sustainability, Transition and Co-Financing Policy](#).

## SECTION 3: OPERATIONALIZATION AND RISK MITIGATION

This section describes the planned implementation arrangements and foreseen risks for the proposed program(s). Applicants are encouraged to **attach an updated Implementation Arrangements Map**. To respond, refer to additional guidance provided in the *Instructions*.

### 3.1 Implementation arrangements summary

Do you propose major changes from past implementation arrangements, e.g. in key implementers, flow of funds or commodities?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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If **yes**, provide an overview of the new implementation arrangements and elaborate how these changes affect the operationalization of the grant.

If **no**, provide a summary of high-level implementation arrangements focusing only on lessons learned for the next period.

In **both cases**, detail how representatives of women's organizations, key populations and people living with the disease(s), as applicable, will actively participate in the implementation.

Include a description of procurement mechanisms.

**(maximum 1 page)**

## BACKGROUND

Nigeria had an allocation of over \$1.1 billion for the 2014 - 2016 New Funding Model (NFM) implementation period. The portfolio has seven active grants across the HIV/AIDS, tuberculosis and malaria programmes. The malaria grants are being managed by two Principal Recipients (PRs): National Malaria Elimination Program (NMEP) implemented malaria treatment and prevention activities in the public sector, and the Society for Family Health (SFH) implemented activities in the private sector. The CCM has shortened the implementation period for the NFM malaria grant to two years; the grant ended on 31<sup>st</sup> December 2016. However, the savings and unspent fund within the allocation has been approved for one-year no cost extension under new Principal Recipients, the Catholic Relief Services and National Malaria Elimination Programme. Four PRs due to Additional safeguard policy and addition of FHI360 - the National Agency for Control of AIDS (NACA), the Family Health International 360 (FHI360), the Association for Reproductive and Family Health (ARFH), and SFH - are managing the four HIV/AIDS grants, with an overall aim of scaling up gender-sensitive HIV/AIDS prevention, treatment, and care and support interventions for adults and children in Nigeria. The two TB grants are managed by two Principal Recipients: ARFH for the expansion of the DOTS strategy and HIV/TB component, and the Institute of Human Virology Nigeria (IHVN) for the Multi-Drug Resistant-TB component.

By the end of the first half of 2016, the GF investment has contributed to over 950,000 PLHIV being placed and maintained on antiretroviral therapy and 310,000 new smear-positive TB cases detected and treated<sup>61</sup>. In addition, the investment also resulted in the distribution of 93.4 million insecticide-treated mosquito nets to prevent the spread of malaria. Despite these significant achievements. Despite several laudable achievements, the Global Fund programs in Nigeria has faced a number of challenges, including grants not achieving impact targets, poor quality of service delivery, and treatment disruptions. This led to GF invoking the additional safeguard policy (ASP) in April 2016, resulting in non-disbursement of funds to NACA and NMEP. As a demonstration of purposeful

leadership, the GoN has made pledges to refund the disallowed and ineligible funds, prosecuted the concerned persons/organizations and commenced capacity building of NMEP and NACA. On the basis of this, the country is looking forward to an official communication from GF indicating the lifting of the ASP.

The GF and PEPFAR continue to engage to ensure harmonisation, standardization, alignment and complementarity of programs in Nigeria. Procurement data from October 2015 to September 2016 showed that about \$154million was spent to procure commodities for the national program with PEPFAR and GF contributing 67% and 32% of the HIV commodity investment respectively.<sup>62</sup>

## PROPOSED IMPLEMENTATION ARRANGEMENT

Nigeria has been under ASP since April 2016; implementation of which involved changing current grant implementation arrangements. In addition, CCM in collaboration with country team embarked on a process of assessing states on the basis of disease burden, willingness to pay for health and readiness to meet counterpart funding requirements. Four states of Lagos, Oyo, Imo and Kaduna were identified for PR decentralization during next grant. This application proposes to continue with this decentralisation process. Grant implementation arrangements architecture review is planned and is expected to result in changes to the arrangements during grant making or implementation.

Nigeria has adopted dual track financing mechanism and used it for grant implementation arrangements (shown in Figure 17). In the current NFM grant for the HIV, there is one Government PR - NACA and three Non-Governmental Organizations (NGOs) PRs - ARFH, SFH and Family Health International 360 (FHI360). All are being recommended to continue as Principal Recipients (PRs) for HIV/AIDS grant. For TB, IHVN and ARFH are current NFM grant PRs and are similarly recommended to continue as Principal Recipients (PRs) for the TB component.

Based on lessons learnt and need for effective coordination, the Government PR will provide oversight and coordination of the national response while Ministries, Departments and Agencies (MDAs) will implement based on their core mandate as Sub-Recipients (SRs). The grant will engage four states – Lagos, Oyo, Imo and Kaduna – as state PRs for all the components of HIV/AIDS, TB and RSSH. The remaining four HIV scale-up states that will not be PRs will be engaged as SRs as was the case in the NFM grant with embedded technical assistance from partners for efficiency gains. States that will neither be PR or SRs will be served by CSO/NGO SRs alongside efforts to build capacity of respective states for grant activities implementation. Existing CSOs/NGOs will be assessed and determination will be made by respective PRs with CCM oversight on whether they will continue in their present responsibilities. ; where there is no existing SR or non-continuation determination has been made; new ones will be selected through transparent and participatory process as was the case for current NFM grant.

## LESSONS LEARNT

The OIG found that the internal control environment supporting the Global Fund grants to NACA and NMEP presented significant issues for procurement and supply chain management. In addition, major financial, fiduciary and program management issues were also identified. Potential risks and the mitigating measures to ensure improved programme quality and efficiency are highlighted in section 3.2 below.

