Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM

FIFTH CALL FOR PROPOSALS

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Fifth Call for Proposals for grant funding. This proposal form should be used to submit proposals to the Global Fund. Please read the accompanying Guidelines for Proposals carefully, before filling out the proposal form.

Timetable: Fifth Round

Deadline for submission of proposals	June 10, 2005
Board consideration of recommended proposals	September 28 – 30, 2005

Resources available: Fifth Round

As of the date of the Fifth Call for Proposals, US$ [to be determined] million is available for commitment for the Fifth Call for Proposals. It is anticipated that additional resources will become available prior to the Board consideration of proposals. The amount available will be updated regularly on the Global Fund's website. Any information submitted to the Global Fund may be made publicly available.

Geneva, 17 March 2005

Notes:

How to use this form:

1 Ensure that you have all the documents that accompany this form—the Guidelines for Proposals, and Annexes A and B to this proposal form.

2 Please read ALL questions carefully. Specific instructions for answering the questions are provided.

3 Where appropriate, indications are given as to the approximate length of the answer to be provided. Please try to respect these indications.

4 To tick any of the boxes in the form, move the cursor to the textbox, right click and choose 'properties', then 'default value' 'checked'.

5 To avoid duplication of effort, we urge you to make maximum use of existing information (e.g., program documents written for other donors/funding agencies).

6 Instructions and guidelines are printed in blue

Annexes:

Annex A: Impact and Coverage Indicators (incl. glossary of terms)
Annex B: Green Light Committee Applications

1 Eligibility

Proposal title	**Scale-up of Comprehensive HIV and AIDS Treatment, Care and Support in Nigeria.**
Name of applicant	Country Coordinating Mechanism (CCM), Nigeria.
Country/countries	NIGERIA

Type of application:

- ☒ National Country Coordinating Mechanism
- ☐ Sub-National Country Coordinating Mechanism
- ☐ Regional Coordinating Mechanism (including Small Island Developing States)
- ☐ Regional Organization
- ☐ Non-Country Coordinating Mechanism

[Please tick one of the boxes to categorize your application type; refer to Guidelines for Proposals, section II, paragraphs C1 to C4.]

Proposal components

- ☒ HIV/AIDS[1]
- ☐ Tuberculosis[2]
- ☐ Malaria
- ☐ Health system strengthening

[Please tick the appropriate box or boxes for your proposal target; refer to Guidelines for Proposals, section III, A.]

Currency in which the Proposal is submitted

- ☒ US$
- ☐ Euro

[Please tick the appropriate box. Please note that all financial amounts appearing in the proposal should be denominated in the selected currency only.]

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[1] In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

[2] In contexts where HIV/AIDS is driving the tuberculosis epidemic, tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

1 Eligibility

[Countries classified as "lower-middle-income" or "upper-middle-income" by the World Bank are eligible to apply only if they meet additional requirements (see the Guidelines for Proposals, section II.A.).]

Country/countries	NIGERIA

☒ Low-income
☐ Lower-middle-income [see paragraph 1.1 below]
☐ Upper-middle-income [see paragraph 1.1 below]

[See the Guidelines for Proposals, Annex 1. For proposals from multiple countries, complete the above referenced information separately for each country.]

1.1 Lower-middle-income and upper-middle-income country

[Sections 1.1.1 and 1.1.2 must be filled out for these two categories; without this information, this proposal will not be considered for financing.]

1.1.1 Counterpart financing and greater reliance on domestic resources

[For definitions and details of counterpart financing requirements, see the Guidelines for Proposals, section II.A.
The field "Total requested from the Global Fund" in the table below should match the request in sections 5.1]

Table 1.1.1 – Counterpart Financing and Greater Reliance on Domestic Resources

Financing Sources	In Euro / US$				
	Year 1	Year 2	Year 3 estimate	Year 4 Estimate	Year 5 estimate
Total requested from the Global Fund (A) [from Table 5.1]					
Counterpart financing (B) [linked to the interventions for which funds are requested under (A)]					
Counterpart financing as a percentage of: B/A x 100 = %					

1.1.2 Poor or vulnerable populations

Describe how these populations have been identified, and how they will be involved in planning and implementing the proposal (2–3 paragraphs).

1.2 CCM functioning - eligibility criteria

[To be eligible for funding National/Sub-National/Regional (C)CM applications have to meet the requirements outlined in 1.2.1 to 1.2.3.][Question not applicable for Non-CCM applications.]

1 Eligibility

1.2.1	Demonstrate CCM membership of people living with and /or affected by the diseases. *[This may be done by demonstrating corresponding CCM membership composition in section 3.6.3 'Membership Information.']*
	The Membership list of CCM Nigeria (Revised-March 2005) has been attached as Annex A for easy reference. Members have also presented constituency authentication note to the CCM for their sector mandate to participate in the CCM in a representative capacity.

1.2.2	Provide evidence that CCM members representing the non-governmental sectors have been selected by their own sector(s) based on a documented, transparent process developed within each sector. *[Please summarize the process and attach documentation as an annex.]*
	CCM Nigeria requested member-constituencies to provide authentication evidence of nomination of representative to the CCM Nigeria and the procedure used in arriving at the nominee. The CCM was therefore restructured to meet the GFATM requirements on the basis of submission of authenticated letter of engagement by constituencies.

1.2.3	Describe and provide evidence of a documented and transparent process to:
a)	Solicit submissions for possible integration into the proposal *[please summarize and attach documentation as an annex.]*
	The CCM Nigeria, during its 12th and 13th meeting reviewed the experiences of previous Rounds of Call for Proposal and concluded that effort will be made to reach the wider general population and stakeholders who may respond to the 5th Round Call when published. It however decided that the process to be adopted to enable management of large responses will be through the representative constituencies and sectors in the CCM. The constituencies were therefore informed at the meeting to note the planned process as against the release of the 5th Round Call. In implementation therefore, the CCM Nigeria initiated a series of three Consensus Building meetings of Stakeholders in the four components of the Round 5 Proposal Call. The consensus building meetings were conducted respectively for HIV-TB (Health Sector) on March 22 2005, Malaria on March 23 and another for HIV (Multi-sector) and Health Systems on April 13 2005. Participants to the consensus building meetings were requested to consult with their constituencies on areas of work to be addressed by the Round 5 Proposal and to bring these inputs along to the meeting. The CCM Nigeria therefore obtained constituency input during three sessions of Consensus building meetings and beyond, which constituted the building blocks of the Proposal structure for the four proposal components. Additionally, "sub-proposals" from NGOs and other organisation were channeled through the relevant Programme of the appropriate component for inclusion in the component proposal section. All relevant documents and minutes of meetings where decisions were taken have been attached as Annex B.
b)	Review submissions for possible integration into the proposal *[please summarize and attach documentation as an annex.]*
	The Technical subcommittee of the CCM Nigeria is charged with multiple responsibilities one of which is the processing of the Country Coordinated Proposal (CCP) and presentation to the CCM Nigeria for endorsement and eventual dispatch. The Technical subcommittee of the CCM Nigeria decided to conduct a Proposal Review Process during its four-day meeting beginning from 30 May through 2 June with a view to assessing the material content and technical quality of the proposal component. It therefore invited the proposal component groups to this meeting at which each group made a presentation of

	the process of input, integration and development of the component proposal as well as responding to the issues raised by members of the Technical sub-committee. All aspects of integration of "sub-proposals" were also addressed at this meeting. The Technical subcommittee received the component proposals and proceeded to complete their collation into the Country Coordinated Proposal (CCP) and presented it to the CCM Nigeria for endorsement. This was done at its 14th meeting which took place on the 3rd of June 2005. The relevant documents and minutes of the Technical Subcommittee meeting (May 30-June 2 2005) have been attached as Annex C.
c)	Nominate (the) Principal Recipient(s) and oversee program implementation *[please summarize and attach documentation as an annex.]*
	The Technical subcommittee then prepared the CCP for presentation to the entire CCM Nigeria at its 14th meeting which held on 3rd of June 2005. At this meeting, the Chairman, Technical subcommittee, made an overview of the four components of the proposal in which also the respective Principal Recipients nominated by the each of the proposal components were discussed and endorsed or rejected by the CCM. The process of nomination of the PRs was referred to the sub-Committee on Selection of PRs, which requested to review suggested PRs and make necessary recommendations for endorsement. The nomination of the PRs by the CCM was therefore made following the due process of selection and recommendation of this committee. CCM members who had all earlier received draft copies of the component proposal and made their input during the Technical subcommittee session of May 30th -2nd June, were also requested to complete the proposal endorsement form. The minutes of the 14th Meeting of the CCM Nigeria has been attached (Annex D) for easy reference.

2 Executive Summary

2.1 Executive Summary

[Please include quantitative information, where possible (4–6 paragraphs total):]

2.1.1	Briefly describe the (national) disease context, existing control strategies and programs as well as program and funding gaps. Explain how the proposed interventions complement existing strategies and programs, particularly where funding from the Global Fund has been received or approved.
2.1.2	Describe the overall strategy by referring to the goals, objectives and service delivery areas for each component, including expected results and associated timeframes. Specify for each component the beneficiaries and expected benefits (including target populations and their estimated number).
2.1.3	If there are several components, describe any synergies expected from the combination of different components—for example, TB/HIV collaborative activities (by synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact).
2.1.4	Indicate whether the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal.

This proposal covers a five-year period between January 2006 and December 2010 and has as its primary focus strengthening treatment, care and support for people living with and affected by HIV/AIDS in Nigeria.

From the latest sentinel surveillance conducted in the year 2003, 5% of adult, sexually active Nigerians were found to be HIV positive. This, in absolute numbers, means that there are currently between 3.2 and 3.8 million persons living with HIV/AIDS in Nigeria. Additionally, experts predict that Nigerian HIV AIDS pandemic is still in its early phase and a variety of factors put Nigeria at high risk of reaching even higher prevalence rates. In fact, Nigeria ranks the third in the world, after India and South Africa, and it is among the five countries (China, India, South Africa and Russia) threatened by the second-waive of the pandemic, if prevention and treatment and care activities are weak. Today approximately 600,000 Nigerians living with HIV AIDS require antiretroviral treatment and this figure is estimated to double in five years therefore, it very important that Nigeria doubles its efforts towards expanding access to treatment, care and support at this point in time is an imperative.

In 2001, the Nigerian Leadership, which has been outspoken on the threat of HIV AIDS and active in developing a national strategy to combat this disease, launched antiretroviral treatment programme in the public sector in 2001. With funds secured from the Global Fund in the First Round, 25 Federal Treatment centres in 17 States were established to provide ART. These centres are presently treating well about 35,000 people a fit made possible with the support of other donors such as PEPFAR and the Global Fund. The GFATM funds are now being used to treat 12,500 and this constitutes a great proportion of the people being presently treated. These achievements still represent a mere 6% of all the people that need the treatment.

Treatment of opportunistic infections is provided throughout the country by government, private and NGO facilities although access to for PLWHA is constrained by inadequacy of drugs and diagnostics, as well as cost. Coverage of services for HIV counselling and testing, prevention of mother to child transmission (PMTCT) and home based care, are still very low in Nigeria compared to other countries in sub-Saharan Africa.

2 Executive Summary

This proposal seeks to address a major gap in the response to HIV/AIDS in Nigeria, build on programmes initiated through Round 1 Global Fund grant, and on existing prevention, treatment and care initiatives of government and other partners. It aims to scale up provision of antiretroviral treatment and related services such as counselling and testing, PMTCT and community care to ensure that a comprehensive package of HIV/AIDS treatment, care and support is available in all parts of the country. Special attention is being paid to addressing treatment, care and support needs of children, including Orphans and Vulnerable children (OVCs) and use this to sensitise the communities to participate actively in the provision of care and support. The essential role that civil society organizations and the private sector play in providing and supporting HIV/AIDS treatment, care and support is being enhanced through additional capacity building for these institutions. Aspects of HIV prevention included in the proposal are those that are closely related to treatment, care and support initiatives.

The provision of antiretroviral treatment in the public sector in Nigeria has so far focused on the establishment of ART services at tertiary level health facilities. This approach has greatly limited the number of people accessing ART with space and personnel in existing ART sites overstretched while resources are available and under-utilized at secondary and primary levels of care.

Therefore, to attain our set goals and objectives, the proposal is set to use the strategy of scaling up HIV/AIDS treatment, care and support through the provision of ART at centres wider than those under Federal only and reach secondary health facilities and PHC in all the 36 States of the country, including the FCT. Services for counselling and testing, PMTCT, TB, adherence support and home-based care will be established or strengthened (if previously existing) alongside centres providing ART. These will collectively form clusters for providing comprehensive HIV/AIDS care.

This new approach to scaling up ART involves developing a network or clusters of secondary and primary facilities that will provide comprehensive HIV/AIDS care, including ART. The proposal and work plan aims at strengthening capacity of and links between general hospitals, PHC facilities and community based efforts to ensure a continuum of care for people living with HIV/AIDS. Decentralizing HIV/AIDS treatment and care to secondary and primary levels will enable more people to access treatment and achieve significant impact on HIV/AIDS related morbidity and mortality.

The proposal therefore aims at increasing the number of people treated from 23,360 to70,300 in recognized centres providing ART to cover all the 37 States. Currently ART services are provided in 21 States. The centres include those run by government, those supported by PEPFAR and those owned by NGOs/FBOs. In addition to ART services the intention is to strengthen and expand related treatment and care services alongside the ART centres. These related services include treatment of opportunistic infections, management of TB, and PMTCT.

If approved and funded, the the GFATM contributions will go along in bridging the gap existing presently and bring hope and happiness to many people living with the disease that would have been left with treatment.

2.2 Component and Funding Summary

Table 2.2 – Total Funding Summary

	Total funds requested in Euro / US$					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	19,753,385	26,670,898	35,300,115	44,329,271	54,588,843	180,642,512

2 Executive Summary

Tuberculosis						
Malaria						
Health systems strengthening						
Total						

Table 3 – Type of Application

Type of application:		
☒	National Country Coordinating Mechanism	→*go to section 3.1*
☐	Sub-National Country Coordinating Mechanism	→*go to section 3.2*
☐	Regional Coordinating Mechanism (including Small Island States)	→*go to section 3.3*
☐	Regional Organization	→*go to section 3.4*
☐	Non-Country Coordinating Mechanism	→*go to section 3.5*

[Complete section 3 as appropriate. Please note that - without these details, and in particular the information requested in section3.6 the proposal cannot be reviewed.]

3.1 National Country Coordinating Mechanism

Table 3.1 – National CCM: Basic Information

Name of National CCM	Date of Composition
Country Coordinating Mechanism (CCM), Nigeria	5 March 2002

3.1.1	Describe how the National CCM operates—in particular, the extent to which the CCM acts as a partnership between government and other actors in civil society, including non-governmental organizations, the private sector and academic institutions, and how it coordinates its activities with other national structures (such as National AIDS Councils) (2 paragraphs). [For example, decision-making mechanisms, constituency consultation processes, structure of subcommittees, frequency of meetings, implementation oversight, etc. Provide statutes of the organization, organizational diagram and terms of reference as attachments.]
	The Organisational Structure of the CCM Nigeria includes a democratically elected Chairman, and a focal Secretary who operates the CCM Secretariat with its staff compliment. Six Sub-committees are set up with their specific Terms of Reference (TOR) to address specific areas namely; Financial Management, Technical, Monitoring and Evaluation, Drug and Procurement, Technical, Fund Raising and Constitution (Annex E). The CCM operates standard and transparent procedures in its conduct of meetings and business; and maintains democratic channels for its decision – making processes on most matters of concern to the CCM, GFATM and Nigeria at large. The CCM

meets every other month, or as emergent issues may dictate with dates of meetings set by consensus, usually during preceding meetings. The Functions and Responsibilities (Annex F) and Minutes of the CCM previous meetings are herewith attached (Annex G) have also been attached.

The CCM membership is drawn from eight constituencies with who it maintains effective linkages through a very open communication channel. By this means, the CCM Nigeria has created an atmosphere of full and equal participation of members. The CCM Nigeria thus depends on the constituency consultations that inform the in put of representatives to the CCM meeting and its entire processes. An annual work plan and budget for the activities is in place.

3.2 Sub-National Coordinating Mechanism

Table 3.2 – Sub-National CCM: Basic Information

Name of Sub-National CCM	Date of Composition

3.2.1	Describe how the Sub-National CCM operates—in particular, the extent to which the CCM acts as a partnership between government and other actors in civil society, including NGOs, the private sector and academic institutions, and how it coordinates its activities with other national structures (e.g., National AIDS Councils) *(2 paragraphs). [For example, decision-making mechanisms, constituency consultation processes, structure of subcommittees, frequency of meetings, implementation oversight, etc. Provide statutes of the organization and organizational diagram as attachments.]*

3.2.2	Explain why a Sub-National CCM has been chosen *[1 paragraph].*

3.2.3	Describe how this proposal is consistent with and complements national strategies and/or the National CCM plans *[1 paragraph].*

3.3 Regional Coordinating Mechanism (including Small Island Developing States)

Table 3.3 – Regional Coordinating Mechanism: Basic Information

Name of Regional CM	Date of Composition

3.3.1	Explain why a Regional Coordinating Mechanism has been chosen *[1 paragraph].*

3.3.2	Describe how this proposal is consistent with and complements national strategies and/or the Regional Coordinating Mechanism plans. Provide details of how it would achieve outcomes that would not be possible with only national approaches *[1 paragraph].*

3.4 Regional Organizations

Table 3.4 – Regional Organization: Basic Information

Name of Regional Organization

3.4.1 Rationale
Describe how this regional proposal complements the national plans of each country involved and how it would achieve outcomes that would not be possible with only national approaches.