The number of NGO SRs that will be engaged for implementation will be limited and based on actual needs, which will be determined during grant making for TB, HIV and RSSH

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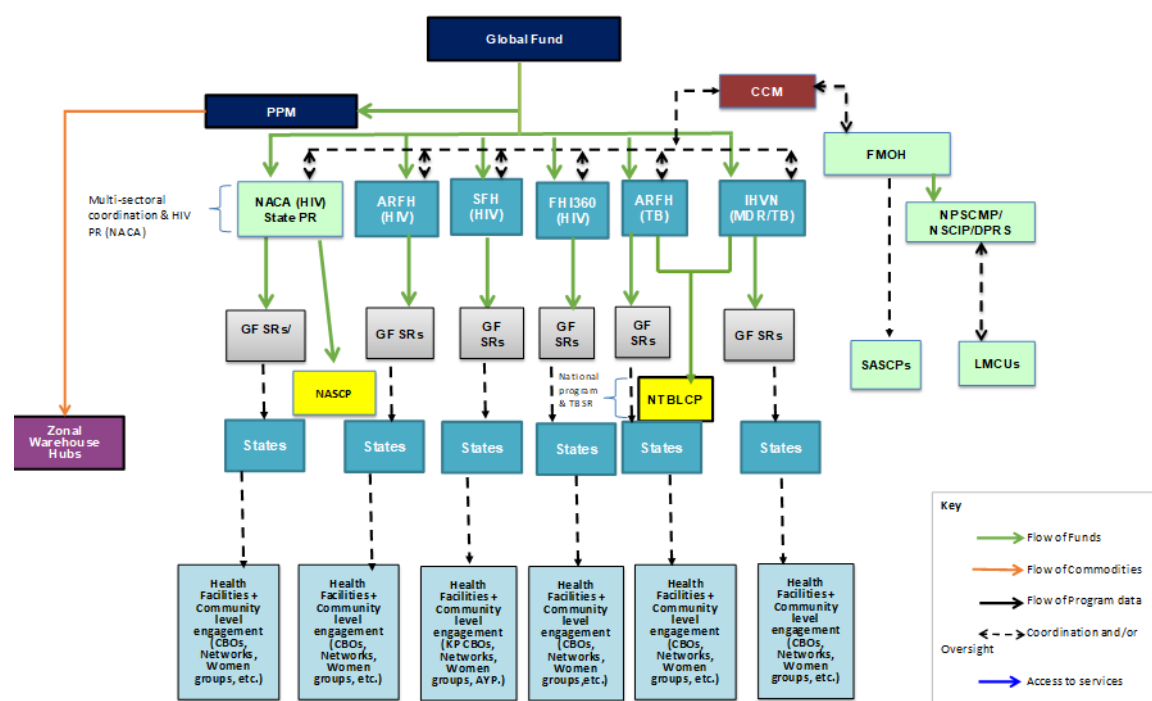
<sup>62</sup> PEPFAR.Nigeria Country Operational Plan2017. Strategic direction summary. Pg.12

components respectively. Going by key lessons learnt from NFM implementation, the SRs will be a combination of NGO, States, and government Ministries, Departments, Agencies (MDAs), including the National TB and Leprosy Control Program (NTBLCP), the National AIDS and STI Control Program (NASCAP), and the Department of Planning, Research and Statistics (DPRS) of the Federal Ministry of Health. Other government agencies like NPHCDA and NAFDAC will be considered as appropriate. This will allow for greater efficiency and value for money, and contribute to the capacity of the governments at all level to be positioned to take responsibility for such programme implementations in the future.

All health products will be procured through the Pooled Procurement Mechanism (PPM) in compliance with national and Global Fund requirements. The national PRs for coordination will be responsible, through the Global Fund, for placing orders with the PPM agents with support from National Product Supply Chain Management Programme (NPSCMP). The Other PRs will coordinate with the PPM agents and track all procurement orders to Nigeria up to the final agreed warehouses at the national or sub-national levels. The PR will also be responsible for ensuring that all ordered health products are reconciled against what is received at the warehouses from the PPM agent in a timely manner. In line with the country's present arrangement, the National Supply Chain Integration Project (NSCIP) will strengthen the management and coordination of warehousing and distribution for the key disease programmes, including malaria and reproductive health commodities. All health products procured through the PPM will be delivered to zonal warehouse hubs in Nigeria. The Last mile distribution strategies will continue to receive attention and support by Logistics Management Coordinating Unit at the state level.

The PRs will work with NMEP, NSCIP, Standard Organisation of Nigeria (SON) and the National Agency for Food and Drug Administration and Control (NAFDAC) to provide quality assurance.

**Figure 18: Implementation arrangement map**



### 3.2 Key implementation risks

Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding over the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context.

Applicant response in table below.

Risk category	Key risk	Mitigation actions	Timeline
Program management	Poor documentation due to inadequate supportive supervision at facility and LGA level	<ul style="list-style-type: none"> <li>The national program will ensure effective supportive supervision for improved documentation and quality of service delivery</li> </ul>	2018
	Weak capacity at facility, LGA and state levels (programmatic, coordination, managerial clinical and analytical) to deliver program needs	<ul style="list-style-type: none"> <li>The national program will review, update and implement the capacity-building plan which includes pre-service and in-service training and retraining of health care workers.</li> <li>Strengthen and support State team through quarterly visits (mentoring) for ongoing capacity building</li> <li>Effective supervisory system in place to identify service delivery issues and proffer solutions.</li> <li>Structural issues will entail measures e.g targeted training, incorporation into the MoU</li> </ul>	



Risk category	Key risk	Mitigation actions	Timeline
		<ul style="list-style-type: none"> <li>with state government and the SRs to retain trained staff for at least 3 years before redeployment. In case of redeployment, strong advocacy will be conducted to redeploy staff to another TB service delivery centre for continuation.</li> <li>Reconstitution of LGA team for effective program coordination and implementation at the grass root level.</li> </ul>	
	Inadequate Government financial commitment to TB at all levels	<ul style="list-style-type: none"> <li>Development and utilization of state specific advocacy tools for national and state legislative houses and state, federal executive members.</li> <li>Engagement of state governments through signing of MoUs and releasing of counterpart funds</li> </ul>	
	Loss of capacity at facility and community level due to staff attrition (transfers, retirement) and poor handover process	<ul style="list-style-type: none"> <li>Specific stipulations in the MOU between the State and SR to ensure that trained staff are retained for the grant duration, and replacements for retired staff should be timely</li> <li>Different approaches will be used for training in healthcare facilities and include more staff members</li> </ul>	2018
	Inadequate HR capacity among SRs to provide technical support to the states in a timely and good quality manner in view of the scale up	<ul style="list-style-type: none"> <li>Build the capacity of SR to respond to the program needs for the rapid scale up</li> </ul>	2018
	Delay in approval GF processes can hamper capacity building plans	<ul style="list-style-type: none"> <li>Improved and timely communication with GF on budgets and approvals needed</li> </ul>	All through the grant
Financial management	Inadequate financial control/internal auditors capacity at the implementation institutions	<ul style="list-style-type: none"> <li>Increase the budget line and deliverables for internal auditors at SR level</li> </ul>	2018
	Weak capacity at the National Program level	<ul style="list-style-type: none"> <li>Capacity building and deployment of accountants to the National Program</li> </ul>	2018
	Inadequate financial management among SSRs	<ul style="list-style-type: none"> <li>Strengthen financial capacity of SSRs by training and continuous supervision and oversight by PR and SRs</li> <li>Capacity building in financial management for accountants and program managers of PR, SR, States, treatment facilities</li> <li>Engage technical assistant to improve-on or change accounting software.</li> </ul>	2018
	Ineffective Data management system at facility, LGA and state levels (completeness quality, analysis)	<ul style="list-style-type: none"> <li>Strengthen capacity at the LGA level to improve data management including : a) provision of an assistant TBLS from the LGA and b) periodic training for the TBLS and the assistant to address data quality issues</li> </ul>	All through the grant
	Transition to electronic reporting adds risk to data management system	<ul style="list-style-type: none"> <li>Enhance the existing electronic management unit to support full deployment and maintenance of data systems, staff and equipment</li> </ul>	2018

Risk category	Key risk	Mitigation actions	Timeline
M&E	Sub-optimal data quality at LGA and facility level	<ul style="list-style-type: none"> <li>Capacity building for LGA and facility staff on quality recording and (electronic) reporting,</li> <li>Continuous oversight and supportive supervision on data quality checks (DQA)</li> </ul>	2018 and 2019
	Sub-optimal capacity at LGA and State level to analyse, properly utilize and present the data for managerial and advocacy purposes	<ul style="list-style-type: none"> <li>Capacity building and continuous oversight of M&amp;E staff at State and LGA level.</li> </ul>	2018 and 2019
	Insecure supply and storage of commodities due to non-insurance	<ul style="list-style-type: none"> <li>Insurance of drugs and commodities at state and zonal stores as part of the MoU</li> </ul>	2018
PSM	Stock outs of Capreomycin exceeding the quantified ratio of 40/60 (C/K), due to increase utilization as a results of increased reported side effects of Kanamycin in the TB program	<ul style="list-style-type: none"> <li>Ensure adherence to SOP for use of Capreomycin by facility and State TB programs.</li> <li>Adoption of the shorter regimens and new drugs to reduce exposure to injectables.</li> </ul>	2018
	Long lead times for 2L drugs and commodities resupplies due to longer pipeline with introduction of NSCIP	<ul style="list-style-type: none"> <li>Ensure that the integration processes is strengthened to comply with requested lead times</li> </ul>	All through the grant
	Expansion of expected GDF standard lead times (e.g. INH, microscopes), leading to shortages of drugs or labs commodities	<ul style="list-style-type: none"> <li>Effective dialogue with GDF request for a mission to address excessive lead times being excluded</li> <li>Timely forecasting and requests to GDF</li> <li>Request shorter lead times from GDF</li> </ul>	All through the grant
	Sub-optimal LMIS system for TB and MDR-TB to include reporting to all facilities	<ul style="list-style-type: none"> <li>Ensure adequate staff for LMIS monitoring, supervision and capacity building of State and facility level staff</li> <li>Install robust LMIS software for treatment centres, laboratories and State TB programs.</li> </ul>	All through the grant
	Inadequate storage capacity for SLD and other TB commodities	<ul style="list-style-type: none"> <li>Support the upgrade of some state stores</li> </ul>	2018 and 2019

## SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY

This section details trends in overall health financing, government commitments to co-financing, and key plans for sustainability. Refer to the **Funding Landscape Table(s)** and supporting documents as applicable. To respond, refer to additional guidance provided in the *Instructions*.

### 4.1 Funding Landscape and Co-financing

a) Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? <b>If yes</b> , provide details below.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
b) Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health-financing reforms? <b>If yes</b> , provide a brief description below.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c) Have previous government commitments for the 2014-16 allocation been realized? <b>If not</b> , provide reasons below.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
d) Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy? <sup>63</sup> <b>If not</b> , provide reasons below.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
e) Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, <b>specify</b> below how realization of co-financing commitments will be tracked and reported.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>(maximum 2 pages)</b>	

The central theme of the Nigeria's new National Health Policy is Universal Health Coverage. National Health Policy. The just finalised National Health Development Strategic Plan II (NHSDP II) framework also has the same central theme, and reiterates the commitment of the government of Nigeria to ensuring adequate and sustained funding for the health sector and the national health programs.