3.5 Non-Country Coordinating Mechanism

Table 3.5 – Non-CCM Applicant: Basic Information

Name of Non-CCM applicant

3.5.1 Indicate the type of your sector (tick appropriate box):

- ☐ Academic/educational sector
- ☐ Government
- ☐ NGOs/community-based organizations
- ☐ People living with HIV/AIDS, tuberculosis and/or malaria
- ☐ Private sector
- ☐ Religious/faith-based organization
- ☐ Multilateral and bi-lateral development partners in country
- ☐ Other (please specify):

3.5.2 Rationale for applying outside an existing CCM

Non-CCM proposals are not eligible unless they satisfactorily explain that they originate from one of the following:

1. *Countries without legitimate governments;*
2. *Countries in conflict, facing natural disasters, or in complex emergency situations (which will be identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs [OCHA]); or*
3. *Countries that suppress or have not established partnerships with civil society and NGOs.*

3.5.2.1 Describe which of the above conditions apply to this proposal *(3–4 paragraphs)*.

3.5.2.2 Describe any attempts to contact the CCM and provide documentary evidence as an annex *(2 paragraphs)*.

3.5.2.3 Non-CCM proposals from countries in which no CCM exists
[Describe how the proposal is consistent with, and complements, national policies and strategies (or, if appropriate, why this proposal is not consistent with national policy) (3–4 paragraphs). Provide evidence (e.g., letters of support) from relevant national authorities in an annex.]

3.5.3 All non-CCM proposals should include as annexes additional documentation describing the organization, such as:

- statutes of organization (official registration papers);
- a summary of the organization, including background and history, scope of work, past and current activities;
- reference letter(s);
- main sources of funding.

3.6 Proposal Endorsement and Membership Section

3.6.1 Representation

Table 3.6.1 – National/Sub-National/Regional (C)CM Leadership Information (not applicable to Non-CCM and Regional Organization applications)

	Chairperson	1st Vice Chairperson	2nd Vice Chairperson
Name	Abdulsalami NASIDI	Tekena HARRY	Willie BELONWU
Title	Dr	Prof	Chief
Mailing address	Director, Special Projects, Federal Ministry of Health, Room 334-336, Federal Secretariat Complex, Abuja	Dept. of Medical Microbiology, University of Maiduguri Teaching Hospital, Maiduguri.	Chief Finance Officer, Mobil Producing Nigeria Unlimited, Lekki Expressway, Victoria Island, Lagos.
Telephone	+234-803-7006849 +234-805-5274370 +234-9-6712643 +234-9-5232048	+234-802-372 4476, +234-76-235 668, +234-76-230 432	+234-802-291 3453, +234-1-262-1721.
Fax	+234-9-5232048		
E-mail address	nasidia@hotmail.com, nasidia2000@yahoo.com	tekenaharry@hotmail.com	willie.belonwu@exxonmobil.com

3.6.2 Contact information

[Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication.]

Table 3.6.2 – Non-CCM Applicants and Regional Organizations: contact information (not applicable to National/Sub-National/Regional [C]CM applications)

	Primary contact	Secondary contact
Name	Dr O Salawu	Mr Ben Nwobi
Title	National Coordinator	Secretary
Organization	Federal Ministry of Health	Country Coordinating Mechanism (CCM) Nigeria
Mailing address	National AIDS/STD Control Programme, Department of	16, Sassandra Street, Off Usuma Street,

	Public Health, Federal Ministry of Health. Federal Secretariat, Abuja.	Off Gana Street, Maitama, Abuja
Telephone	234-803-311-5573	234-803-705-4008
Fax		
E-mail address	tofsal@yahoo.com	emekanwobi@hotmail.com

3.6.3 Membership information

[Applicable to submissions from National/Sub-National/Regional (C)CMs. Not applicable to Non-CCM Applicants and Regional Organization applications. One of the tables below must be completed for each national/Sub-National/Regional (C)CM member.]
[To be eligible for funding National/Sub-National/Regional (C)CMs must demonstrate evidence of membership of people living with and /or affected by the diseases.]

Table 3.6.3 – National/Sub-National/Regional (C)CM Member Information

National/Sub-National/Regional (C)CM member details			
Member 1			
Agency/organization	Department of Special Projects (DSP), Federal Ministry of Health	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi /bilateral development partners)*	Government	Sector represented	Government (FMOH)
Name of representative	Dr. Abdulsalami Nasidi	CCM member since	5 March 2002
Title in agency	Director	Fax	+234-9-5232048
E-mail address	nasidia@hotmail.com, abdulnsd@yahoo.com	Telephone	+234-803-7006849, +234-805-5274370, +234-9-6712643, +234-9-5232048.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Chairman, CCM Nigeria	Mailing address	Room 336, Floor 3, Federal Ministry of Health Federal Secretariat, Abuja
Member 2...			

3.6..3.2

National/Sub-National/Regional (C)CM member details			
Member 2			
Agency/organization	University of Maiduguri.	Website	
Type *(academic/educational sector, government, nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector, religious/faith-based organizations; multi-/bilateral development partners)*	Academic	Sector represented	Dept. of Microbiology, University of Maiduguri Teaching Hospital Maiduguri
Name of representative	Tekena O. Harry	CCM member since	5 March 2002
Title in agency	Prof.	Fax	
E-mail address	tekenaharry@hotmail.com, maiduguri-lab@who-nigeria.org	Telephone	+234-76-235668, +234-802-3724476.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Vice Chairman, CCM Nigeria	Mailing address	Dept. of Microbiology University of Maiduguri Teaching Hospital. PMB 1414, Maiduguri.
Member 3...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 3			
Agency/organization	ExxonMobil Producing Unlimited.	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS; tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Private Sector	Sector represented	Oil Sector
Name of representative	Chief W. Belonwu	CCM member since	5 March 2002
Title in agency	Chief Finance Officer	Fax	
E-mail address	willie.belonwu@exxonmobil.com	Telephone	+234-9-5237652 +234-802-291-3453 +234-1-262-1721.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	2nd Vice Chairman; Member, Fund Raising and Finance subcommittees	Mailing address	ExxonMobil Producing Nigeria,. Lekki Express way, Victoria Island, Lagos.
Member 4			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 4			
Agency/organization	National Institute for Pharmaceutical Research and Development (NIPRD)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government Research Institute (FMOH)	Sector represented	Government : Research Organisation
Name of representative	Dr. U.S. Inyang	CCM member since	5 March 2002
Title in agency	Director General, NIPRD.	Fax	
E-mail address	ufordi@yahoo.com	Telephone	+234-802-3041654 +234-9-5239089 +234-802-304 1654.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Chairman, Technical subcommittee; member Finance; Drug and Procurement subcommittees.	Mailing address	National Institute for Pharmaceutical Research and Development (NIPRD),
			Idu Industrial Park,
			PMB 21 Garki, Abuja
Member 5...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 5			
Agency/organization	International Network for Rational Use of Drugs.	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non-governmental Organisation	Sector represented	Civil Society Organisations
Name of representative	Prof. A.F.B. Mabadeje	CCM member since	5 March 2002
Title in agency	President	Fax	
E-mail address	biolamabadeje@yahoo.com	Telephone	234-1-5552053 234-1-821501 234-802-310 0941 234-805-614 5059
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member; Chairman, Drug Procurement subcommittee.	Mailing address	No. 3 Adenike Moyosore Close Gbagada Phase II P.O. Box 191, Unilag Post Office Akoka, Lagos
Member 6...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 6			
Agency/organization	National AIDS Research Network (NARN)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Academia	Sector represented	Research Organisation
Name of representative	Prof. John A. Idoko	CCM member since	5 March 2002
Title in agency	President.	Fax	
E-mail address	jonidoko@yahoo.com, haltaids@infoweb.abs.net	Telephone	+234-73-460380, +234-8033215961.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Chairman, M & E subcommittee and member, Finance subcommittee.	Mailing address	No. 2, Lafia Close Off Ilorin Street, Area 8, Garki, Abuja.
Member 7...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 7			
Agency/organization	National Parents-Teachers Association (NAPTAN)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non-governmental-educational.	Sector represented	Civil Society Organisation
Name of representative	Chief Mishael O. Nwachukwu	CCM member since	5 March 2002
Title in agency	National Vice-President, NAPTAN	Fax	
E-mail address	monwachukwu@yahoo.com	Telephone	+234-803-3304112 +234-1-5894956
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Chairman, Fund-Raising subcommittee.	Mailing address	191 Babs Animashaun Road, Surulere, Lagos.
Member 8...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 8			
Agency/organization	National Action Committee on AIDS (NACA)	Website	www.naca.gov.ng
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government -NACA	Sector represented	Government - NACA
Name of representative	Prof. Babatunde Osotimehin	CCM member since	5 March 2002
Title in agency	Chairman, NACA.	Fax	
E-mail address	osotimehin2000@yahoo.co.uk bosotimehin@naca.gov.ng	Telephone	234-9-2904410-19 234-803-315-4600 234-804-418-4949
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Principal Recipient-HIV (PMTCT & ARV) Projects, and member, M & E subcommittee.	Mailing address	Chairman NACA, The Presidency Plot 823 Ralph Shodeinde Street Central Business District, Abuja.
Member 9...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 9			
Agency/organization	Yakubu Gowon Center for National Unity and International Cooperation (YGC).	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	NGO	Sector represented	NGO
Name of representative	Ambassador M. Ekpang	CCM member since	5 March 2003
Title in agency	Dep. Chief Executive, YGC.	Fax	
E-mail address	ekpangm@yahoo.com	Telephone	234-9-314-0613 234-803-320-5149.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Principal Recipient	Mailing address	Yakubu Gowon Center (YGC)
			Plot 20, Yakubu Gowon Crescent
			Asokoro, Abuja
Member 10...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 10			
Agency/organization	Malaria Society of Nigeria.	Website	
Type *(academic/educational sector, government, nongovernmental and community-based organizations, people living with HIV/AIDS, tuberculosis and/or malaria, the private sector, religious/faith-based organizations, multi-/bilateral development partners)*	Non-governmental organisation.	Sector represented	Civil Society Organisations (Malaria)
Name of representative	Dr. O.J. Ekanem	CCM member since	5 March 2002
Title in agency	Chairman.	Fax	
E-mail address	ojekanem@yahoo.com	Telephone	234-1-880520 234-1-4806565 234-802-310-9852
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, M&E committee and Technical in put to proposal development process.	Mailing address	House 5, A-Close, 112 Road Festac Town, Lagos
Member 11...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 11			
Agency/organization	Civil Society Network on HIV and AIDS in Nigeria (CISNHAN)	Website	
Type *(academic/educational sector, governmental, nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non-governmental organisation.	Sector represented	Civil Society Organisations (HIV/AIDS).
Name of representative	Lady Nkechi Onah	CCM member since	5 March 2002
Title in agency	National Moderator.	Fax	
E-mail address	cisoghan@yahoo.com, waro_2000@yahoo.com	Telephone	234-9-2344518, 234-42-259275, 234-42-457812 234-803-338-5951
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, Finance and Secretariat subcommittees.	Mailing address	CISNHAN
			38A Umuezebi St.
			P.O. Box 15672 New Haven
			Enugu
Member 12...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 12			
Agency/organization	Civil Society Network on HIV and AIDS in Nigeria (CiSNHAN)	Website	
Type *(academic/educational sector, government, nongovernmental and community based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non-governmental organisation.	Sector represented	Civil Society Organisations (HIV/AIDS).
Name of representative	M. Y. Gidado	CCM member since	
Title in agency	Programme Officer	Fax	
E-mail address	ciscghan@yahoo.com	Telephone	
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member.	Mailing address	CiSNHAN Hq; No. 2, Lafia Close, Off Ilorin Street, Area 8, Garki. Abuja.
Member 13...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 13			
Agency/organization	Nigerian Union of Journalists.	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Private Sector	Sector represented	Private Sector - Media
Name of representative	Mr. E. Couson	CCM member since	5 March 2002
Title in agency	Manager, Northern Operations	Fax	
E-mail address	emmaabi@yahoo.com	Telephone	+234-803-588-2742, +234-9-3143016, +234-66-221103, +234-66-225046.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Representative - Media	Mailing address	Nigerian Union of Journalists Head Quarters. Area 11, Garki Abuja
Member 14...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 14			
Agency/organization	Supreme Council for Islamic Affairs of Nigeria (SCIAN).	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Faith-based Organisation	Sector represented	Faith-based Organisation Islam
Name of representative	Amin Igwegbe	CCM member since	5 March 2002
Title in agency	Ustaz	Fax	
E-mail address	nsciaa@yahoo.com	Telephone	234-9-523 0796 234-76-232 949 234-76-235 683 234-802-375 2922.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, Fund-raising subcommittee.	Mailing address	Supreme Council for Islamic Affairs of Nigeria C/o University of Maiduguri Maiduguri
Member 15...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 15			
Agency/organization	Federal Ministry of Education (FMOE)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith based organizations; multi-/bilateral development partners)*	Government (FMOE)	Sector represented	Government (FMOE)
Name of representative	Aisha Umar	CCM member since	5 March 2002
Title in agency	Deputy Director	Fax	
E-mail address	alidan@yahoo.com	Telephone	08033118976
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member.	Mailing address	Federal Ministry of Education (FMOE), Federal Secretariat Complex Abuja
Member 16			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 16			
Agency/organization	Pharmaceutical Manufacturers Group (PMAN).	Website	
Type *(academic/educational sector, government, nongovernmental and community-based organizations, people living with HIV/AIDS, tuberculosis and/or malaria, the private sector, religious/faith-based organizations, multi-/bilateral development partners)*	Private Sector	Sector represented	Private Sector
Name of representative	Emma Ebere	CCM member since	5 March 2002
Title in agency	President, PMAN-MAN.	Fax	
E-mail address	emmaebere@hotmail.com	Telephone	234-803-432-3415 234-1-288-3056 234-1-588-2172.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, Drug Procurement subcommittee.	Mailing address	Pharmaceutical Manufacturers Group (PMAN) c/o Gemini Pharmaceutical Ltd Isolo-Apapa Expressway Lagos
Member 17...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 17			
Agency/organization	UNICEF	Website	
Type *(academic/educational sector; government, nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Development Partner - UNICEF	Sector represented	UN System-Malaria.
Name of representative	E.I. Gemade	CCM member since	5 March 2002
Title in agency	Project Officer, (Health) UNICEF.	Fax	
E-mail address	egemade@unicef.org	Telephone	234-803-403-5235
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, Finance subcommittee. Technical input.	Mailing address	UNICEF
			UN Plaza
			Abuja
Member 18...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 18			
Agency/organization	Joint United Nations Programme on HIV/AIDS (UNAIDS)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Development Partner - UNAIDS	Sector represented	UN System-HIV-AIDS.
Name of representative	Dr. P. M'pele	CCM member since	5 March 2002
Title in agency	UNAIDS Country Coordinator (UCC)	Fax	
E-mail address	pierre.mpele@undp.org	Telephone	234-9-461-8588, 234-803-402-3546
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, Technical and Secretariat subcommittees. Technical and Financial input.	Mailing address	UNAIDS UN Plaza Abuja
Member 19...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 19			
Agency/organization	Federal Ministry of Labour and Productivity (FMOL&P).	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government (FMOL&P)	Sector represented	Government – Labour
Name of representative	Dr. E. C. **Meribole**	CCM member since	5 March 2004
Title in agency	Coordinator, FMOL&P - HIV/AIDS Response	Fax	
E-mail address		Telephone	08033140228
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, Finance subcommittee.	Mailing address	Federal Ministry of Labour and Productivity
			Federal Secretariat Complex
			Abuja
Member 20...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 20			
Agency/organization	Enhanse – Futures Group, USAID/Nigeria	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Development Partner	Sector represented	Development Partner
Name of representative	Dr. Jerome Mafeni	CCM member since	5 March 2002
Title in agency	Chief of Party	Fax	
E-mail address	jmafeni@futuresgroup.com	Telephone	+234-8037001609, +234-9-413-5944, +234-9-413-5945.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Secretary, Finance subcommittee; Technical Assistance, Proposal Development.	Mailing address	Enhanse Project 2A Lake Chad Crescent off IBB Way, Maitama Abuja
Member 21...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 21			
Agency/organization	USAID	Website	www.usaid.gov
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Development Partner	Sector represented	Development Partner
Name of representative	Dr. Polly Dunford	CCM member since	5 March 2002
Title in agency	Team Leader SO 14, HIV/AIDS & TB, USAID.	Fax	
E-mail address	pdunfor@usaid.gov,	Telephone	+234-9-234-3048 +234-8037002205
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, Finance Committee, Technical Assistance, Proposal Development.	Mailing address	3rd Floor, Metro Plaza
			Plot 994, Zakari Maimalari Street
			Opp. War College, Garki
			Abuja
Member 22...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 22			
Agency/organization	National Planning Commission.	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government	Sector represented	Government
Name of representative	Mr. Rafiu Ibraheem	CCM member since	5 March 2002
Title in agency		Fax	
E-mail address	ribraheem@yahoo.com	Telephone	+234-95231331, +234-8042144535.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member.	Mailing address	Dept. of Soc. Services
			Nat. Planning Commission
			Wuse Zone 1
			Abuja
Member 23			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 23			
Agency/organization	National Council of Women Societies (NCWS) Nigeria	Website	
Type *(academic/educational sector, government, nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Civil Society Organisations	Sector represented	Civil Society Organisations-Women Societies.
Name of representative	Dr. B. Ketebu-Nwokeafor	CCM member since	5 March 2002
Title in agency	President, NCWS.	Fax	
E-mail address	ncwsnigeria@yahoo.com	Telephone	+234-8033146995, +234-9-3143741, +234-9-3143740
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Represents Women umbrella-organisations.	Mailing address	NCWS Nigeria Secretariat, Area 11 Abuja
Member 24...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 24			
Agency/organization	Teepac Research Organisation,	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non-governmental Organisation	Sector represented	NGO- TB Prevention.
Name of representative	Mr. Toni Nwosu	CCM member since	5 March 2002
Title in agency	President, Teepac Research Organisation.	Fax	
E-mail address	toninwosu@yahoo.com	Telephone	+234-8043229641
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member.	Mailing address	Teepac Research Organisation, P.O. Box. 312, Ihiala, Anambra State.
Member 25...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 25			
Agency/organization	Center for the Right to Health (CRH)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Person Living with TB	Sector represented	Person Living with TB
Name of representative	Mrs. Georgina Ahamefule	CCM member since	5 March 2002
Title in agency		Fax	
E-mail address	crhaids@yahoo.com	Telephone	+234-1-7743816, +234-8033671231.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Person Living with TB	Mailing address	No. 3 Oban'le Aro Avenue Ilupeju, Lagos P.O. Box 72944 Victoria Island Lagos.
Member 26...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 26			
Agency/organization	Network of PLWA Nigeria (NEPWHAN)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	People living with HIV	Sector represented	People living with HIV
Name of representative	Dr. Pat. Matemilola	CCM member since	5 March 2002
Title in agency	Coordinator.	Fax	
E-mail address	newpwhan@nepwhan.com,	Telephone	+234-8038150948, +234-8033061278, +234-9-2345238, +234-9-2349281.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, Technical and Drug Procurement subcommittees.	Mailing address	No. 2, Lafia Close, Off Ilorin Street, Area 8, Garki Abuja
Member 27			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 27			
Agency/organization	Soc for Prevention and Eradication of Tuberculosis, (SPETB)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non-governmental Organisation	Sector represented	Civil Society OrganisaWtions (Tuberculosis)
Name of representative	Dr. Baba Gana **Adam**	CCM member since	5 March 2002
Title in agency	Secretary, SPETB	Fax	
E-mail address	dr_bgadam@yahoo.com	Telephone	+234-76-342752; +234-8042160284, +234-8035043697.
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Member, M & E subcommittee	Mailing address	SPETB No 3 Ibrahim Abacha Way Maiduguri.
Member 28...			

3.6.3.2

National/Sub-National/Regional (C)CM member details			
Member 28			
Agency/organization	WHO	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Multi-/Bilateral Development Partner	Sector represented	Development Partner
Name of representative	Dr. Belhocine	CCM member since	5 March 2004
Title in agency	Country Representative	Fax	
E-mail address	aweayo@yahoo.co.uk	Telephone	+234-8023144120
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Representative of the UN-System (TB)	Mailing address	World Health Organisation, UN Plaza Abuja

National/Sub-National/Regional (C)CM member details			
Member 29			
Agency/organization	CSO	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	NGO	Sector represented	Development Partner
Name of representative	Prof. H. Abdulkareem	CCM member since	5 March 2002
Title in agency	President	Fax	
E-mail address		Telephone	
Main role in the		Mailing address	

Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*			UN Plaza Abuja

3.6.4. National/Sub-National/Regional (C)CM Endorsement of Proposal

[Please note: The entire proposal, including the signature page, must be received by the Global Fund Secretariat before the deadline for submitting proposals. The minutes of the CCM meetings at which the proposal was developed and endorsed must be attached as an annex to this proposal.

PROPOSAL TITLE:

"We, the undersigned, hereby certify that we have participated in the proposal development process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and support it. If the proposal is approved we further pledge to continue our involvement in the Coordinating Mechanism during its implementation."]

Table 3.6.4 – National/Sub-national /Regional (C)CM Endorsement

Agency/organization	Name of representative	Title	Date	Signature

3.6.5 CCM Endorsement Details for Applications from Regional Organizations:

[Regional Organizations must receive the agreement of the full CCM membership of each country in which they wish to work.]

List below each of the CCMs that have agreed to this proposal and provide in annexes the minutes of CCM meetings in which the proposal was approved. (If no CCM exists in a country included in the proposal, include evidence of support from relevant national authorities.)

Table 3.6.5 – Regional Organization Endorsement

Names of CCM	Country	Attachment number

4 Components Section

Scale-up of Comprehensive HIV and AIDS Treatment, Care and Support in Nigeria.

[PLEASE NOTE THAT THIS SECTION AND THE NEXT MUST BE COMPLETED FOR EACH COMPONENT. Thus, for example, if the proposal targets three components, sections 4 and 5 must be completed three times.]

4.1 Identify the Component Addressed in this Section

☒ HIV/AIDS[3]
☐ Tberculosis[4]
☐ Malaria
☐ Health system strengthening

4.1.1 Indicate the Estimated Start Time and Duration of the Component

[Please take note of the timing of proposal approval by the Board of the Global Fund (described on the cover page of the proposal form), as well as the fact that generally, disbursement of funds does not occur for a minimum of two months following Board approval. Approved proposals must have a start date within 12 months of proposal approval.]

Table 4.1.1 – Proposal Start Time and Duration

	From	To
Month and year:	January 2006	December 2010

4.2 Contact Persons for Questions Regarding this Component

[Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes.]

Table 4.2 – Component contact persons

	Primary contact	Secondary contact
Name	Dr O Salawu	Mr Ben Nwobi
Title	National Coordinator	Secretary
Organization	Federal Ministry of Health	Country Coordinating Mechanism (CCM) Nigeria
Mailing address	National AIDS/STD Control Programme, Department of Public Health, Federal Ministry of Health. Federal Secretariat, Abuja.	16, Sassandra Street, Off Usuma Street, Off Gana Street, Maitama, Abuja
Telephone	234-803-311-5573	234-803-705-4008
Fax		
E-mail address	tofsal@yahoo.com	emekanwobi@hotmail.com

[3] In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

[4] In contexts where HIV/AIDS is driving the tuberculosis epidemic, tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

4 Components Section

Executive Summary

This proposal covers a five-year period between January 2006 and December 2010 and has as its primary focus strengthening treatment, care and support for people living with and affected by HIV/AIDS in Nigeria.

It is estimated that there are currently between 3.2 and 3.8 million persons living with HIV/AIDS in Nigeria. Out of these, approximately 600,000 require antiretroviral treatment and this number is expected to double in 5 years. Expanding access to treatment, care and support at this point in time is an imperative. It is for this reason that the Federal Government of Nigeria launched antiretroviral treatment programme in the public sector in 2001. With funds secured from the Global Fund in the First Round, 25 Federal Centre in 17 States were established to provide ART. As at mid 2005 it is estimated that 35,000 people are receiving ART from various providers in the country representing a mere 6% of all the people that need the treatment.

Treatment of opportunistic infections is provided throughout the country by government, private and NGO facilities although access to for PLWHA is constrained by inadequacy of drugs and diagnostics, as well as cost. Coverage of services for HIV counselling and testing, prevention of mother to child transmission (PMTCT) and home based care, are still very low in Nigeria compared to other countries in sub-Saharan Africa.

This proposal seeks to address a major gap in the response to HIV/AIDS in Nigeria, build on programmes initiated through Round 1 Global Fund grant, and on existing prevention, treatment and care initiatives of government and other partners. It aims to scale up provision of antiretroviral treatment and related services such as counselling and testing, PMTCT and community care to ensure that a comprehensive package of HIV/AIDS treatment, care and support is available in all parts of the country. Special attention is being paid to addressing treatment, care and support needs of children, including Orphans and Vulnerable children (OVCs). The essential role that civil society organizations and the private sector play in providing and supporting HIV/AIDS treatment, care and support is being enhanced through additional capacity building for these institutions. Aspects of HIV prevention included in the proposal are those that are closely related to treatment, care and support initiatives.

The provision of antiretroviral treatment in the public sector in Nigeria has so far focused on the establishment of ART services at tertiary level health facilities. This approach has greatly limited the number of people accessing ART with space and personnel in existing ART sites overstretched while resources are available and under-utilized at secondary and primary levels of care.

The approach to be followed in scaling up HIV/AIDS treatment, care and support is to extend provision of ART to tertiary and secondary level health facilities in all the 37 States of the country. Services for counselling and testing, PMTCT, TB, adherence support and home-based care will be established or strengthened (if previously existing) alongside centres providing ART. These will collectively form clusters for providing comprehensive HIV/AIDS care.

This new approach to scaling up ART involves developing a network or clusters of secondary and primary facilities that will provide comprehensive HIV/AIDS care, including ART. The proposal and work plan aims at strengthening capacity of and links between general hospitals, PHC facilities and community based efforts to ensure a continuum of care for people living with HIV/AIDS. Decentralizing HIV/AIDS treatment and care to secondary and primary levels will enable more people to access treatment and achieve significant impact on HIV/AIDS related morbidity and mortality.

4.3 National Program Context and Gap Analysis for this Component

[The context in which proposed interventions will be implemented provides the basis for reviewing this proposal. Therefore, historical, current and projected data on the epidemiological situation, disease-control strategies, broader development frameworks, and resource availability and gaps need to be clearly documented.]

4.3.1 Epidemiological and Disease-Specific Background

Describe, and provide the latest data on, the stage and type of epidemic and its dynamics (including breakdown by age, gender, population group and geographical location, wherever possible), the most affected population groups, and data on drug resistance, where relevant. (Information on drug resistance is of specific relevance if the proposal includes anti-malarial drugs or insecticides. In the case of TB components, indicate, in addition, the treatment regimes in use or to be used and the reasons for their use.)

Nigeria is experiencing a generalized HIV/AIDS epidemic that is driven predominantly through heterosexual transmission. The first AIDS case in Nigeria was reported in 1986. Since then, the epidemic has steadily grown with a concomitant fall in life expectancy from 53 years in 1990 to 51 years in 2002 negating positive effects that might have occurred as a result of other improvements in life standards and health care[1]. The 2003 HIV Sero-prevalence Sentinel Survey[2] among antenatal clinic attendees showed a national median prevalence of 5.0%, which represents a slight decrease from 5.8% recorded in 2001.

Whilst the HIV prevalence in the country may appear relatively low compared with some countries in sub-Saharan Africa, it nevertheless translates into 3.2 - 3.8 million people living with HIV & AIDS in Nigeria. In terms of absolute number of people living with HIV/AIDS Nigeria therefore ranks 3rd most affected globally, after South Africa and India.

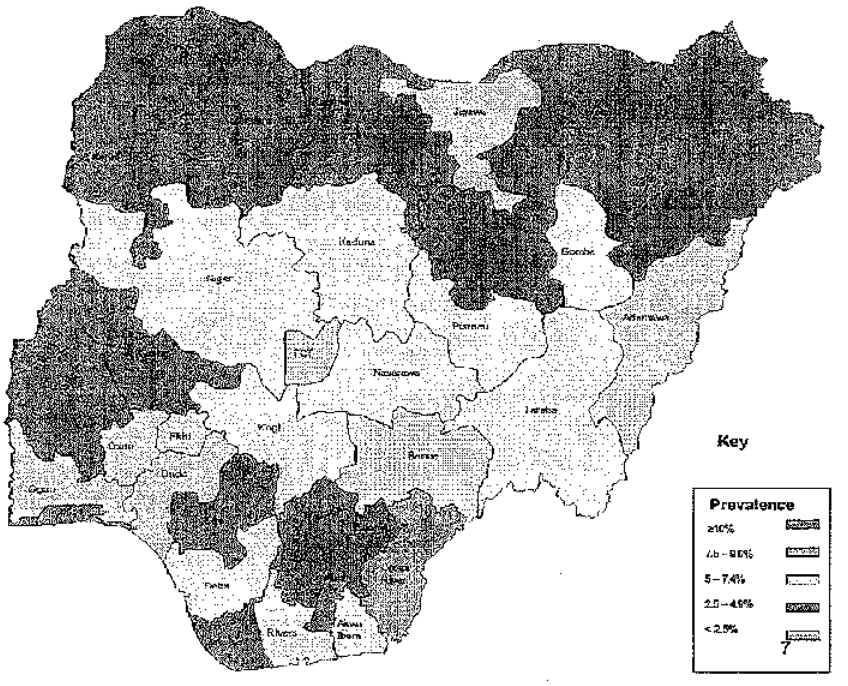
The Survey indicates that prevalence ranges from 1% (Osun State) to 12% (Cross River State), but all states and communities are affected. Thirteen states and the FCT had prevalence rates above 5%. Young adults aged 15-29 years are the most affected. The age group of 20-24 years had the highest national prevalence of 5.6%. HIV prevalence was found to be generally high in both urban and rural areas, however; the prevalence was significantly higher in the urban areas (5.1%) than in the rural areas (3.7%)[1].

Heterosexual intercourse is the dominant method of transmission accounting for an estimated 80% of all infections. Ten percent of infections are estimated to be spread through mother-to-child transmission while the remaining 10% is estimated to be through use of unsterilized needles and surgical implements, infected blood transfusions and occupational exposures.

Surveillance in population groups other than the general population reveals very much higher HIV prevalence levels. HIV prevalence rate among Female Sex Workers in Nigeria has remained high and on the increase, from 17.5% in 1991, through 22.5% (1993) to 35.6% (1995). This group constitutes an important reservoir of HIV infection for transmission to the general population, through sexual networking. Also, prevalence among tuberculosis patients has remained relatively high – 21.0% (1991), 7.9% (1993), 13% (1995) and 17.0% (2000).

Projections carried out by UNAIDS and WHO for Nigeria, provide low and high case scenarios[2]. The high case scenario estimated prevalence reaching 9.41% in 2012 before levelling off. The low case scenario puts prevalence at 6.9% in the next five years. The different indicators that can provide accurate projections have important implications for Policy and Strategic Planning.

Fig. 2 HIV Prevalence from 2003 National Sero-Prevalence Survey



Life expectancy

It is thought that life expectancy in Nigeria has fallen to about 51 years in 2002 from 53.0 years in 1990. If the epidemic did not exist, the current life expectancy rate would have been about 57 years[1]. Without the epidemic, life expectancy by 2015 should have reached nearly 62 years though current expectations are that it will be between 49 and 50 years by 2015 if the epidemic continues to progress as it is currently, levelling off population growth. It is therefore expected that the control efforts, if successful, will result firstly in a halt to the decline in life expectancy and subsequently an increase.

Impact on livelihoods

The study in Benue State on Impact on Livelihoods[3] found that the percentage of households reporting an adult death in the past 5 years, increased in Idoma and Igede households from 2% in 1997 to 14% in 2002 with significantly more of the AIDS-affected being women (61% of women compared with 39% of men).

The impact of HIV & AIDS at household level was felt in many different ways. Affected households deal not only with the psychological stress as a result of chronic illness and death of beloved ones, but also with the costs in terms of labour and expenditures for medical care and burial. In addition, they will have to forego production and income because the patient, as well as the caregivers, can no longer attend to their usual activities. The money spent on health care and funerals, means less money available for food and basic needs, school fees etc. The fact that children are not being educated means fewer opportunities and less paying jobs. Death of a man may connote loss of assets by his widow/s.

Again, the successful implementation of the control programme is expected to lead to a halt in the socio-economic and psychological "taxes" on individuals, families and communities due to the HIV/AIDS epidemic. The HIV/AIDS epidemic is already having its impact on health workers and teachers as part of the general population and this is a negative effect on education, health and other social and development services. The potential contribution of HIV/AIDS control will be a significant effort towards the achievement of the Millennium Development Goal 8 in particular as well as Goals 4 and 5

with indirect impact on Goals 1 and 2.

Factors driving the epidemic

There are many different factors driving the epidemic, underpinned by poverty and gender inequality. There are cultural practices such as polygamy and traditional practices which include genital mutilation and festivities involving casual partner-exchange. All these combine to explain the variation in prevalence across Nigeria. Additional factors include migrant workers concentrated around the oil extracting industries, mass transfer of public servants away from their spouses and long distance transport workers exposed to high-risk sexual behaviour. The HIV/AIDS epidemic continued to grow largely through heterosexual unprotected sexual exposures as well as the other under listed factors.

Awareness of HIV & AIDS

While awareness about HIV & AIDS is generally high (83% in the rural areas and 98% in the urban areas), knowledge about transmission routes for HIV was found to be reasonably good with 54% of respondents knowing the four main transmission routes (2003 National HIV/AIDS and Reproductive Health Survey[4]), personal risk assessment remains poor as a study found that 72% of respondents considered that they were at no risk at all of getting HIV. These data confirm that there are dangerous gaps in knowledge with low personal risk assessment; behaviour change will be difficult and further compounded by the anti-condom campaign of some faith-based organizations.

Transmission through infected blood

Specific data on this area is scanty and hardly available. However, anecdotal evidence suggests that over 70% of blood transfusion is undertaken in the private sector where regulation by Government is still a major challenge. There is no current *National* data available on prevalence of HIV amongst blood donors or information regarding suspected transmission of HIV through infected blood.

Unsafe injecting practices in clinical settings

Transmission of diseases such as HIV and hepatitis B through re-utilization of needles and accidental needle pricks in health workers should indicate a decrease in the popularity of injections. However, this is not the case as injection use is still the preferred route of drug administration. The baseline assessment of the Nigerian Pharmaceutical sector found that 38% of the prescriptions assessed during the study were for injections. A more recent study by FMOH, found that patients had an average of 4.9 injections a year and though disposable needles were used in most cases, 5% of the providers admitted re-using disposable needles or syringes. Meanwhile 50% of health providers reported having had a needle prick injury during the previous 12 months and only 6% of these providers had been offered Post Exposure Prophylaxis (PEP).