### CURRENT/PLANNED ACTIONS TO INCREASE DOMESTIC RESOURCES FOR HEALTH

The following are the current /planned actions to increase domestic resources for health:

- i. **Health Insurance:** The National Health Insurance Scheme (NHIS) covers both the formal and informal sectors, including the private sector. In the 2016 budget, NHIS was allocated NGN 49, 031,950,206.00 (<http://www.budgetoffice.gov.ng>) (equivalent to \$160m). NACA is currently advocating for NHIS to integrate coverage of patients living with HIV for both testing and in their basic package of care as part of sustainable long-term solution to the HIV and AIDS funding. Also, Community Based Health Insurance Scheme (CBHIS) was instituted to support the artisans and other informal sectors to access quality health services at a minimal cost (Ipaye, 2016).
- ii. **Program for Results initiatives:**

<sup>63</sup> Refer to the [Sustainability, Transition and Co-Financing Policy](#).

- a. The Saving One Million Lives Initiative (SOML-PforR) provides an opportunity for States to address governance and management issues towards ensuring greater focus on results; increased accountability; improved measurement; and encouragement of innovation.[SOML Implementation Framework; SOML 2016]. The SOML is financed by a \$500 million International Development Association credit from the World Bank to the Federal Government and then disbursed to the states as grants and good performance as reflected by improvement in maternal and newborn indices attracts additional financing for some malaria-related activities.
- iii. PHC Revitalization: The Government of Nigeria has initiated the revitalization of 10,000 PHCs in the 9,423 wards from the 774 LGAs in Nigeria. The revitalization program involves upgrading the existing PHCs to acceptable minimum standard as recommended by WHO, which includes provision of qualified medical personnel, facility and medical equipment. It builds on existing state-led initiative to reform PHCs, provides a platform for partner programs focusing on improving inputs for service delivery and is backed by federal resources. In the 2017 budget, the sum of N3bn was earmarked for the revitalization. In addition, the Federal Government has commenced the upgrading of 110 PHCs with necessary infrastructure.
- iv. Pharma-grade Commodity Stores: In the light of non-availability of Government-owned Pharma-grade facilities for the storage of health products in the public sector, the government of Nigeria has offered some existing Central Medical Stores in 5 States – Cross River, Gombe, Imo, Lagos and Sokoto states – for upgrade to the status of Pharma-grade with support of partners (NSCIP, 2016). The Federal Government has also provided land for the construction of another pharma-grade facility (Warehouse in a Box) in Abuja and Lagos, with the support of partners.
- v. Private Sector Engagement Strategy: A PPP Platform, launched in 2016 by the Malaria Ambassador, Alhaji Aliko Dangote, provides a framework for private sector investment/engagement in Malaria Control. Additionally, the partnership between TANA netting and local partners for production of WHOPEs approved LLINs in Nigeria has reached advanced stages. In addition, the MTN Foundation is providing support for HIV/AIDS prevention as well as psychosocial support to people infected and affected by HIV.
- vi. Presidential Committee on North-East Intervention (PCNI): This special intervention of the Federal Government initiated in October 2016 with a budget of \$44.95m [NPHCDA/DPRS-FMOH] and aimed at immediate provision of basic social and natural resource management infrastructure and services to the communities affected by the Boko Haram insurgency, thus assisting the promotion of resettlement, recovery, and welfare of the internally displaced persons (IDPs), and the returnees.
- vii. Third World Bank HIV Prevention Development(HPDP III): The Minister of Finance, National Planning and Budget and the Country Director of World Bank have commenced the processing of HPDP III to enable Nigeria augment the expected shortfall in commodity funding as a result of Lower Middle income country classification, which will impact on resources available for commodities and programs by as much as \$55million
- viii. Earmarking a proportion of monthly federal allocation to States for HIV: The 59<sup>th</sup> national council of Health resolved that 0.5 – 1% of the monthly federal allocation to States be earmarked for financing the implementation of HIV sustainability roadmap.

- ix. GoN commitment to universal free antenatal services: Government of Nigeria supports the accelerated implementation of universal free antenatal services and abolition of user fees associated with clients accessing PMTCT services

#### **4.1B) GLOBAL FUND'S REQUESTED SUPPORT FOR DEVELOPING A HEALTH FINANCING STRATEGY AND HEALTH FINANCING REFORMS**

Most recently, NACA with the financial support of GoN has taken responsibility for the management and treatment of PLWHA in Abia and Taraba States. Though initial work had begun, the Country intends to expand this in the current FMOH operational budget for 2017. In addition, the TB programme plan to procure GeneXpert machines with Government resources in 2017 worth \$1.3million and second line drugs worth \$462757. This application will be requesting Global Fund's support for the implementation of the Harmonized Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund (BHCPF) service package, which includes PMTCT. This BHCPF guideline is a strategy for operationalising the National Health Act, which is the overarching framework for health care financing sustainability in Nigeria.

#### **4.1c) Demonstration of WTP**

Though the country is currently in economic recession [NBS, GDP 2016], with its attendant challenge for the Federal and State governments to meet their recurrent financial obligations, the Federal Government has appropriated \$15,798,831 for all the three disease streams' OIG refunds and GoN effecting part payment in the 2017 Federal Budget for 2017 [Nigeria Budget, P.1147] following sustained high-level advocacy. In addition, Nigeria's is currently working towards effecting the mobilization of the Counterpart Fund of \$45.7m, \$19m-MDR-TB and \$6.9m PMTCT for the NFM.

In addition, the National Programs and Agency is working with the state actors to complete the documentation on the actual expenditure as required to fulfill the counterpart financing in NFM. The computation will be validated in line with national system with the Audited report from Accountant General. The Hon. Minister of Finance and counter-sign by Hon. Minister of Health will sign the forwarding letter as required.

#### **4.1d) Government Expenditure on Health aims to Achieve Implementation of the National Health Act through the Universal Health Coverage (UHC) Goals**

There has been an increase in the absolute financial allocation to health and HIV/TB in the Federal budget (Table 4). Through Human Resources costs, investments in equipment and commodities, and other health-related costs, the Federal Government of Nigeria has met the NFM co-financing requirements of \$100,206,308. These costs include those of the National Health Insurance Scheme (NHIS), which at a budget of NGN49,031,950,206 (\$160,760,492) in 2016 [<http://www.budgetoffice.gov.ng>] represents a core strategy for addressing UHC by addressing barriers to access to health care for the major causes of ill health (notably malaria). For the 2017-2019 allocation period, the projected commitment from NHIS alone is over \$700m, hence this exceeds Nigeria's co-financing requirement.

**Table 4: Federal Budget and Health Allocation, Nigeria, 2014-2016**

FEDERAL BUDGET (\$, 000)					
ITEM	2014	2015	2016	2017	TOTAL
FEDERAL BUDGET	16,268,852	14,288,524	19,934,426	23,934,426	74,426,229
HEALTH BUDGET	861,450	844,405	843,875	997,347	3,547,079

#### **4.1e) National Health Accounts**

The Government of Nigeria in its current pursuit for accountability is progressively increasing the emphasis on the value of tracking resources for health including out of pocket expenses. Through the Global Fund's support, FMOH institutionalized National Health Accounts. The framework, tools and technical support to set up a harmonized, integrated platform for annual and timely collection of health expenditure data are still on-going. This, if achieved, will strengthen the capacity of FMOH to monitor and report health expenditures using existing global standard frameworks. In addition, these expenditures will be analysed to produce relevant data for national planning purposes. Part of the \$30,724,287 allocation to the HMIS/M&E being requested in this grant application under the RSSH component will be used to institutionalise mechanisms for routine health and disease expenditure tracking. Approximately, \$300,000 will be used to support NHA 2015-2016 survey and institutionalization of routine health and disease expenditure tracking through NBS and NHMIS.

## 4.2 Sustainability

Describe below how the government will increasingly take up health program costs, and actions to improve sustainability of Global Fund financed programs. Specifically,

- a) Explain the costs, availability of funds and the funding gap for major program areas. Specify in particular how the government will increasingly take up key costs of national disease plans and/or support health systems; including scaling up investments in programs for key and vulnerable population, removal of human rights and gender-related barriers and enabling environment interventions.
- b) Describe actions to improve sustainability of Global Fund financed programs. Specifically, highlight key sustainability challenges of the program(s) covered by the funding request, and any current and/or planned actions to address them.

(maximum 1 page)

## Part A

*Government of Nigeria initiatives:* These include the Basic Health Care Provision Fund, the health insurance scheme, and the Program for Results initiatives as described in section

The GoN, over time, has promoted the mainstreaming of HIV treatment, care and support into the general health care delivery, with emphasis on ownership of the response by sub-national entities such as the local and state governments. With this approach, both the national and sub-national governments will increasingly take over responsibility for the HIV programme. The designation of some state PRs under the GF grant is one of the steps in the direction. Related but slightly different arrangements are in place for TB and Malaria.

The sustainability of the country's HIV and TB response is hinged on implementation of the respective strategic plans/framework. For HIV, a strategic framework has been developed and is being used by states to develop their investment plans. Within this context, UNAIDS for example, is currently supporting development of investment cases through Avenir Health in six States (Benue, Akwa Ibom, Nasarawa, Cross River, Rivers and Kaduna). The resulting state investment plans will enhance high-level advocacy with State Governors for states' investment that will ensure the sustainability of HIV program. All HIV state investment plans will be consolidated to come up with costed NSP and its investment portfolio.

Efforts have already started to mobilize resources for TB program with 2017 declared as a year of accelerating TB case finding. In addition, plan is in place to mobilize resources through World Bank loan as well as engaging the Private Sector for supporting the program as part of their Corporate Social Responsibility. For RSSH, a sector strategic plan is currently under development, alongside the PHC revitalization flagship programme and enhanced implementation and revision of nation health insurance scheme. All these are geared towards ensuring that the health system is sustainably funded.

### Existing Funding Gaps for Key Interventions

For interventions with funding gaps as reflected in Table 5, Nigeria will be requesting the GF to co-finance these interventions in order to sustain the gains already made, while programming for sustainability and transitioning through engagement in high-level in-country advocacy for increased resource mobilization.