Stigma and discrimination and denial

Stigma and discrimination against PLWHAs remains rife, with frequent reports of abuse, discrimination at the workplace and in health facilities and reluctance to seek care for HIV patients and children orphaned by HIV & AIDS. As long as this continues, many people will be reluctant to seek tests, reveal their status, seek support and protect others from becoming infected. Benue and Enugu states have enacted laws to protect PLWHAs against stigma and discrimination while the Health Bill provides anti discriminatory clause for employees and for users of the health system. Effort has been made to address the gender dimension of stigma and discrimination and attendant widowhood and other harmful practices and other driving forces that tend to aggravate the slide in poverty of female-headed households.

4.3.2 Health Systems, Disease-Control Initiatives and Broader Development Frameworks

[Proposals to the Global Fund should be developed based on a comprehensive review of the capacity of health systems, disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases.]

a) Describe the (national) health system, including both the public and private sectors, as relevant to fighting the disease in question.

The National Health System

Nigeria's Health System is in three tiers which is tailored along the country's administrative structure comprising of the Federal, State and the Local Governments and categorized along three levels:

- The Local Government is largely responsible for the Primary Health Care (PHC) facilities, which are usually staffed with nurses and Community Health Care workers with the support of the State Ministry of Health. It is estimated that more than 18,000 Primary Health Care centres exist. Currently, comprehensive HIV/AIDS treatment is not being provided at the primary health care level.
- The State Governments is responsible for the Secondary level hospitals (General hospitals) which primarily provide specialized services to patients referred from the primary health care level in form of general in- and out- patient health care services through their staff retinue of physicians and other specialized health workers. More than 3000[5] secondary level General Hospitals exist, extending over 774 Local Government Areas (LGAs). The government has planned to extend its ART programme together with the implementation of the 2nd phase of the GFATM Round 1 grant to selected secondary level hospitals which have demonstrated particular suitability to develop into comprehensive ART site and reference centres.
- The Federal Government is responsible for the tertiary level hospitals (Teaching and Specialist hospitals) providing highly specialized care/referral services in all major disciplines to the primary and secondary levels of the health care delivery system. These facilities are in the domain of the federal and state governments. Currently, there are 29 such hospitals distributed across the 36 States and the Federal Capital Territory. Eighteen (18) of the 25 sites that currently provide anti-retroviral treatment under the government programme (including the activities of the 1st phase of the GFATM Round 1 ART Project) are tertiary level hospitals.

The Federal Ministry of Health's "Health Sector Reform Agenda[6]" is providing direction for the future development of Nigeria's health sector by emphasizing the importance of decentralizing health services and strengthening of the secondary and primary level facilities. This 'Reform Agenda' summarizes the guiding principles of this proposal to scale up comprehensive HIV and AIDS services to secondary and primary health care facilities.

The Private Health sub-sector

The Private Health Care Sector is a major player in the health care delivery system in Nigeria as it is estimated that it controls not less than 45% of the clientele in the health sector. This figure has decreased compared with a few years ago as confirmed by a recent USAID- funded study[7] found that access to private sector provision of HIV services is limited largely because of high cost of services.

This sector consists of 'for-profit' hospitals and clinics and 'not-for-profit institutions' such as Hospitals owned and managed by faith-based missions and the health facilities run by large employers of Labour in the organized private sector providing HIV & AIDS related services to staff and families within their staff health services scheme.

The wide distribution of private health sector facilities including the faith-based network of health care providers offers a great opportunity for the scaling up of Treatment, Care and Support of HIV/AIDS programme. For example the Christian Health Association of Nigeria (CHAN), is well known for its network of about 358 hospitals that have been providing health care in most parts of Nigeria for the past 30 years. In all, CHAN's membership has over 4,000 health facilities at different levels of the health care system.

b) Describe comprehensively the current disease-control strategies and programs aimed at the target disease, including all relevant goals and objectives with regard to addressing the disease. (Include both existing Global Fund-financed programs and other programs currently implemented or planned by all stakeholders and existing and planned commitments to major international initiatives and partnerships).

Nigeria's HIV/AIDS control efforts receives attention, support and leadership from the highest level through the National Action Committee on AIDS (NACA), which reports directly to the President. NACA is complemented by 36 State Action Committees on AIDS (SACAs) and 774 Local Action Committees on AIDS (LACAs). Few Local Government Areas have initiated Community Action Committees on AIDS (CACAs) with some exceptions such as Enugu State that has been actively promoting the concept with some degree of success. In the periphery, however, there are significant capacity gaps and governance structure and most committees continue to be led by the health sector.

HIV/AIDS plans in Nigeria have evolved from the short-term plans of the 1980s, when the response was health sector-based, through the Medium Term Plans (MTPs) of the 1990s, when Nigeria had a health sector-led response, to the HIV/AIDS Emergency Action Plan (HEAP) of 2001-2004. The HIV/AIDS Emergency Action Plan (HEAP) 2001-2004, which covers all sectors, was launched in 2000. The HEAP identified two main approaches to the HIV/AIDS response in Nigeria. The first approach was to create an enabling environment through mobilizing leaders and communities, strengthening capacity of national institutions and improving information management. The second approach was delivery of specific intervention such as prevention (focusing on high-risk situations and targeting specific population such as young people, women, sex workers and uniformed services. Care and support interventions mainly comprised of management of opportunistic infections, home based care and care for orphans and vulnerable children.

The country has fully embraced the "Three Ones" concept (i.e. One national coordinating body, One national strategic plan and One monitoring and evaluation mechanism) through its policy development and coordination setup. Various sectors have their own coordinating mechanisms involving all major stakeholders and all these are in turn coordinated through one multi-sectoral body. The health sector response is coordinated by the National AIDS and STI Control Programme (NASCP) in the Department of Public Health of the Federal Ministry of Health with corresponding State level equivalents in State AIDS and STI Control Programmes (SASCPs).

The HEAP served as an interim framework for the broad (multisectoral) national response to HIV/AIDS. A new National Strategic Framework (NSF) for HIV/AIDS for the period 2005-2009 is to be developed this year following a situation and response analysis of HIV-AIDS in all sectors. The NSF will constitute an over-arching strategic framework that will reflect all of the sectors involved in the HIV-AIDS response with each sector being responsible for developing a sector-specific plan. It is in this context that the Health Sector Strategic Plan for HIV-AIDS[8] (HSSP) was developed to guide implementation and resources allocation in line with national priorities. It proposes 7 major health sector responses, and work has been started to further operationalize the HSSP in an accompanying Implementation Plan[9].

Finally, NASCP has developed an "Antiretroviral Treatment Scale-up Plan[10a]" which sets the target of providing anti-retroviral treatment to 1 Million PLWHA by 2009, and proposes a number of priority activity areas contributing to the achievement of this target, including:

a. Improve capacity of health facilities to deliver ART
b. Defining minimum requirements for ART Centres
c. Identification and assessment of potential ART Centres
d. Carry out improvements of potential ART Centres.
e. Training of medical and non-medical personnel to deliver ART
f. Ensure continuous availability of drugs, reagents and supplies
g. Develop systems for monitoring, evaluation and research in ART efforts
h. Strengthen involvement of communities
i. Strengthen integration and linkages between ART and other related health programs
j. Develop mechanisms to improve access to ART services for the poor, vulnerable population groups and workers.

The cost for implementing the ART Scale-up plan over a 5-year period is estimated to be USD 1.89 billion.

HIV/ADS interventions have been broadly categorized into prevention, treatment, care and support. Programmes under prevention include Voluntary Counselling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT), Blood Safety, Universal Precaution (UP) and Injection Safety (IS), Post-Exposure Prophylaxis and Condom Distribution, Communication and Advocacy. Treatment, care and support interventions include ART, OI management, palliative care, STI control, nutrition psychosocial support and care for OVCs. Other care interventions include Directly Observed Treatment Strategy (DOTS) for treatment of TB as well as Home Based Care which aims at ensuring care for people living with HIV within the context of their families and communities. NGOs and FBOs have so far provided most of the HBC support including spiritual support. The primary health care system is also being strengthened to be able to support the delivery of quality services including prevention and treatment to members of the community.

A number of external partners are supporting ongoing HIV/AIDS programmes. They include the following:

The US government support includes:

- USAID supports national responses in social marketing, behaviour change, preventive mechanisms, and policy development projects at national level;
- The Global AIDS Program (GAP) CDC is providing support to Nigeria focused on three key areas of infrastructure and capacity development, primary prevention, and care and treatment;
- The US President's Emergency Plan For AIDS Relief (PEPFAR) is committed to Nigeria for the supply of ARVs to 350,000 people by 2008;
- The AIDS Prevention Programme in Nigeria (APIN) of Harvard School of Public Health with funding from the Bill and Melinda Gates Foundation is presently supporting 3 sites with PMTCT, diagnosis of HIV/AIDS, and monitoring of clients on ARV therapy.
- The Department of Labor (USDOL) has been supporting workplace programmes through the SmartWork Project developed in collaboration with AED.

Other bilateral and multilateral programmes include:

- The World Bank through the Multi-country Aids Project (MAP);
- CIDA contributions to the Nigerian health sector responses with a 4-year initiative (2003-2007)on PMTCT and reproductive health and HIV/AIDS prevention and care for adolescent and youth, TB/HIV and DOTs;
- DFID is implementing a 7-year national behaviour change and social marketing programme which also includes multi-sector institutional strengthening, the health system reform and the development of the Health sector plan for HIV/AIDS;
- The Global Fund to fight AIDS, TB and Malaria granted Nigeria three HIV/AIDS specific proposals in Round 1. Phase one, which has focused on the establishment of ART in 25 tertiary hospitals, is coming to an end in 2005, and will be succeeded, by phase 2 which is proposed to expand ART provision to secondary level hospitals.

Programmes of United Nations agencies include:

- Ongoing technical assistance from WHO in health sector reform and development of health sector response to HIV/AIDS;
- UNICEF is supporting the PMTCT services in 8 states and FCT; UNDP has collaborated with DFID to spearhead the formation of support groups through the Ambassadors of Hope. UNDP has also focused on income generation through micro credits to empower PLWHA, and Human Rights issues;
- UNODC is linked to the Health sector response through the association of drug use and HIV/AIDS. It operates the Partnership against Drug Abuse and HIV/AIDS, both at national and West African sub regional levels. It has intervention programmes in 6 universities and 2 cities (Kano and Port Harcourt)
- UNFPA is supporting VCTs and PMTCT, and presently operates in 6 states. There are plans to scale up, and also integrate onto government sites. Support is being given to NGOs in 2 states, with hopes to link up to community activities.

c) Describe the role of AIDS-, tuberculosis- and/or malaria-control efforts in broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative, the Millennium Development Goals or sector-wide approaches. Outline any links to international initiatives such as the WHO/UNAIDS '3-by-5 Initiative' or the Global Plan to Stop TB or the Roll Back Malaria Initiative.

The broad developmental framework for poverty reduction in Nigeria is the National Economic Empowerment Development Strategy (NEEDS). The NEEDS document[11] addresses health issues within its Social Charter on Human Development Agenda. Overall, the health sector development strategy in the NEEDS will continue to emphasize the strengthening of preventive and curative primary health care services. The goal of the health sector's component of the NEEDS is to improve the health status of Nigerians as a significant co-factor in the country's poverty reduction strategy. The initiative will involve the undertaking of a comprehensive health sector reform largely aimed at strengthening the national health system, and enhancing the delivery of effective, efficient, quality and affordable health services to Nigerians.

In this context, proposed policy thrusts include:

1. To improve government's performance of its stewardship role of policy formulation, health legislation, regulation, resource mobilization, coordination, monitoring and evaluation.
2. To strengthen the national health system and improve its management.
3. To improve the availability and management of health resources (financial, human, infrastructure, etc.)
4. To reduce the 'disease burden' attributable to priority diseases and health problems, including malaria, tuberculosis, HIV/AIDS, and reproductive ill-health.
5. To improve the population's physical and financial access to quality health services.
6. To increase consumers' awareness of their health rights and obligations.
7. To foster effective collaboration and partnership with all health actors.

Addressing HIV/AIDS, one of the 7 major thrusts of the NEEDS, is a significant component of the overal development and proverty reduction strategy in Nigeria. This proposal contributes directly to national development efforts by mobilizing additional needed resources for the national response to HIV/AIDS.

As a contribution towards attainment of the Millennium Development Goals (MDG), Nigeria has constituted an MDG committee chaired by His Excellency, the President to give policy direction and monitor progress made towards its implementation process. The health sector has the responsibility of developing and implementing relevant policies and

strategies in relationship to MD Goals numbers 4, 5 and 6 which have to do with Reducing Child mortality, Improving maternal health and Combating HIV/AIDS, Malaria and TB. At the centre of realising these goals is the level of poverty.

In 2002 Nigeria started providing antiretroviral treatment in the public sector to people living with HIV/AIDS. This was in recognition of the fact that ART provision was an essential element of the overall response to HIV/AIDS and that this service needed to be made available to Nigerians regardless of socioecomic status. The initial efforts in providing ART were on very limited pilot scale. Expansion of the service has been limted largely due to inadequate funding. When the "3 by 5" Initiative[12] was launched in September 2003, Nigeria invited a WHO scoping mission to discuss its implementation in the country. Since then Nigeria has fully embrassed the 3 by 5 Initiative. The country has developed an ART scale up plan that sets an ambitious target of providing ART to 1,000,000 people by 2009. In this proposal is contained a request for funding to contribute towards reaching that target.

4.3.3 Financial and Programmatic Gap Analysis

[Interventions included in the proposal should be identified through an analysis of the gaps in the financing and programmatic coverage of existing programs. Global Fund financing must be additional to existing efforts, rather than replacing them, and efforts to ensure this additionality should be described Use Table 4.3.3.a to provide in summarized form all the figures used in sections 4.3.3.1 to 4.3.3.3.]. [For health systems strengthening components the financial and programmatic gap analysis needs to provide information relevant to the proposed health systems strengthening intervention(s).]

4.3.3.1 Detail current and planned expenditures from all relevant sources, whether domestic, external or from debt relief, including previous grants from the Global Fund.

[List the financial contributions dedicated to the fight against this disease by all domestic and external sources. Indicate duration and amount, and ensure that the amount for domestic sources is consistent with Table 1.1.1]

Funding for HIV/AIDS activities comes from a diversity of sources and partners. It is not possible to capture and quantify all the available funding for HIV/AIDS in the country, especially contributions from individual, communities, NGOs and private sector. The major sources of HIV/AIDS funds are as follows:

Overall estimates on the current and planned expenditures for the overall fight against HIV/AIDS (multisectoral response) are not available. However, some data are available on current and planned expenditures related to the health sector response to HIV/AIDS , including, amongst others, comprehensive HIV/AIDS treatment, testing and counseling and PMTCT. These expenditures increase from 45 million USD per year in 2004 to 370 Million in 2010, including a significant contribution by the Government. The increase is mainly driven by external donor support.

Some of the major sources of external funding for HIV/AIDS are as follows:

- The World Bank Multi-country Aids Project (MAP) provides funding in the sum of $90.3 million over 5 years (2002-2007).
- The US President's Emergency Plan For AIDS Relief (PEPFAR) plans to devote $194 million over the next 5 years on treatment, prevention, care and support.
- The AIDS Prevention Programme in Nigeria (APIN) of Harvard School of Public Health with funding from the Bill and Melinda Gates Foundation is presently supporting 3 sites with PMTCT, diagnosis of HIV/AIDS, and monitoring of clients on ARV therapy.
- CIDA contributions to the Nigerian health sector responses with a 4-year initiative (2003-2007) to the tune of $900,000.
- DFID is implementing a 7-year prevention programme to the tune of £52.8million.

- The Global Fund to fight AIDS, TB and Malaria granted Nigeria grants from Round 1 amount to about $80 million.

4.3.3.2 Provide an estimate of the costs of meeting overall (national) goals and objectives and provide information about how this costing has been developed (e.g., costed national strategies).

Similar to the income side, the total funds needed have not been estimated for the multisectoral response. However, a proxy to the funds needed to meet the objectives of the Health Sector Strategic Plan (2004-2009) (with and extension into 2010) can be obtained by adding (a) the planned budget for the HSSP as published in HSSP, and (b) costs estimated for provision of comprehensive anti-retroviral treatment to 1 Million PLWHA in 2009 as published in the NASCP ARV Plan. The needs calculated on this basis amount to yearly 148 Million USD in 2004 and increase to 770 Million USD in 2010. This amount still represents an underestimation, as it does not include funds needed to scale up testing and counseling and PMTCT.

4.3.3.3 Provide a calculation of the gaps between the estimated costs and current and planned expenditures.

A comparison of budgets needed and budgets committed demonstrate significant funding gaps, increasing from about USD 18 Million USD in 2004 to almost 500 Million in 2009 - despite substantial contributions from a variety of domestic and external donors. This financial gap corresponds to an unmet need of more than 600,000 people living with HIV/AIDS who will need anti-retroviral therapy in 2010.