**Table 5: Programme/Intervention Areas, Available Fund and Gaps**



		2018	2019	2020	2021
		(\$)	(\$)	(\$)	(\$)
<b>Prevention</b>					
Funding Need		299,013,558	337,646,110	381,269,987	430,530,069
Domestic		135,144,235	135,144,235	82,887,683	82,887,683
Non Global Fund External		78,125,946	68,298,903		
Funding Gap		85,743,378	134,202,972	298,382,304	347,642,387
<b>HIV Testing Services (HTS)</b>					
Funding Need		105,284,365	118,887,105	134,247,319	151,592,073
Domestic		47,585,050	47,585,050	29,185,222	29,185,222
Non Global Fund External		27,508,587	24,048,430	0	
Funding Gap		30,190,728	47,253,626	105,062,097	122,406,851
<b>EMTCT</b>					
Funding Need		52,911,963	59,748,189	67,467,655	76,184,476
Domestic		23,914,457	23,914,457	14,667,395	14,667,395
Non Global Fund External		13,824,782	12,085,837		
Funding Gap		15,172,725	23,747,895	52,800,260	61,517,081
<b>Treatment</b>					
Funding Need		80,814,870	91,256,151	103,046,446	116,360,046
Domestic		36,525,647	36,525,647	22,402,186	22,402,186
Non Global Fund External		21,115,224	18,459,253		
Funding Gap		23,173,999	36,271,251	80,644,260	93,957,861
<b>Care &amp; Support</b>					
Funding Need		148,618,841	167,820,395	189,502,791	213,986,551
Domestic		67,170,799	67,170,799	41,197,702	41,197,702

<b>Total Funding Gap</b>		<b>196,897,899</b>	<b>308,178,706</b>	<b>685,194,010</b>	<b>798,313,028</b>
<b>Total Allocated Fund (GF) in New Grant</b>		<b>60,041,158.14</b>	<b>71,233,666.18</b>	<b>85,307,566.83</b>	<b>0</b>
<b>Total Remaining Funding Gap.</b>		<b>136,856,740</b>	<b>236,945,040</b>	<b>599,886,443</b>	<b>798,313,028</b>

Specifically, the Government will increasingly take up program costs of the National disease plan by:

- Ensuring that evidence-based annual TB/HIV plans and budgets (at national and subnational levels) feed into the overall health sector development plans;
- Advocate for States to maintain and increase funding for TB/HIV programs in the state annual budgets;
- Increasingly utilizing government personnel to provide the required technical input to implement ATM programs.

#### 4.2B. GAINING EFFICIENCIES IN PROGRAM IMPLEMENTATION

Efficiency gains will be achieved through adopting approaches that reduce expenditure on routine program implementation activities identified to drive implementation costs including: the use of ICT-platforms for training; fostering service integration; leveraging on the USG PEPFAR Site Improvement through Monitoring Systems (SIMS) tools and training state personnel to use the tools; targeting high-yield groups and geographical areas for HTS and other services; use of differentiated care approach in service delivery; and, engagement of private sectors in the transportation of specimens and results regarding viral load testing to

optimise the use of available diagnostic facilities. Joint programming by GoN and key partners in terms of PSM through the National Supply Chain Integration Project enhances efficiencies; the intended engagement of the private sector will also enhance efficiencies.

## SECTION 5: PRIORITIZED ABOVE ALLOCATION REQUEST / UPDATE

### Prioritized Above Allocation Request

Provide in the table below a prioritized above allocation request which, if deemed technically sound and strategically focused by the TRP, could be funded using savings or efficiencies identified during grant-making, or put on the Register of Unfunded Quality Demand to be financed should additional resources become available from the Global Fund or other actors (e.g. private donors and approved public mechanisms such as UNITAID and Debt2Health). This above allocation request should include clear rationale and should be aligned with the programming of the allocation for maximum impact. The request should reflect the order in which interventions will be funded if additional resources become available. In line with the Global Fund's Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the allocation amount).

[HIV and AIDS Component] – Copy the table as needed, if your funding request includes more than one component

Module	Interventions	Amount requested	Brief Rationale, including expected outcomes and impact (how the request builds on the allocation)
Differentiated ART Service Delivery for Adults	ART-Adults	18,240,000	The unmet need for treatment in Nigeria is very huge even though there are will be more than 1 million people on treatment by end of 2017. PEPFAR is scaling in 32 LGAs with high burden and under this allocation GF grants will focus on 8 scale up States with high burden and focus on LGAs with high HIV burden and huge unmet needs. This additional 60,000 people to be supported on treatment will help close the treatment gap in these priority States and the national treatment coverage will increase to 53% by end of 2020. This additional target will yield significant benefits in terms new infections averted, deaths averted and life years gained as shown with the investment in the allocated amount. It is important to note that the GON is committed to closing the treatment gap with domestic resources and so this additional investment will serve as an impetus via global solidarity to encourage GON to do more for its people. The world cannot meet its fast track target and celebrate ending AIDS without Nigeria.

Differentiated ART Service Delivery for Adults	HTS for Adults	10,000,000	To put 60,000 more people on treatment will require testing about 2,000,000 people in high burden states.
Differentiated ART Service Delivery for Children	Paed ART	5,776,000	This additional investment will put 21,000 children additional on treatment and will increase pediatric coverage from 42% in 2018 to 51% in 2019 and 65% by end of 2020. This target is realistic although not achieving the 90-90-90 target for children. Nigeria will however, be on track to achieving this target when PEPFAR makes its commitments in its next country operational plan. This is a great opportunity to build on what works for Nigeria based on the experiences from the implementation of the previous GF grants as well as building synergies on PEPFARs experiences and investment.
Differentiated ART Service Delivery for Children	HTS for Children and young adolescents <15 years	3,500,000	To put 21,000 children on ART, it will require testing 700,000 children and young adolescents <15 years.
ART Service Delivery for Children	EID	1,800,000	All HIV exposed infants will be screen for HIV as part of early infant diagnosis. 90,000 babies will be screen.
PMTCT	PMTCT ARV	13,680,000	This prioritized request for PMTCT is to help Nigeria fast track its efforts towards its elimination target because without Nigeria, it will be impossible for the world to eliminate MTCT as per the Global Plan and the Political Declaration 2016 at the high level meeting. This additional investment for PMTCT is to ensure that Nigeria achieves the "Start Free, Stay free and AIDS free" agenda of UNAIDS and OGAC towards an HIV free generation. This prioritized request will significantly close the gap on unmet need for PMTCT in Nigeria. PMTCT coverage in addition to the targets in the allocated amount will increase from 65% in 2018 to 77% in 2019 and 92% in 2020. This investment will definitely lead to saturation in the 8 scale up States as well as other States with high PMTCT need. The potential impact of this will be enormous and will surely change the game in Nigeria and will have a significant global effect.
PMTCT	PMTCT HTS	23,076,923	For the above target of 90,000 HIV positive women to be reached with PMTCT services to be achieved, additional 4.6 million pregnant women will have to be tested aggressively in