Table 4.3.3 - Financial Contributions to National Response

	Financial contributions in US$ for HIV/AIDS health sector response***						
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Government	6,000,000	10,700,000	15,000,000*	20,000,000*	25,000,000*	35,000,000*	50,000,000*
GFATM Rd 1	5,772,000	12,000,000	24,000,000	20,000,000	18,000,000		
PEPFAR	37,000	37,000	37,000	37,000*	37,000*		
World Bank MAP	400,000	400,000	400,000	400,000			
UNFPA	6,000,000	6,000,000	6,000,000	6,000,000			
DFID	16,300,000	16,300,000	16,300,000	16,300,000	16,300,000		
USDOL	300,000	300,000	300,000				
CIDA	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
NGO & private sector	3,000,000	5,000,000	8,000,000*	10,000,000*	12,000,000*	15,000,000*	20,000,000*
Gates Foundation	5,000,000	5,000,000					
UN Agencies	7,400,000	8,000,000	9,200,000*	10,000,000*	12,000,000*	14,500,000*	16,000,000*
TOTAL PLEDGED	**51,709,000**	**65,237,000**	**48,537,000**	**43,837,000**	**35,837,000**	**1,500,000**	**1,500,000**

Total need (C)	102,970,000	183,400,000	253,600,000	361,900,000	468,200,000	762,000,000	770,000,000
Unmet need	51,261,000	118,163,000	205,063,000	318,063,000	432,363,000	760,500,000	768,500,000

**Represent estimates obtained from the respective organisations rather than firm pledges.*
Blanks spaces are unavailable estimates which depend on continuation of the respective programme strategic plans

4.3.4	Confirm that Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources, and explain plans to ensure that this is the case.
Funds from the Global Fund will indeed be additional to existing and planned resources. The needs of Nigeria are enormous and will continue to grow. Therefore meeting those needs will require strong commitment from government and partners to make available increasing sustained increase in the amount of resources availble. Global Fund resources will by no means be substitute other funding but rather to fund additional efforts in the national response to HIV/AIDS.	

4.4 Component Strategy

4.4.1	Description and justification of the program strategy

[This section must be supported by a summary of the Program Strategy section in tabular form.

- *Tables 4.4a and b (following section 4.4.1) are designed to help applicants clearly summarize the strategy and rationale behind this proposal. For definitions of the terms used in the tables, see Annex A. (See Guidelines for Proposals, section V.B.2, for more information.)*
- *In addition, please also provide a detailed quarterly work plan for the first 12 months and an indicative work plan for the second year. These should be attached as an annex to the proposal form.]*

Narrative information in section 4.4.1 should refer to Tables 4.4a and 4.4b, but should not consist merely of a description of the tables.]

Rationale

The primary focus of this proposal is to strengthen treatment care and support for people living with and affected by HIV/AIDS in Nigeria. It is estimated that currently there are between 3.2 and 3.8 million persons living with HIV/AIDS in Nigeria. Out of these, approximately 600,000 require antiretroviral treatment and this number is expected to double in 5 years. Expanding access to treatment, care and support at this point in time is an imperative. The country is at the stage of the epidemic when the impact of HIV/AIDS on individuals, families and communities is becoming increasingly evident.

It is for this reason that the Federal Government of Nigeria launched antiretroviral treatment programme in the public sector in 2001. With funds secured from the Global Fund in the First Round, 25 Federal Centre in 17 States were established to provide ART. As at mid 2005 it is estimated that 35,000 people are receiving ART from various providers in the country. This figure represents a mere 6% of all the people that need the treatment. Treatment of opportunistic infections is provided by government, private and NGO facilities throughout the country. However, access to OI treatment for PLWHA is constrained by inadequacy of drugs and diagnostics, as well as cost. Coverage of services for HIV counselling and testing, prevention of mother to child transmission (PMTCT) and home based care, are still very low in Nigeria compared to other countries in sub-Saharan Africa.

This proposal seeks to address a major gap in the response to HIV/AIDS in Nigeria, builds programmes initiated through Round 1 Global Fund grant, and builds on existing prevention treatment and care initiatives of government and all other partners. It aims to scale up provision of antiretroviral treatment and related services such as counselling and testing, PMTCT and community care to ensure that a comprehensive package of HIV/AIDS treatment, care and support is available in all parts of the country. Special attention is being paid to addressing treatment, care and support needs of children, including OVCs. The essential role that civil society organizations and the private sector play in providing and supporting HIV/AIDS treatment, care and support is being enhanced through additional capacity building for these institutions. Aspects of HIV prevention included in the proposal are those that are closely related to treatment, care and support initiatives.

Approach

The provision of antiretroviral treatment in the public sector in Nigeria has so far focused on the establishment of ART services at tertiary level health facilities. This approach has greatly limited the number of people accessing ART. Some of the weaknesses of the current approach are as follows:

Limited access: The localization of treatment centres in tertiary level facilities has privileged access to service by urban populations who lived in their vicinity. Even though ARV services are provided free of charge or at minimal charge, their co-location with other,

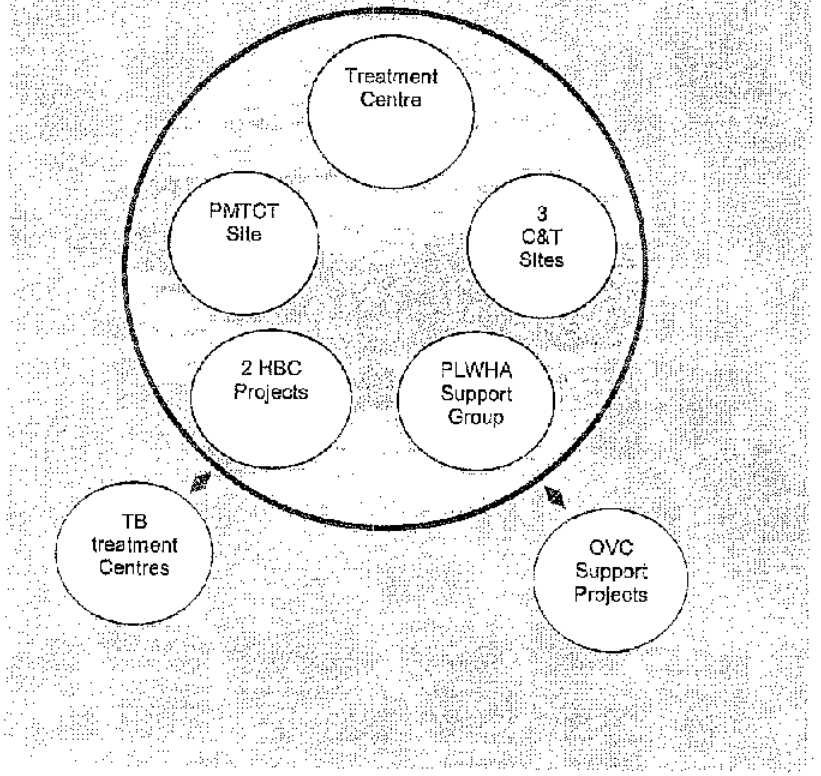
costly health services in tertiary facilities might have favoured use to the more affluent part of the population.

Limited capacity: With close to, or more than, 1000 patients per service, the current expansion in tertiary centres is reaching its ceiling - space and personnel in existing ART sites have been over-stretched; while resources are available and under-utilized at secondary and primary levels of care.

The approach to be followed in scaling up HIV/AIDS treatment, care and support is to extend provision of ART to tertiary and secondary level health facilities in all the 37 States of the country. Along side centres providing ART will be existing or established related services for counselling and testing; PMTCT, TB, adherence support and home based care. These will collectively form clusters for providing comprehensive HIV/AIDS care.

A new approach to scaling up ART has been developed. It involves developing a network or clusters of secondary and primary facilities that will provide comprehensive HIV/AIDS care, including ART. The approach aims at strengthening capacity of and links between general hospitals, PHC facilities and community based efforts to ensure a continuum of care for people living with HIV/AIDS. Decentralizing HIV/AIDS treatment and care to secondary and primary levels will enable more people to access treatment and achieve significant impact on HIV/AIDS related morbidity and mortality.

Cluster of Comprehensive HIV/AIDS Treatment, Care and Support



1x Treatment centre (ART, OI, STI, HIV/TB)

3 x Counselling & Testing (C&T) sites

1 x PMTCT centres

2 x Home based care projects

1 x PLWHA support group

Table 4.4a. Goals and Impact Indicators over Life of Program

Goal No.	Goals over five years
# 1	Reduced morbidity and mortality from HIV/AIDS in Nigeria

Goal No.	Impact Indicator	Baseline			Year 1 target 2006	Year 2 target 2007	Year 3 target 2008	Year 4 target 2009	Year 5 target 2010	Source and comments
		Value	Year	Source						
#	Increased percentage of people still alive 12 months after initiation of antiretroviral treatment	Not available	2005	Patient Management and Monitoring (PMM)	70%	80%	95%	95%	95%	National Sentinel Surveillance Data and estimates, 2-yearly

[Impact indicators are not normally measured every year, and values for targets do not need to be entered for every year. It is advisable to refer to the list of coverage indicators provided in Annex A.]

Table 4.4b. Objectives, Service Delivery Areas and Coverage Indicators over Life of Program

Program objectives over five years		
Objective No.	**Objective description**	**Link to goal by number**
# 1	To scale up comprehensive HIV/AIDS treatment, care and support for people living with HIV/AIDS to all 37 States in the country.	# 1
# 2	To expand access to HIV testing and counselling services to cover all 37 States in the country.	# 1
# 3	To strengthen the role of the community, civil society organizations and networks of PLWHA in providing and supporting HIV/AIDS treatment and care.	# 1
# 4	To increase access to care and support services for orphans and vulnerable children (OVC) in all 37 States.	# 1
# 5	To increase capacity of the private sector to implement workplace HIV/AIDS programs in 12 States.	# 1
# 6	To strengthen capacity of Implementing institutions for effective programme management, coordination, monitoring and evaluation.	# 1

Objective No.	Service delivery area	Directly tied	Indicator description	Baseline		Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Frequency of data collection
				Value	Year	2006	2007	2008	2009	2010	
# 1	1a. Antiretroviral Treatment (chronic HIV care)	No, National target[5]	Number of people with advanced HIV infection receiving anti-retroviral combination therapy	13,500	2004	175,000	250,000	300,000	400,000	500,000	Quarterly
		Proposal targets[6]				23,360	35,720	46,080	59,940	70,300	
		yes*	Number of service delivery points providing antiretroviral combination therapy	25	2004	37	74	111	148	185	Quarterly

[5] The numbers in this role represent what achievable at a national level taking into account all available resources
[6] The numbers in this role represent what is achievable with this proposal

# 1	1b. Prophylaxis and treatment for opportunistic infections (acute HIV care) (palliative care)	no	Number of people living with HIV/AIDS receiving co-trimoxozole prophylaxis	0	2005	300,000	500,000	700,000	900,000	1,100,000	Quarterly
# 1	1c. HIV/TB collaborative activities	yes*	Percentage of newly diagnosed HIV-positive clients receiving INH prophylaxis	0	2005	5%	10%	15%	20%	30%	Quarterly
# 1	1d. Prevention of Mother to Child Transmission	yes*	Number of PMTCT centres established/supported	11	2004	37	74	111	148	185	Quarterly
			Percentage of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis for prevention of mother to child transmission	0.45%	2004	1%	3%	5%	7.5%	10%	Annually
# 2	2 Counselling and Testing	yes*	Number of people completing the testing and counselling process	35,000	2004	250,000	400,000	700,000	800,000	1,000,000	6-monthly
			Number of service delivery points providing counselling and testing with minimum conditions to provide quality services	Not available	2004	111	222	333	444	555	Quarterly
# 3	3a. Stigma reduction and respect for confidentiality	yes*	Number of PLWHA support groups fighting against discrimination	Not available	2005	37	74	111	148	185	Annually
# 3	3b. Home based care	yes*	Number of organizations or service delivery points supported for home based care	Not available	2005	74	148	222	296	370	6-monthly
# 3	3c. Youth education	yes*	Number National Youth Corps members trained to provide HIV/AIDS education on stigma reduction and treatment support	0	2005	7,400	14,800	22,200	29,600	37,000	6-monthly
# 4	4. Care and support for orphans and vulnerable children	yes*	Number of orphans and vulnerable children receiving material and psychosocial support	Not available	2005	48,000	72,000	96,000	120,000	148,000	6-monthly

# 5	5. Workplace policy and programmes	yes*	Number of private enterprises providing interventions for HIV/AIDS prevention and treatment to the workforce	Not available	2005	60	120	150	170	170	6-monthly
# 6	6a. Coordination and partnership development	yes*	Number of organizations with enhanced capacity to provide and support HIV/AIDS treatment & care services	Not available	2005	45	45	45	45	45	Annually
# 6	6b. Monitoring and evaluation	yes*	Percentage of service delivery points submitting timely reports	10%	2005	30%	50%	70%	100%	100%	Quarterly

[It is advisable to refer to the list of indicators provided in Annex A. However, if the service delivery areas and indicators do not adequately reflect the proposed strategy, they may be expanded.]

4.4.1.1 Provide a clear description of the program's goal(s), objectives and service delivery areas (provide quantitative information, where possible).

The **goal** of this component is: Reduced morbidity and mortality from HIV and AIDS in Nigeria.

This is to be achieved through scaled up delivery of comprehensive HIV/AIDS treatment, care and support services. Comprehensive HIV/AIDS treatment, care and support includes the following: antiretroviral treatment; treatment of opportunistic infections; prophylaxis and treatment of TB, counselling and testing; management of sexually transmitted infections; PMTCT; community adherence support and home based care. The programmes will be implemented by government agencies at Federal, State and Local Government levels with and array of partners including civil society organizations, networks of people living with HIV/AIDS, faith-based organizations, private sector and local communities. Programmes in this proposal will complement those undertaken with resources from other sources such as government, PEPFAR, the World Bank, businesses and other bilateral and multilateral agencies. It is expected that the combined effect of all these efforts will lead to reduction in deaths and improvement in the quality of life among people living with HIV/AIDS (including children), which in turn contributes, to minimizing the socioeconomic impact of HIV/AIDS on individuals, families, communities and the nation.

The indicator to measure this goal will be the ' the percentage of people still alive 12 months after initiation of antiretroviral treatment'. The current baseline value is not know as data has not yet been analysed. However the national target is to increase the percentage to 95%. Experience from some ART programmes in Africa such as Senegal and Uganda suggest that this is achievable. Data for this indicator will be obtained from health facilities through the patient tracking system and the Nigeria National Response Management System for HIV/AIDS.

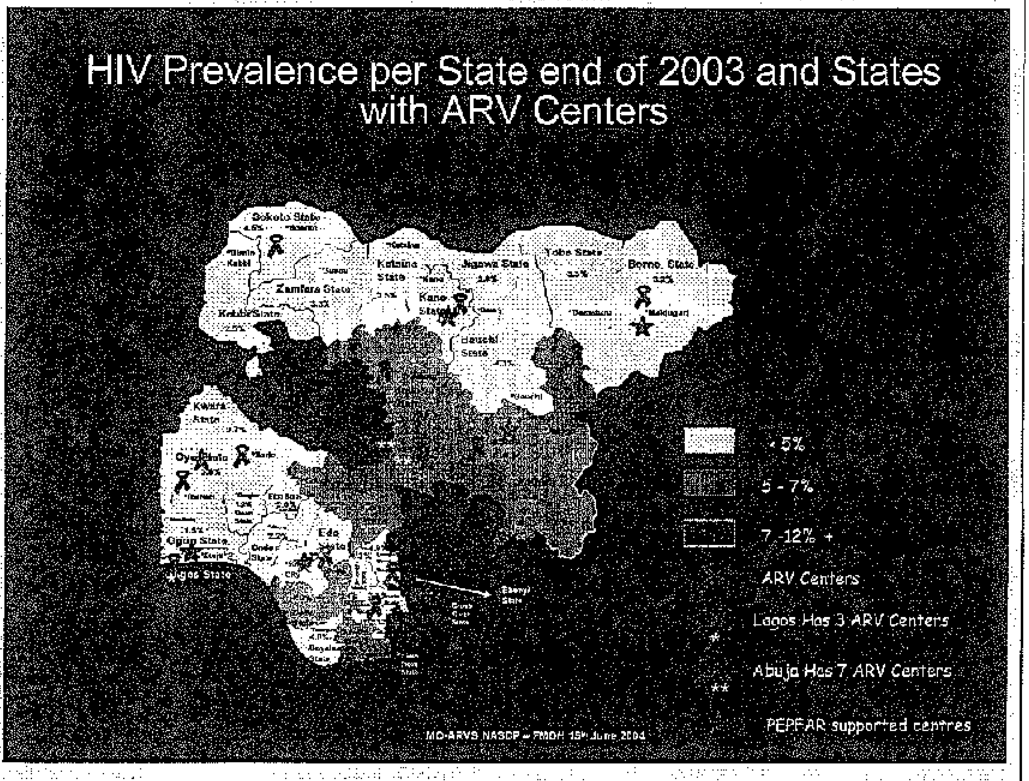
There are six major objectives under this goal, as follows:

1. To scale up comprehensive HIV/AIDS treatment, care and support for people living with HIV/AIDS to all 37 States in the country.
2. To expand access to HIV testing and counselling services to cover all 37 States in the country.
3. To strengthen the role of the community, civil society organizations and networks of PLWHA in providing and supporting HIV/AIDS treatment and care.
4. To increase access to care and support services for orphans and vulnerable children (OVC) in all 37 States.
5. To increase capacity of the private sector to implement workplace HIV/AIDS programs in 12 States.
6. To strengthen capacity of implementing institutions for effective programme management, coordination, monitoring and evaluation.

Objective 1: To scale up comprehensive HIV/AIDS treatment, care and support for people living with HIV/AIDS to all 37 States in the country.

The aim is to increase the number of recognized centres providing ART to cover all the 37 States. Currently ART services are provided in 21 States. The centres include those run by government, those supported by PEPFAR and those owned by NGOs/FBOs. In addition to ART services the intention is to strengthen and expand related treatment and care services alongside the ART centres. These related services include treatment of opportunistic infections, management of TB, and PMTCT.

The primary beneficiaries are people living with HIV/AIDS. Consideration will be made to ensure that children have access to these services. This will be achieved by ensuring availability of paediatric formulations, appropriate training, providing free treatment to children and establishment of linkages between treatment centres and services such as PMTCT and OVC support. Attempts will also be made to improve access to treatment services for some population groups such the youth and the poor by providing subsidized or free services.



Service delivery areas under this objective are as follows:

- **Antiretroviral Treatment (chronic HIV care).** In 2001 the Federal Government of Nigeria adopted a policy to provide antiretroviral treatment to people living with HIV/AIDS in the country. Implementation of the program began in 2002 in 25 centres located in various parts of the country. By April 2005 there were approximately 14,000 people receiving ARV treatment from these centres and about 17,000 more are on waiting lists. The 25 centres have served as pilot sites to demonstrate that it is possible to provide antiretroviral treatment in the public sector with an equal amount of success as in other developing countries. The government ART program has also provided useful lessons to guide expansion of these services to other parts of the country. ART services are also provided in some other government and parastatal health and by other providers such non-governmental organizations and the private sector. There are a total of 33 recognized centres currently providing ART in the country. Twenty-five of these are in government facilities, 6 are supported by PEPFAR and one each run by the Catholic Relief Services (CRS) and Medicins Sans Frontiers (MSF).

  National guidelines for antiretroviral and opportunistic infections treatment were revised in 2004[13] and guidelines for the treatment of children were also developed in 2004. The recommended first line regimen includes Stavudine, Lamivudine and Nevirapine or Efavirenz. Stavudine is replaced by Zidovudine as alternative first line treatment. First line for children includes Lamivudine, Nevirapine and Stavudine or Zidovudine.

The Ministry of Health has adopted a plan to scale up antiretroviral treatment[10]. The Plan aims to scale up treatment to 1,000,000 people by 2009. However, taking into consideration the amount of resources potentially available for ART, including what is requested in this proposal, it is likely that only about 500,000 people will be receiving ART by 2010.

Training of health workers in delivery of ART is currently being coordinated by the Nigeria Institute for Medical Research (NIMR). NIMR has developed a training programme[14] and 1,176 health workers (268 clinicians, 109 pharmacists, 253 nurses, 257 laboratory staff, 246 counsellors, 43 records officers) have so far been trained in ART provision, mostly from tertiary level institutions. There are plans to adopt the Integrated Management of Adult Illness (IMAI) training materials to cover training of clinical teams and coordinators at secondary and primary levels.

The patient tracking system currently in place will be reviewed in the light of the new IMAI training approach with the aim of introducing a system more appropriate for secondary and primary level facilities. NIMR is also coordinating efforts in monitoring drug resistance. An expert committee on drug resistance monitoring has been commissioned to develop the necessary protocols and capacities.

This proposal aims at contributing to scaling up ART services in the country to cover an additional 70,300 people in 5 years. This will involve increasing the number of centres providing ART from the current 33 to reach a total of 185 centres. Health workers will need to be trained, health facilities improved and the necessary antiretroviral and other drugs procured. It will also be important to strengthen linkages between ART and other services.

- **Prophylaxis and treatment for opportunistic infections (acute HIV care).** It is estimated that currently only about 10% of all health facilities in Nigeria provide treatment of opportunistic infections in line with national guidelines. The major constraints to availability of quality opportunistic infection services are inadequacy of drugs and skills in the health facilities. Support for treatment of opportunistic infections will be provided through training of health care workers and procurement of the necessary drugs. Co-trimoxazole prophylactic treatment will be introduced and provided to 1.1 million people living with HIV/AIDS in the 5 years of this proposal.

- **HIV/TB collaborative activities**. The HIV and TB co-infection rate in Nigeria is estimated to be 35%. This suggests that about 1 million adults have both HIV and TB infection. Such dually infected people develop TB at a rate of about 5% per year. Nigeria can thus expect an additional burden of some 50,000 TB cases annually from among those already infected with HIV. A TB/HIV collaborative proposal was developed in 2004 and has received approval for funding by USAID. The proposal intends to establish and implement TB/HIV activities in 6 States (one for each zone), 2 LGAs per state, and 2 DOTS centres per LGA. A total of 24 DOTS centres will be involved over a two year period. Already, guidelines and training materials have been developed. Areas of collaboration include counselling and testing for HIV among TB clients, referral of TB patient who are HIV positive for HIV services and vice versa, INH prophylaxis and antiretroviral treatment for TB patients.

  The TB component of this proposal has included HIV counselling testing services, for TB clients. This component address providing antiretroviral treatment for TB patients (within service delivery area one of this objective) and provision of INH prophylaxis to people living with HIV/AIDS. It is estimated that currently only 5% of people living with HIV/AIDS are receiving INH prophylaxis. Through this proposal this is to be increased to 30% over 5 years.

- **Prevention of Mother to Child Transmission.** The number of infants born to HIV infected women is around 270,000 and number of HIV positive infants per annum is 67,500 to 125,500. Within the context of PMTCT interventions to prevent HIV infections in children born to HIV-infected women are provided as well as provision of HIV related care and treatment to women, their infants and families, including sexual and reproductive health interventions for HIV-infected women; other care interventions for HIV-infected women and children.

  Currently there are only 11 recognized PMTCT centres located in 10 States. This is indeed very low coverage of PMTCT services for a country of the size of Nigeria. The intention in this proposal is to extend PMTCT services to all the 37 States in the country. The new PMTCT services will be integrated in or linked to centres that will be providing antiretroviral treatment. Therefore, the number of centres providing PMTCT services will have increased from the current 11 to 185 centres (same number as ART centres).

Objective 2: To expand access to HIV testing and counselling services to cover all 37 States in the country.

- **Counselling and testing**

Counselling and testing are essential entry point to HIV/AIDS prevention and care. When people know their HIV status they are better able to take appropriate individual and collective measures to prevent transmission. Counselling and testing also enables HIV positive people to enter early into treatment, care and support and so increase chances of better health outcomes. Positive prevention can be carried out in the context of counselling and testing services in addition to treatment and other settings.

National guidelines for counselling and testing[15] provide for routine offer of testing at health facilities voluntary and confidential counselling and testing (VCT) in non-health sites. Minimum standards for counselling and testing including facilities and tests are defined in the national guidelines for counselling and testing.

Counselling and testing services in Nigeria are provided by a number of providers including government, NGOs and private sector. The number of sites providing counselling and testing services in the country is unknown. However, it is clear that coverage of counselling and testing is very low. In this proposal the intention is to extend quality counselling and testing services to all 37 States. Three such centres will be linked to each of the antiretroviral treatment centres planned in this proposal. Therefore at the end of 5 years there will be 555 counselling & testing sites established/assisted through this proposal and will have tested over 1 million people. Clearly this is still inadequate for Nigeria, but there will be concurrent efforts to establish/improve other sites with support from other sources.

Objective 3: To strengthen the role of the community, civil society organizations and networks of PLWHA in providing and supporting HIV/AIDS treatment and care.

Strong involvement of communities, civil society organizations and people living with HIV/AIDS is critical in scaling up HIV/ADS treatment care and support. The public sector alone does not have all the necessary capacity, skills and proximity to adequately address the treatment, care and support needs of people living with HIV/AIDS. Community groups, civil society and people living are numerous in number, diverse in nature and ubiquitous in presence. Their combine effort in providing and supporting HIV/AIDS treatment, care and prevention is enormous and a necessary complement to public and private efforts for a strong national response. Their diverse and ubiquitous

nature also puts these entities in closer geographical and social proximity to the population that sometimes gives them comparative advantage in carrying out targeted and sustained interventions for specific affected or vulnerable groups.

In the context of this proposal community and civil society efforts will focus on addressing HIV/AIDS related stigma and discrimination, preparing communities for HIV/AIDS treatment, providing home and community based care for people living with or affected by HIV/AIDS, and promoting HIV prevention among HIV positive and negative people.

The involvement of civil society and people living with HIV/AIDS in the response to HIV/AIDS in Nigeria is coordinated through the Civil Society Network on HIV/AIDS in Nigeria (CISNHAN) and the Network of People Living With HIV/AIDS in Nigeria (NEPWHAN), respectively. The approach in this proposal is to channel support through CISNHAN and NEPWHAN to community groups and support groups of people living with HIV/AIDS throughout the country. It is envisaged that support will be provided to at least one treatment support group linked to each of the 185 antiretroviral centres to be established under this component. Complementary efforts to establish and support other similar support groups are and will also be ongoing, with funds from other sources.

Service delivery areas under this objective are as follows:

- **Stigma reduction and respect for confidentiality.** Fighting stigma and discrimination is an integral component of the response to HIV/AIDS. Evidence has shown that where stigma and discrimination are rife, people are less willing to know their HIV status, less likely to take preventive measures (such as using a condom), less likely to seek treatment and support, and more likely to experience severe psychosocial stress. An environment free of stigma and discrimination, on the other hand, allows for more open communication on HIV/AIDS and empowers people living with HIV/AIDS, communities and service providers to engage more fully in the HIV/AIDS response.

  Legal framework for protecting the rights of people living with HV/AIDS exists in some but not all states. However, ongoing review of laws and regulations in this regard will continue to be an ongoing process with support from elsewhere. This proposal will focus on promoting adherence to those laws and regulations at all levels. This will be done mainly through training in stigma reduction for personnel in civil society organizations and PLWHA groups. In addition, support will be provided to create and strengthen support groups involved in fighting stigma and discrimination and promoting community treatment preparedness. At least one such group to be supported will be linked to each of the HIV treatment centres.

- **Home based care.** Home-based care is an important part of the continuum of care. Much of the care for the sick happens in the home with household members being the primary care givers. Home based care provides opportunity for multidisciplinary HIV/AIDS care which includes psychosocial support, palliative care, adherence support and prevention among people who are HIV positive.

  In Nigeria, home-based care is mainly supported through non-governmental organizations, faith based organizations and community HIV/AIDS support groups. The total number of groups carrying out home-based care programmes in Nigeria is not known. However, there are about 79 health units and 47 NGOs involved in providing systematic home based care to approximately 17,790 PLWHA with the support of supervisors trained by the Ministry of Health. The training was provided using Round 1 Global Fund resources. Guidelines for training of home based care volunteers have been developed by the Ministry of Health.

The purpose in this proposal in to strengthen home based care as an essential component of the continuum of care from hospital to home. This will be done by providing training, material and logistic support to home-based care programmes. This includes supply of drugs and care materials, and support with transportation and communications for caregivers and the sick, where necessary. As a first step it will be necessary to conduct a nationwide assessment of home based care programmes to identify who is providing the service and the type/quality of services being provided. In addition, national guidelines for home-based care will be revised and distributed.

- **Youth education.** The intention here is to mobilize for HIV/AIDS stigma reduction, care and support the huge resource of young people that is available in Nigeria through the National Youth Service Corps (NYSC). The NYSC program, established 32 years ago, requires that graduates of tertiary educational institutions who are under the age of 30 devote one year (as Corps members) to national service. Annually, about 100, 000 Corps members are posted mainly to schools and other organizations especially in rural communities where they serve as role models to other young people and agents of social mobilization and change. HIV/AIDS activities in the NYSC so far mainly focused on training Corps members in HIV prevention to serve as peer educators as well as trainers in secondary schools where they are posted on assignments. The secondary school students they train in turn serve as peer educators.

  This proposal aims at adding a stronger stigma reduction and treatment preparedness component to existing NYSC HIV/AIDS efforts. This will be achieved through development of appropriate training programmes for NYSC staff and Corps members for stigma reduction, care and support. Training will be provided to 7,400 of the 100,000 young people who enter the Corps each year. In addition to training, the programme will also mobilize the young people for increased uptake of VCT, STI, OI and ART services.

Objective 4: To increase access to care and support services for orphans and vulnerable children (OVC).

- **Care and support for orphans and vulnerable children.**

It is estimated that currently there are over 7 million orphans in Nigeria and HIV/AIDS is responsible for over 1.3 million of these. National efforts at addressing the needs of orphans and vulnerable children have so far been inadequate. There are already established structures such as OVC steering committee, OVC coordinating unit, Donors coordinating group on OVC and the OVC stakeholders' forum. These structures, with the leadership of the Federal Ministry of Women Affairs, will ensure participation of implementing institutions at all levels, especially at the state and community levels where the beneficiaries will be targeted. The actual number of organizations implementing OVC programmes is not known.

This proposal will aim to strengthen programmes supporting OVCs to enhance coping capacity and increase their access to HIV/AIDS prevention, treatment, care and support. This will be achieved mainly through training of staff in organizations that are supporting OVCs and providing material assistance (health, schooling, etc) to OVCs. In the first year of the programme a nationwide assessment will be carried out to obtain a picture of OVC support in the country. While these efforts are being carried out consideration will be given to facilitating access of OVCs to HIV/AIDS prevention, treatment and care by establishing direct links between OVC and treatment programmes.

Objective 5: To increase capacity of the private sector to implement workplace HIV/AIDS programs.

- **Workplace policy and programmes.**

The nature and location of work of individuals or their spouses is an important factor in their chances of becoming infected with HIV or accessing treatment care and support services. Due to the nature of their productive activity, some workplaces may create environments that are more or less favourable for the workforce to respond to and cope with HIV/AIDS. Each context requires solutions adapted to its particular characteristics and capacities. Workplace programmes also bring to the HIV/AIDS response advantages of captive audience, management and communications skills, and material assets such as premises, finances and products. Despite the clear need, in Nigeria, there has been few workplace interventions designed to address issues surrounding HIV/AIDS in the workplace.

A number of large larger businesses (multinationals) have already begun to implement HIV & AIDS workplace programmes that include prevention, treatment, care and support services for employees. However, the vast majority of small and medium sized enterprises (SMEs), which make up 70 – 80% of businesses in the country, have not put in place actionable programmes to address HIVAIDS. The Nigerian Business Coalition Against AIDS (NIBUCAA) is leading efforts to promote and coordinate the response to HIV/AIDS by the business sector. Currently NIBUCAA has 34 enlisted member companies, 85% of which are multinational corporations. In March 2005 the National Executive Council of the Nigerian Business Coalition Against AIDS approved *The National Workplace Policy on HIV & AIDS*. Currently 60% of NIBUCAA member companies have workplace policies with varying levels of implementation. A select study of collaborating companies of AED/SMARTWork Nigeria showed 53.3% (2005) had adopted some form of workplace policy on HIV & AIDS. The establishment of a workplace policy on HIV & AIDS in companies serves as the framework in which employees living with HIV & AIDS are given the same rights, benefits and opportunities as their colleagues living with other life-threatening conditions.

Due to capacity constraints this programme will be implemented in 12 States and will target 10 enterprises in each State. The 12 States were selected based on HIV prevalence and industrial density. They as follows: Benue (9.3%); Federal Capital Territory (8.4%); Adamawa (7.6%); Gombe (6.8%); Kaduna (6.0%); Kano (4.1%); Enugu (4.9%); Anambra (3.8%); Akwa-Ibom (7.2%); Cross Rivers (12%); Lagos (4.7%) and Oyo (3.9%).

Objective 6: To strengthen capacity of implementing institutions for effective programme management, coordination, monitoring and evaluation.

Implementation of the programmes contained in this proposal will require building additional capacity of existing institutions. Nearly all the implementing institutions face capacity constraints of one sort or another. These shortcomings include inadequacy of human resources, skills, equipment and facilities for management, coordination and monitoring.

To this end, resources are being provided for in this proposal to support the management capacity of the Principal Recipient(s), Sub-Recipients and implementing institutions. In the course of preparing this proposal some implementers clearly defined their management capacity needs while others did not. Resources will be allocated accordingly to those that indicated their needs. To those that have not specified their management needs, some resources, (not exceeding 5% of the total cost of activities they are to implement) will be allocated to support management capacity.

Service delivery areas under this objective are as follows:

- **Coordination and partnership development.** The major emphasis here will be institutional capacity development in addition to strengthening coordination and partnerships building. The health systems strengthening component of this proposal is addressing a lot of the institutional capacity needs. That component is designed to address capacity issues that that cut across all the three diseases (HIV/AIDS, TB and Malaria). Included in this component are the specific capacities integral to implementing the service delivery areas.

- **Monitoring and evaluation.** Emphasis here will be placed on developing and making available the necessary skills and tools for monitoring specific service delivery areas. These include skills and tools for areas such as tracking patients on ART, OI, PMTCT, counselling and testing, home based care, OVC support, community support and workplace programmes. Methods for data collection and necessary monitoring and evaluation capacities are described in section 4.6 of this component.

4.4.1.2 Describe how these goals and objectives are linked to the key problems and gaps arising from the description of the national context. Demonstrate clearly how the proposed goals fit within the overall (national) strategy and how the proposed objectives and service delivery areas relate to the goals and to each other.

In the description of the national context with respect to HIV/AIDS reference is made to the fact that the epidemic has already resulted in a reduction in life of 3 years between 1990 and 2002. Described also is the impact of HIV/AIDS on households, communities and the country as a whole. Considering the experience of other African countries, with more advanced epidemics, and where for instance HIV/AIDS has cut life expectancy by as much as 20 years, the indication could be that the worst is still to come for Nigeria. It is for this reason the strengthening of treatment, care and support services as presented in this proposal constitutes an important effort towards attaining national goals on HIV/AIDS.