			order to achieve the desired impact on the elimination agenda in Nigeria. The capacity to deliver on this target is available in country and will leverage the existing foundation already laid by PEPFAR and the current grant.
Prevention programs for MSM	MSM PrEP	1,138,500	This intervention expands the scope of prevention intervention for MSM, and pilots the use of PrEP for MSM in Nigeria. PrEP will target between 15-20% of MSM at substantial risk to HIV. The intervention will be in addition to the minimum package, which will be reviewed during implementation. PrEP will significantly reduce the incidence of HIV among MSM.
Prevention programs for MSM	MSM HBV Test	441,105	This intervention expands the scope of prevention intervention for MSM with regards to early detection of HBV, and will therefore facilitate linkage to treatment that will improve health and survival of MSM
Prevention programs for FSW and their clients	MPPI for FSW	7,500,000	By reaching additional 30,000 FSWs in 2019 and 2020 the national coverage will increase from 21% to 29%.
Prevention programs for FSW and their clients	FSWs PrEP	617,854	Since PrEP is a new intervention, it is assumed that between 5-10% of FSW at substantial risk will be provided with PrEP during the period of implementation. This intervention will reach over 9,000 FSW and it is anticipated to significantly reduce the incidence of HIV among FSW.
Prevention programs for FSW and their clients	FSW- Repeat HBV test	225,000	A total of 30,000 FSW will be tested for HBV as part of the minimum package for FSW. This package will be additional to the minimum package which will be reviewed during the course of implementation.
Prevention programs for PWID and their partners	MPPI for PWID	831,360	By putting additional 716 PWID per year, a total of 2,598 PWID will be reached to increase the national coverage from 96% to 100% over the period of implementation.
Prevention programs for PWID and their partners	PWIDs HBV and HCV tests	564,030	This intervention provides an opportunity to build on the prevention intervention targeted at PWID under the existing grant. The proposed grant will provide maintenance intervention for PWID currently covered by GF grant, and cover additional PWID
Prevention programs for adolescents and youth	Adolescent and Young Persons	18,000,000	HIV sero-prevalence has increased from 1.7% in 2007 to 2.9% in 2012 among adolescents in Nigeria, and the females have higher rate compared to males. Interventions to reduce HIV and the associated behavioural risk among adolescents and youth is critical to the future trajectory of the HIV epidemics

			in Nigeria. A total of 320,000 adolescent and young persons will be reached with combination prevention package
<b>Sub total for HIV</b>		<b>\$105,390,772</b>	
<b>TUBERCULOSIS</b>			
<b>Module</b>	<b>Interventions</b>	<b>Amount requested</b>	<b>Brief Rationale, including expected outcomes and impact (how the request builds on the allocation)</b>
TB care and prevention-detection and diagnosis	Engage all health facilities (Non-DOTS facilities) in identification and referral of presumptive TB cases	\$1,600,000	<ul style="list-style-type: none"> <li>• TB services are currently provided in 6620 DOTS centres representing about 20% of the total health facilities in the country.</li> <li>• The remaining 80% of the health facilities (Non-DOTS facilities) in the country, though diagnosed TB cases, the TB cases diagnosed in these Non-DOTS facilities are not reported to the NTBLCP, consequently contributing to low TB case detection rate of 17%.</li> <li>• This intervention intends to expand basic TB services (TB identification and referral of Presumptive TB cases) to all the Non-DOT health facilities across 14 states which accounts for 40% of the missing TB cases (Katsina, Bauchi, Jigawa, Imo, Borno, Niger, Akwa-Ibom, Ogun, Benue, Ondo, Enugu, Edo, Kogi and Osun in the country.</li> <li>• This intervention will contribute at least a total of about 5,000 additional DS-TB and 200 DR-TB cases to the programme</li> </ul>
TB care and prevention-detection and diagnosis	Integration of TB in maternal and child health services to find the missing TB cases among Children	\$2,800,000	<ul style="list-style-type: none"> <li>• The country currently missed 92% of the estimated TB cases among children.</li> <li>• To address, the programme for the first time with the above allocation intends to invest in the integration of TB into the maternal and child health services in 8 priority states.</li> <li>• Routine and systematic TB screening including the use of Xray and GeneXpert for diagnostic services will be implemented in all maternal and childhealth services in these states.</li> </ul>