[For health systems strengthening components only:]

4.4.1.3 Describe in detail how the proposed objectives and service delivery areas are linked to the fight against the three diseases. In order to demonstrate this link, applicants should relate proposed health systems interventions to disease specific goals and their impact indicators. To demonstrate the contribution of the proposed health systems strengthening intervention(s) in fighting the disease(s) include at least three disease relevant indicators with a baseline and annual targets over the life of the program. *[This may be done in form of an annex based on the format of table 4.4.b.]*

Clearly explain why the proposed health systems strengthening activities are necessary to improve coverage in the fight against the three diseases. *[When completing this section, applicants should refer to the Guidelines for Proposals, section III.B.&F.]*

4.4.1.4 Provide a description of the target groups, and their inclusion during planning, implementation and evaluation of the proposal. Describe the impact that the project will have on these group(s).

Nigeria has evolved a multisectoral and inclusive approach to responding to HIV/AIDS. Key stakeholders and population groups such as people living with HIV/AIDS and civil society are represented at all levels of policy planning and implementation of

programmes. NEPWHAN (representing people living with HIV/AIDS), CiSNHAN (representing civil society organizations), Ministry of Women Affairs (representing women's initiatives) and the National Youth Service, were all activity involved in developing this proposal, including submitting requirements of their constituencies and taking decisions on what to include in the proposal. In addition, these entities are also proposed to be principal or sub-recipients, indicating that they will receive funds directly and pass them on to their constituencies. It is expected that at the level of states, local governments and communities, consultations will always be made in setting priorities and reviewing performs of programmes in this proposal and other initiatives.

4.4.1.5 Provide estimates of how many of those reached are women, how many are youth, how many are living in rural areas. The estimates must be based on a serious assessment of each objective.

Table 4.4.1.5 Objectives

	Estimated percentage of people reached who are:		
	Women	Youth	Living in rural areas
Objective 1	50%	40%	30%
Objective 2	60%	70%	40%
Objective 3			50%
Objective 4	60%	50%	60%
Objective 5	40%	30%	10%
Objective 6	50%	10%	30%

4.4.1.6 Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. This should provide reviewers with a clear understanding of what activities are proposed, how these will be implemented, and by whom.

Objective 1: To scale up comprehensive HIV/AIDS treatment, care and support for people living with HIV/AIDS to all 37 States in the country.

Service delivery area: Antiretroviral Treatment (chronic HIV care)

Activity 1.1.1 Improve infrastructural capacity of health facilities to deliver ART

The aim here will be to ensure that at least 185 health facilities have the necessary structures and equipment to meet minimum requirements for provision of antiretroviral treatment. The National AIDS and STI Control Programme (NASCP) has already developed a set of draft standards that must be met by all health facilities (public, parastatal, NGO and private) to be formally recognized as ART centres. These standards define the minimum requirements for ART delivery. The guidelines will be finalized by end of 2005.

The plan is to have a minimum of 3 centres in each State that are able to provide ART. In the first year efforts will aim at expanding the treatment to an additional 13 centres to cover all the other states not included in the current programme.

Identification of potential centres to start ARV treatment will be made by the State Ministries of Health (SMoH) in collaboration with State Action Committees on AIDS (SACAs). The SMoH/SACAs could select public, private or NGO facilities. Once selection has been made the SMoH would then inform NASCP who will send assessment teams to

determine the status of the facilities and recommend necessary improvements required.

Six teams (one team per geopolitical zone) representing NASCP, the state level, PLWHA and a representative of development partners, will conduct the visits to assess the health facilities before they are selected to participate in this project. The teams will take approximately five days to assess the facilities.

Capacity gaps identified during assessments in terms of staffing, skills, equipment, renovations, supplies and others will be noted for each of the selected health facilities for strengthening by the governments or other relevant authorities, before being allowed to deliver ART services. This proposal has a budget to support the refurbishing of buildings, and procurement of the needed equipment according to identified needs.

The laboratory services are crucial in the scaling up of ART, in confirming the diagnosis of HIV infection, assessing patient eligibility for initiating ART, and monitoring patients on ART medication. Laboratory facilities must also have the capacity to diagnose opportunistic infections. Through this support, the total laboratory quality management system will be put in place in all the 185 facilities that will be included in this proposal.

Laboratories at all the 185 centres will be strengthened to perform the following tests: rapid HIV testing and ELISA testing, CD4 determination, sputum microscopy for TB, pregnancy test, haematological profile, liver function tests, renal function tests, gram staining, and bacterial culture and sensitivity testing. Laboratory equipment and reagents as well as other supplies will be included in procurement done in Activity 1.1.3.

Activity 1.1.2 Train and mentor health workers in provision of ART, opportunistic infections and related services.

Training in ART and OI provision
The minimum staffing requirement for each level of service delivery to deliver an integrated package of services including ART, palliative care and management of opportunistic infections, is envisaged as follows:

Tertiary/Secondary Health Facility

- 1 Doctor,
- 1 Nurse,
- 1 Counsellor,
- 1 Pharmacist/Pharmaceutical Assistant,
- 1 Lab scientist or technician and
- 1 Record Clerk.

PHC Clinic

- 1 Community Health/Nurse Midwife
- 1 Counsellor.

The approximate number of staff to be trained is about 1,110 for Tertiary and Secondary Health Facilities and 1,130 for the Primary Health Care Units, for all the centres to be supported under the proposal. Most of the health facilities in Nigeria are understaffed, for several reasons including budgetary constraints, inadequate staff motivation and geographical preferences. Modalities for staff re-deployment and retention through motivation will be explored and applied to ensure adequate staffing of the selected facilities using existing staff.

ART treatment guidelines for adults and children are available and will be distributed to facilities and personnel who will be providing ART.

WHO has developed the Integrated Management of Adolescent and Adult Illness (IMAI), a package serving the decentralized district approach for HIV services scale up. The package includes harmonized training for the different cadres of the HIV clinical care team

(Doctors, nurses and counsellor) and training for several community interventions. These guidelines will be adapted for Nigeria with support already mobilized. Trainers will be trained to scale up the training of service providers throughout the country. The adapted IMAI training package will be used to train a total of 2240 health providers in five years. The training will be conducted in groups of 30 participants, each lasting for five days followed by a period of five days practical attachment to a centre already delivering ART services.

The training will cover all the main aspects of ART provision at a health facility, such as counselling, diagnosis, treatment, follow-up, networking, project management, supply chain management and reporting. Following each training the ART team in each Secondary Health Facility will provide supportive supervision every three months to the PHC Clinics under their jurisdiction. During these supervisions, on the job training will be provided and constraints addressed.

Training for HIV/TB

Training materials will be reviewed to include TB components in HIV/AIDS training. Relevant staff in each facility will receive training on joint TB/HIV collaboration. This will include training on management of dual TB/HIV disease, data use and management, referral systems and commodity management. In addition to HIV staff, TB staff in the same hospitals will be trained on VCT, HIV prevention and Syndromic management of STIs and train HIV staff in the DOTS strategy and INH prophylaxis.

Training for PMTCT, STI, Counselling and Testing

Personnel in secondary health facilities and primary health facilities will be trained on PMTCT for duration of five days. The trainings will be phased and will be held at zonal and state levels, with existing PMTCT sites (with already trained trainers) functioning as training sites. Personnel from 37 health facilities will be trained each year for the five years.

A Training of Trainers (TOT) of health care providers on the syndromic management of STI will be conducted in each of the six geo-political zones annually. At the secondary health care level, two doctors and two nurses will be trained per state giving an average of about 24 health workers to be trained per geo-political zone. The trained health care provider will be responsible for stepping down the training at the state level using other funds.

A three-day counselling and testing training workshop will be organized in each of the six zones annually. Two persons will be trained per state and a total of thirty-six persons in each zone. This training will be a continuous annual exercise till the entire primary and secondary facilities are covered. At the end of the first year, 222 persons would have been trained and at the end of five years, a minimum of 1110 persons would have been trained. These training needs are expected to be integrated into the training of laboratory personnel providing VCT in each of these facilities.

Activity 1.1.3 Procure drugs, reagents and supplies

Strengthening procurement and supply management systems is an on going process to which all the health sector programmes including the GFATM Round 1 grant contribute.

This component will include funds for procurement of the drugs, reagents and commodities. Generic antiretroviral drugs will be procured from pre-qualified sources. Other drugs to be procured include co-trimoxazole, INH, and STI drugs. Various laboratory reagents and commodities for ART and OI management will be procured. The support in this proposal will include support the procurement, storage and distribution costs. Condoms are purchased mainly with resources from the government and Society for Family Health (SFH).

Activity 1.1.4 Strengthen linkages between ART and other related services

It is important that strong links exist between ART and other services such as PMTCT, TB, STI testing and counselling, Reproductive health, home based care, youth and orphans. Guidelines will be developed to describe the relationship between the services. Consultations will be held among service providers to define how the comprehensive treatment clusters will operate in each location. Thereafter, guidelines will be developed and distributed to facilities. Interaction between services and levels (and types) of facilities will be integrated in all training programmes described under Activity 1.1.2.

Service delivery area: Prophylaxis and treatment for opportunistic infections (acute HIV care).

Treatment of Opportunistic Infections is included in both the training associated with ART as well as procurement of drugs and improvement of health facilities.

Service delivery area: HIV/TB collaborative activities

Activity 1.2.1 Provide INH prophylaxis

INH prophylactic treatment will be introduced gradually in tertiary and secondary health facilities. This will go hand in hand with training of health personnel (described in Activity 1.1.2) and procurement of INH (Activity 1.1.3). Linkages are being strengthened with TB centres to identify HIV positive people who also have TB.

Service delivery area: Prevention of Mother to Child Transmission

Activity 1.3.1 Improve quality of PMTCT facilities including laboratories

National guidelines for PMTCT already exist. They define PMTCT activities and standards of facilities. Assessment of existing and potential PMTCT centres to see that they meet the minimum standards. During the assessment of centres, gaps will be identified. Gaps such as infrastructure will be collated for each of the selected sites. Such sites will be supported in addressing the identified gaps through provision of budget lines for furnishing of PMTCT offices and/or equipment supply for the counselling room and laboratory. Training of staff at PMTCT centres will be carried out as described in Activity 1.1.2.

Objective 2: To expand access to HIV testing and counselling services to cover all 37 States in the country.

Service delivery area: Counselling and Testing

Activity 2.1.1 Establish and accredit additional counselling & testing centres

National guidelines for counselling and testing already exist. However, these guidelines are currently being reviewed to clearly indicate the country position with respect to provider initiated or routine offer of testing. Standards of counselling and testing facilities have already been defined. Assessment of existing and potential counselling and testing centres will be undertaken. System and tools for accrediting counselling and testing centres will be developed by NASCP. Criteria for accreditation will be circulated to implementing partners. Any provider of existing or prospective counselling and testing centres will be free to request for accreditation.

In order to deliver efficient high quality VCT services, the VCT guidelines requires the following complement of staff at secondary and primary levels:

- VCT Coordinator:

- Medical record/Receptionist
- Counsellors
- Medical laboratory Scientist
- Community Coordinator

PHC

- VCT Coordinator:
- Counsellors
- Community Coordinator

VCT personnel in the above categories will be will be drawn from among existing staff identified in secondary and primary health facilities (affiliated of the secondary sites) as well as from the community.

Activity 2.1.2 Improve quality of counselling & testing facilities including laboratories

During the assessment of counselling centres, inadequacies in facilities and skills will be identified. Such sites will be supported in addressing the identified gaps through provision of budget lines for furnishing of counselling rooms and laboratories. The same assessment teams looking at ART centres will also be available to assess counselling and testing sites.

Activity 2.1.4 Procure test kits and VDRL reagents

Provision has been made in this proposal for purchase of HIV and VDRL tests kits as well as other relevant commodities. These will be distributed between the accredited counselling and testing centres. Testing for HIV will happen concurrently with screening for syphilis.

Objective 3: To strengthen the role of the community, civil society organizations and networks of PLWHA in providing and supporting HIV/AIDS treatment and care.

Service delivery area: Stigma reduction and respect for confidentiality

Activity 3.1.1 Provide training to personnel in civil society organizations and networks of PLWHA in stigma reduction

To ensure the delivery of quality community based care and support of PLWHAs, the care providers at the community and home level will receive training in stigma reduction. The training will target identified community based care groups and Community volunteers (TBAs/VHWs). Attempt will also be made to extend training to a larger target audience through the development and dissemination of IEC messages as posters and handbills.

Two representatives from each of the community support/HBC groups, will be trained on provision of home care and support for HIV infected and the affected families and households. A 2- day training will be organized in the state capitals.

Two community volunteers (Traditional Birth Attendant/ Village Health Worker will be attached to each of the secondary facility and PHC affiliate/ support group and trained to provide support to the HIV affected households. This training may be combined with the one above.

Activity 3.1.2 Create and strengthen support groups for PLWHA

Support groups of people living with HIV/AIDS will be linked to the treatment and care

facilities described above. These groups will be supported through training and seed funding to focus on addressing stigma reduction in their communities and promoting treatment preparedness. The intention is to have at least 3 such support groups linked to the 185 HIV/AIDS treatment services described above. PLWHAs from these support groups are to be included in the training of counsellors. In addition, other support groups within the community will also be established or strengthened. Support to these groups will mainly be facilitated through NEPWHAN and CiSNHAN.

Technical assistance will be offered to establish standards/guidelines and build capacity for effective programme implementation and management. A consultant with experience in PHC will be engaged to facilitate technical assistance.

Service delivery area: Home based care (palliative care)

Activity 3.2.1 Adapt, produce and disseminate guidelines and training materials for community support/home based care.

It is proposed to develop and field test training modules and curricula for different category of care givers in the community in line with the guidelines to ensure standard and uniformity of services that will be delivered. A consultant may be required to produce a draft and two meetings, each comprising of 20 participants will be conducted to review and adopt the document. 10,000 copies of the documents will be produced and disseminated.

Activity 3.2.2 Carry out mapping of community/home based care projects in the country

A database of community and home based care projects in the country will be developed. The database will serve as a tool for assessing coverage of home based care services, identifying capacity needs and facilitating linkages between home based care projects and other services. As a first step a mapping exercise will be carried out. An institution will be hired to design mapping tools, undertake baseline survey and develop a database of home base care projects in the country. CiSNHAN will be responsible for this activity and will work in collaboration with other partners such as NASCP and faith based organizations.

Activity 3.2.3 Provide training and material support to community-based organization providing home based care.

It is planned to associate 2 recognized NGO/CBOs with each of the 185 HIV/AIDS clusters who will be capacitated and charged to providing community support and home based care in association with the nodal centre, focusing on the following four tasks areas:

1. Raise treatment awareness and literacy in the community,
2. Co-organize patient self-help / support in the HIV/AIDS treatment sites
3. Provide psychosocial support to patients and family members
4. Provide home based care

To establish these community support/HBC groups, the following activities will be undertaken:

a. Review of guidelines and training materials for community Home Base Care facilitated Federal Ministry of Health in collaboration with CiSNHAN. This will involve a five-day meeting of selected technical group of 15 participants drawn from the NASCP, National Primary Health Care Development Agency, and other stakeholders.
b. Assessment and identification of suitable CBOs to implement community treatment support and Home Based Care will be developed by government in collaboration with partners, CBOs, NGOs, building on achievement in the private participation in other service areas like VCT and PMTCT. The process will borrow from identified

best practices both local and international. The selected CBOs will work closely with the health facilities and form a great system of patient follow up and supervision.

c. This will involve a 2 two-day meeting annually of selected technical group of 15 participants drawn from the NASCP, National Primary Health Care Development Agency, and other stakeholders. This workshop will select the organizations that will be supported for each year.
d. It is necessary to field test training modules and curricula for different category of care givers in the community in line with the guidelines to ensure standard and uniformity of services that will be delivered.
e. Production and dissemination of 10,000 copies of the community home based care guidelines.

Service delivery area: Community treatment awareness and support programmes

Activity 3.3.1 Support community treatment preparedness and adherence programs

Support groups of people living with HIV/AIDS and other community groups involved in HIV prevention, treatment, care and support will be encouraged and assisted to promote treatment preparedness and adherence support. The aim will be to have at least 3 such groups functioning in communities served by each of the HIV/AIDS treatment centres. Support to be provided will take the form of training and some incentives for treatment supporters. Some of the activities to be carried out by the support groups include recruiting volunteers from family members, community health workers and other community members to provide adherence support to patients. CISNHAN and NEPWHAN will coordinate this activity in collaboration with NASCP and other partners.

Activity 3.3.2 Provide adherence support services for clients receiving ART
Manuals for adherence will be developed to guide training of the treatment supporters. Trainers will be identified and oriented. Supporters will be identified and trained.

Service delivery area: Youth education

Activity 3.4.1 Train NYSC staff and Corp members on HIV VCT, stigma reduction, treatment, care and support of PLWHA

7,400 Corps members of the NYSC (200 in each state) will be trained each year in stigma reduction, treatment literacy and care and support for people living with HIV/AIDS. The aim of the training is to equip these young people to serve as social mobilizers for stigma reduction, treatment, care and support for PLWHA.

This training will take place during the general NYSC orientation activities in camp and will be conducted by the already existing pool of facilitators among the staff of NYSC Directorate, the Ministry of Intergovernmental Affairs, Youth Development and Special duties in collaboration with partners. It is further projected that the trained corpers will further empower 1, 480,000 Adolescents as Peer Educators and as Agency of Social Mobilization for HIV/AIDS Stigma Reduction, Treatment, Care and Support in Schools and Communities where they will be posted to serve. The NYSC will be responsible for organizing and carrying out this activity.