			<p>This will contribute to increasing the TB case finding among children in these states by 50% relative to 2016 level</p>
<p>TB care and prevention- Case detection and diagnosis</p>	<p>Implement evidence based ACSM strategies to raise awareness about TB and commitment</p>	<p>\$8,000,000</p>	<ul style="list-style-type: none"> <li>• The KAP survey in 2012 revealed that only 22% of Nigerians are aware about TB</li> <li>• The National Prevalence survey also revealed that majority of the TB patients are in the community and do not seek services</li> <li>• The programme with the above allocation intends to invest in raising awareness about TB using evidence based medium and platforms. The current ACSM implementation will be reviewed to generate and implement interventions that will yield results</li> <li>• IEC materials and posters will also be produced</li> <li>• The Nigeria STOP TB partnership efforts in mobilizing high level political commitment for the programme will be supported and strengthened to include all the 36 states and FCT</li> </ul> <p>This will contribute to increased TB in awareness and political commitment, which will have significant effect on finding the missing TB cases and enhancing programme sustainability</p>
<p>MDR TB</p>	<p>High quality MDR-TB Treatment</p>	<p>\$24,870,650</p>	<ul style="list-style-type: none"> <li>• 2<sup>nd</sup> line anti TB treatment (shorter and individualized regimen) for 50% (5033) of the expected number of RR and/or MDR-TB cases (10,065) to be notified during the period of grant implementation (2018 – 2020) are provided for within the allocation amount</li> <li>• The above allocation will be used to care for the remaining gap of 50% (5033) of RR and/or MDR-TB cases without treatment (see TB Programmatic table)</li> <li>• This will ensure that second line treatment, ancillary drugs, investigations and other supports are provided for 5,033 RR and /or MDRTB and 252 XDR TB cases that are not provided for within the allocation amount, thus reducing morbidity and mortality among this group of patients.</li> </ul> <p>Capacities to treat XDR-TB will also be expanded to 5 zones in the country to enhance access</p>

MDR-TB	Strengthen Laboratory network and capacities to function effectively	\$10,000,000	<ul style="list-style-type: none"> <li>The above allocation was invested in ensuring optimization for some of the GeneXpert sites and reference laboratories, leaving some gaps.</li> <li>The above allocation will also be used to support EQA, Accreditation and capacities of the reference laboratories to function effectively including HR support. This also include upgrading some of the labs (BSL2 and LPA) to be able to address the planned commencement and scale up of the shorter regimen</li> <li>This will ensure maximal functioning of all reference laboratories in the country and will also facilitate the roll out of shorter regimen for the 10,065 DR-TB patients</li> </ul>
TB care and prevention- Case detection and diagnosis	Active TB case finding in slums and congregate settings in 5 states	\$5,000,000	<ul style="list-style-type: none"> <li>National TB case finding target for the years 2018 to 2020 is 1,514,332 as reflected in TB NSP. This funding application caters for 427,110 within allocation and 27,500 through catalytic funding request. The 5,000 included in above allocation is for a specific intervention of TB screening that has not been catered for within allocation or through incentive funding. This intervention is expected to increase detection of TB suspects that are thereafter referred to DOTS centres for diagnostic assessment. If the above allocation is not approved, planned introduction of TB screening facilities will have to be postponed</li> <li>The active case finding supported within the slums yielded appreciable results in 5 of the states (the 5 states are: Lagos, Oyo, Kano, Osun, and Kaduna) contributing greatly to the 10% increase in case notification observed in 2016.</li> <li>The programme therefore intend to invest the above allocation to conduct active case finding in additional slums within these 5 states and increasing these other congregate settings within the 5 states</li> <li>Access to on the spot GeneXpert services will be enhanced in the slums. The screening algorithm</li> </ul>

			<p>will also be modified to include X-ray to further enhance the sensitivity of the scree</p> <p>This is expected to contribute to finding the missing TB cases and will increase contribution to case finding by 25% relative to 2016 level in these states.</p>
TB care and prevention- detection and diagnosis	High quality DOTS Expansion and Enhancement including strengthened capacities for patient centered TB/HIV services	\$15,000,000	<ul style="list-style-type: none"> <li>• To achieve the population coverage with DOTS and microscopy centres as stated in the NSP</li> <li>• 1,765 additional DOTS centres (765 in 2018; 800 in 2019 and 200 in 2020) will be established in the grant period to achieve the NSP target of 1 per 25,000 populations for DOTS treatment centres</li> <li>• The capacities of the 1,765 facilities will also be enhanced to provide patient-centred TB/HIV services using one-stop shop model</li> <li>• 1,427 additional microscopy centres will also be established in the grant period to achieve the NSP target of 1 per 50,000 populations for microscopy centres</li> <li>• To make the non-functioning DOTS centres functional, the challenges at the 20% of the existing DOTS centres that not functioning will be addressed and the centres makes functional</li> <li>• The QA for the microscopy centres for the 36 states and FCT was also not covered in the allocation amount and thus included here</li> <li>• This will significantly contribute to increase case notification and reduce the gap in case finding</li> </ul>
TB care & Prevention and MDR-TB	Operational Research and M&E	\$6,000,000	<ul style="list-style-type: none"> <li>• The investment in MDR-TB with the and patients' allocation amount focused more on diagnosis, drugs and patients support with no investment in Operational Research and other key M&amp;E interventions.</li> <li>• The above allocation will therefore be used to support operational research, TB QUAL, data harmonization, State DR-TB Meeting and other DR-TB focused supervisions.</li> <li>• The gap in M&amp;E component of the DS-TB such as end term evaluation of the NSP, operational</li> </ul>

			researches, epi-analysis also included This will help generate evidence for enhancing programme performance and for changing policy towards addressing and reducing the current 85% gap in DS-TB and 94% gap in MDR-TB case detection.
<b>Sub-Total for TB</b>		<b>\$73,270,650</b>	
<b>TOTAL AMOUNT (HIV + TB)</b>		<b>\$178,661,422</b>	

#### Relevant Additional Information (optional)

Provide any additional contextual information relevant to the prioritized above allocation request (e.g. any explanations that further clarify linkages to the allocation funding; any considerations or data that informed the request or updates of the request; etc.)