Activity 3.4.2 Support community and institution advocacy for stigma reduction, access to treatment, care and support for adolescents and youths

Further to the training of the corps members, 370 regular members of staff of the NYSC Directorate will be trained to serve as Institutional resource persons for social mobilization in the various catchment communities per annum for 5 years (Total 1850). In addition to the 10,000 corps members trained during orientation, these staff will also promote uptake of services such as VCT, ARV and OI treatments for those who are infected, while encouraging those who are positive to form or join support groups.

Activity 3.4.3 Establish and empower support group of Corpers Living With HIV/AIDS as Ambassadors of hope

To date there are no Corps members that have publicly declared positive sero status at present. However, up to twenty individuals have been identified through confidential voluntary counselling and testing.

The NYSC will embark on a programme to support young people willing to make public their HIV/AIDS status to become advocates among their peers, as 'Ambassadors of Hope'. They will in turn encourage positive living among other Corps member who might also be living with the virus. The NYSC Directorate in collaboration with NEPWAN and existing NGO with experience in managing similar programmes will provide training to these youth.

Objective 4: To increase access to care and support services for orphans and vulnerable children (OVC).

Service delivery area: Care and support for orphans and vulnerable children

Activity 4.1.1 Train community groups and care givers in skills for caring for OVC.

To contribute towards provision of appropriate care and support is provided to orphans and vulnerable children by communities and community based organizations, training programmes will be developed for groups working with OVCs. The training will cover areas such as psychosocial support, health care and education.

Activity 4.1.2 Develop and maintain national database of community based organizations providing support to OVC.

Using a participatory approach, a situation analysis will be carried out by a research agency selected by the Federal Ministry of Women Affairs. The outcome of the PSA shall be used to establish a database, which would be distributed to all stakeholders and project community members. The database shall be updated periodically. Consultants will be hired to design the situation analysis, collect the data and present findings. A dissemination workshop will be held to discuss the findings and identify approaches to better streamlining the work and best meet the needs of OVCs.

Activity 4.1.3 Provide material and logistic support to community based organizations working with OVC.

A small fund will be created to assist OVCs to access health and educational services. The fund will be administered by the Federal Ministry of Women's Affairs in collaboration with the Donors Forum. The fund will answer to the need of OVC who are in dire situations and not able to access health services. Local authorities at LGA and state levels will identify the beneficiaries of this fund. Strict criteria for eligibility for support will be developed and a transparent selection system will be instituted. The fund will mainly cover subsidies for treatment, purchase of drugs and other related health care costs.

Objective 5: To increase capacity of the private sector to implement workplace HIV/AIDS programs.

Service delivery area: Workplace policy and programmes.

Activity 5.1.1: Advocate for development and implementation of workplace HIV/AIDS policies.

Advocacy visits will be paid to 10 companies in each of the 12 target states to promote development of workplace policies and programmes and to encourage companies to actively participate in NIBUCAA. The aim will be to get companies to incorporate at least two components of the NIBUCAA workplace HIV programmatic menu in each year. Similar visits will be paid to the Chambers of Commerce in the target states as well as two visits to Small and Medium Scale Enterprises Development Agency of Nigeria (SMEDAN) with a view to integrating more SMEs into the project. Cost for advocacy visits to Lagos State (NIBUCAA office) will be covered by other resources within NIBUCAA. There will be 60 companies covered in the first year, another 60 in the second year, 30 in the third year and 20 in the fourth. A total of 170 companies will be covered in the 5 years. The costs will include travel expenses for NIBUCAA staff that will carry out the advocacy visits.

Activity 5.1.2: Undertake baseline assessment of HIV/AIDS programs in private companies

The purpose for carrying out the baseline survey to more clearly understand the nature of private sector response to HIV/AIDS. Information on HIV/AIDS response in the private sector is very scanty due to the diverse nature of the sector and also because till now there was no national body focusing on HIV/AIDS in private sector. The baseline survey will also serve to inform the project management team and provide input for decision making in order to refine the strategy and better focus project activities to maximize impact. The baseline survey will also serve as a tool to assess knowledge and attitudes on HIV/AIDS in the workplace. There will be a follow up survey after the 3rd year of implementation.

The survey will be conducted within the 12-targeted states over a period of three months. The research will be based on qualitative and quantitative data from selected companies, including the distribution of structured questionnaires, focus group discussions (FGDs) and in-depth interviews (IDIs). 600 questionnaires will be distributed per State in a minimum of 20 companies and 45 in depth interviews conducted per State (not same as places were questionnaires distributed) and three FGDs per company. A mapping of the private sector will be conducted prior to the survey as information on the structure of the private sector in Nigeria, (sectors, number of companies per state; company profile-workforce; turnover) is not readily available. With information collected from the mapping process the final study design and sample size will be determined. The Selection Criteria of the enterprises and workers to be surveyed will ensure a diversity of size, age groups, gender and sectors of economic activity.

Activity 5.1.3: Train workplace peer educators.

Training workshops will be carried in each of the 12 States. There will be one workshop per state in the first year. The training will initially target management, human resources, health personnel and union leaders. The following training workshops will be conducted during the project year in the 12 targeted states:

1. Policy Development Workshops (12)
2. Zonal Peer Educators' Training of Trainers Workshop (6)
3. State Peer Educators' Workshop and refresher training (24)
4. Peer Educators Trainings for SMEs and refresher training (24)

Training over the first four years of the project will also focus on providing employees at all levels with peer-led HIV & AIDS education. Employees have been shown to be more accepting of information provided by trusted and respected peers (employees and local community members) who are seen to have a greater understanding of the working and social environments. To achieve this, six 5-day zonal master training of trainers of peer

educators (one per geo-political zone) will be conducted, with a step down training by master trainers in each of 12 States for 10 companies per state for 5 days. Peer educators will also be encouraged to reach out to the members of the community in which they operate. Refresher training workshops of 3 days will be conducted in each state after six months. NIBUCAA will be responsible for organizing training of trainers workshops at national level. Consultants will be hired to carry out the training. Peer educators from companies who have undergone the training of trainers will in turn facilitate the training at state level and in individual corporations.

Activity 5.1.4: Support GIPA project in small and medium sized enterprises (SMEs).

Currently NIBUCAA is undertaking a GIPA Private sector initiative in collaboration with UNAIDS, NEPWHAN and NACA and willing member companies. This involves recruiting PLWHA into industry to be the face of HIV/AIDS. Currently all participating members are multinational companies. NIBUCAA intends to pilot a similar project in small and medium scale enterprises that form findings may not be able sustain a GIPA fieldworker.

The GIPA project will be piloted in two (Lagos and Kaduna State) of the 12 targeted states within ten SMEs. The GIPA Workplace Model, will place trained fieldworkers (PLWHA), living openly with HIV/AIDS, in select SMEs in different sectors so that they could assist in setting up, reviewing or enriching workplace policies and programmes. Experience had shown that persons living with or affected by HIV & AIDS can add considerable value to workplace HIV & AIDS programmes. Among other benefits, GIPA fieldworkers will provide role models to reduce stigmatization; help develop or improve workplace HIV & AIDS policies and communicate policies to employees; improve the effectiveness of peer education; provide formal pre- and post-test counselling; and extend the process to surrounding communities.

The project will involve funding salaries of the field workers (PLWHA) over the life of the project. Other funding components will include placement of adverts, training of fieldworkers (5 day training in the 2 pilot states), technical assistance, monitoring and supervision of the activities of the field workers. Three local consultants and one international consultant will be hired to provide technical support in the training in counselling, HIV and Law, HIV in the workplace and to drive the process. In order to ensure the efficacy of the GIPA fieldworkers, bi monthly review/consultative meetings will be held with GIPA field workers to review challenges, constraints and share information on project progress.

Activity 5.1.5: Strengthen linkages between public and private programs, and improve coordination within the private sector.

The Public-Private Partnership Forum (PPPF) was set up in order to facilitate national and state planning, coordination and cooperation regarding private sector participation in the national response to HIV. The Forum will draft a plan of action on Private/Public Sector Partnership with other stakeholders including the FBOs, CSOs and NEPWHAN. Partnership meetings will involve sharing of best practices by members and updates on joint activities undertaken by the partners. At least three meetings per year will be held during the life of the project year. The Partnership Forum will also develop guidelines for referrals and collaboration between public sector facilities and programmes and those of the private sector, especially with regards to people on antiretroviral treatment.

The project will support the establishment of a private sector response to HIV & AIDS database within the NIBUCAA secretariat. NIBUCAA will undertake data compilation and dissemination regarding workplace HIV & AIDS including a map of activities, strengths and impact of investment in HIV & AIDS-related programmes by participating companies and partners. Monthly, quarterly, semi annual and annual report will be produced from the database. Feedback will be given on a quarterly basis to all collaborating companies. The project will provide technical advice, training and software and in collaboration with NIBUCAA partners support the documentation of Nigerian best practices in workplace HIV initiatives.

Objective 6: To strengthen capacity of implementing institutions for effective programme management, coordination, monitoring and evaluation.

Service delivery area: Coordination and partnership development

Activity 6.1.1: Provide support to implementing institutions to strengthen programme management, supervision and monitoring.

The management institutions involved in the coordination of the proposal include National Action Committee on AIDS (NACA), National HIV/AIDS and STI Control Programme (NASCP), NEPWHAN, CiSNHAN, NIBUCAA, Nigerian Institute of Medical Research (NIMR), Federal Ministry of Women Affairs (FMOWA), Federal Ministry of Intergovernmental Affairs and Special Duties (FMIA) and National Youth Service Corps (NYSC).

NACA is the secretariat of the Presidential Committee on AIDS (PCA), and has the overall responsible for the national response for coordination, implementation, reducing duplication and overlap of HIV/AIDS activities in the country. NACA has representation from all Federal Ministries in Nigeria, major development partners, NGOs, FBOs, trade unions and private sector organizations therefore can play a critical central role in implementation of the sectoral activities. It was a principal recipient in the Round 1 Global Fund Proposal and can further serve as channel for funds to other sectors of its constituencies such as the civil society and ministries.

FMOH (NASCP) is the lead ministry for the health sector response to HIV/AIDS in Nigeria; it also has the oversight function of coordinating health sector responses (ART, PMTCT, VCT, TB, STI, OIs). It will be responsible for implementing the ART scale up component of this proposal. The individual institutions such as tertiary or secondary hospitals where services are rendered have their respective hospital management teams and ART committees.

The proposed institutional development issues are in the areas of personnel development, office equipments and supplies as well as token running cost. NACA was the PR for the round 1 GFATM. It has responded over time to the needs of

Generally training needs and activities would be in two categories-Managerial and Technical. The managerial training will need to address development of skills in advocacy including negotiation and presentation, coordination and networking, and team building and resource management. It will also aim at developing skills in planning, resource mobilization and management of technical assistance, programming, monitoring and supervision.

Training will be done centrally and will include participants from states, federal ministries and the other managers. The key institution for the Youth activities is the Ministry of Intergovernmental Affairs, Youth Development and Special Duties. The unit responsible for the implementation of the activities in this proposal is the Directorate of National Youth Service Corp, which has a national headquarter in Abuja, and offices in all the 37 states of the country.

Training needs will be for the staff of NYSC directorate. Areas of focus will be managerial skills, personnel management and skills to provide training for trainers as well as for behaviour change even among the youth corpers and their peers. This is a mixture of administrative and technical training. The training will be outsourced to already existing training institutions or be conducted

The overall management of the Scale up proposal relies on the national authority and severally on the implementing agencies (Sub-recipients). The NACA representing the Presidency has the overall oversight function for coordination and supervision of the

implementation. Horizontal supervision will also be available from Donor community, UN agencies, and other stakeholders through the various forums such as the Expanded theme Group (ETG), Donors Forum and similar Task forces.

The Ministry of Health through its Unit (NASCP) is the key responsible for the health sector response to HIV/AIDS. There is a National coordinator and focal points for each of the key areas of the response (ART, PMTCT, TB/HIV, STI, Laboratory etc). These focal points will coordinate the national implementation of their areas on day-to-day basis. Activities in the states and local government areas are routinely coordinated through the State Ministries of Health with the state AIDS Programme Coordinators as managers.

The Ministry of Intergovernmental Affairs Youth development and Special duties has a unit that provides oversight functions, logistic and material support to the Scheme. A division has been created within NYSC Directorate with a critical mass of officers that implement programmes supported by UNCEF, CIDA and SFH for this purpose.

The Federal Ministry of Women Affairs has a unit for OVC. The unit in turn has four sub units (Programme Management, Finance and Monitoring and Evaluation). The primary function of the ministry through the OVC unit is to coordinate the activities of all stakeholders working in the area of OVC in Nigeria. To support the ministry in this function, a steering committee has been set up. It is anticipated that after the national Situation analysis had been conducted, stakeholders in the respective local of implementation will be engaged for implementation of this proposal through submission and selection of competitive proposals.. These include NGOs, FBO, and other members of civil society organization. Collaboration with development partners has already been established.

They key personnel in these responsible agencies will need project management skills and/or re orientation to meet the added demands of the programme implementation. Such training will be outsourced to capable institutions within the country.

For each of the service delivery area included in this proposal, support will be provided to develop necessary data collection tools, logistics, capacity to analyse, use and disseminate strategic information. This is to contribute to improved implementation, timely monitoring and reporting. Some of the activities will be in form of training, technical assistance (as indicate above), equipment and logistic support.

Activity 6.1.2 Establish and support forums for program coordination at national and state levels.

ART Committee
A high level advisory committee on ARV already exists at the federal level. Its membership consists of FMOH, NACA, academia, WHO, UNAIDS, UNICEF, APIN, Policy Project, USAID, CDC, NAFDAC, Research Institutes, NGOs and representatives of Plash and Individuals. At the state level, a similar committee with functions including oversight, policy direction, and resource allocation will be constituted.
Similar committees already exist at the 25 sites with the various professionals who are managing HIV/AIDS patients as members.
The committees need to be strengthened to enable them hold regular meetings and ensure that appropriate decisions are taken.

Certification Panels
This panel will consist of the appropriate regulatory officers in the various departments of the Federal and state ministries of health, representatives of teaching hospitals, professional boards and relevant individuals of note.
The panels will review the states of health care facilities and training centres applying for certification and /or training.

The Network For HIV/AIDS Management In Nigeria (NETHIM)
The objectives of the ART network are to: Generate, disseminate and utilize strategic information on comprehensive care for all people living with HIV and AIDS; Contribute to

strengthening of human and infra-structural capacities for ART implementation in all parts of Nigeria; advocate to all tiers of government, development partners and other stakeholders for better mobilization and management of resources; create and strengthen linkages and support private-public partnership; ensure that all medical practitioners have the national guidelines for the use of ARVs; ensure greater and meaningful involvement of people living with HIV and AIDS in the Nigerian ART response; encourage research, dissemination and utilization of research findings on HIV/AIDS.

The constituencies are: The public sector, PLWHA, Researchers, NGOs, FBOs, Private, and the Business sector. Support for this network will be directed towards ensuring regular meetings, retrieval of information and dissemination of lesions learnt form the programme

NYSC Consultative forum
A Project Consultative Group made up of representatives of stakeholders will also be constituted to act in Advisory capacity. Its functions will include project review, advocacy, link NYSC with sources of assistance (financial and technical). It is also proposed that similar body will be set up at the State level to perform similar functions.

NIBUCAA General Meeting (Annual General Meetings)
A General Meeting is held once in every calendar year at such time and place as may be determined by the Board, The above-mentioned General Meeting is referred to as Annual General Meetings (AGM). All other General Meetings are called Extra-Ordinary General Meetings. There is also provision for another meeting of the Coalition to be held every calendar year to be known as a Business Meeting at such time and place as the Board may determine.

Activity 6.1.3: Provide appropriate and timely technical assistance for programme implementation and management.

Implementation of all the programmes included in this proposal will require a significant amount of technical assistance. It is evident that implementing institutions will not always have the necessary skills and expertise for all required tasks. Technical assistance will focus on addressing 3 main ways as follows: (1) design of interventions including development or review of guidelines, protocols and tools for implementation; (2) training including development of curricula, training materials and undertaking training of trainers; (3) problem-solving including review of performance, identifying and overcoming technical and management bottlenecks to programme implementation. Implementation of all the technical areas included in this proposal will require technical assistance at some point or other. Some of the key areas in which technical assistance will be required are as follows:

- Antiretroviral treatment (development of accreditation system; adaptation of training materials; paediatric treatment; community preparedness strategies)
- Counselling and testing (review of national testing policy; review of training)
- Management of opportunistic infections (review of STI control strategies,
- PMTCT
- Community involvement
- Greater Involvement of People Living with HIV/AIDS (GIPA)
- OVC support
- Private sector response
- Procurement and supply management
- Monitoring and evaluation
- Programme management and coordination

A range of institutions both national and international will provide technical assistance. Local technical assistance has largely been obtained in the form of individual consultants who are hired to perform specific tasks. Universities and research institutions have provided institutional technical assistance.

International institutions providing technical assistance include the World Health Organization and other UN agencies such as UNAIDS, UNICEF, UNFPA, UNDP, ILO and

UNODC. Other major international providers of technical assistance include Harvard University, Medicins Sans Frontiers (MSF), Family Health International (FHI) and the US Centres for Disease Control and Prevention (CDC).

Obtaining technical assistance from these providers will involve paying for consultancies; contracting out specific tasks; or paying for technical staff to be attached to implementing institutions for various periods of time.

4.4.1.7 Outline whether these are new interventions or existing interventions that are to be scaled up, and how they link to existing programs.

The Round one Global Fund program just commenced in the country with a target of 12,400 patients in 2005. This will be expanded to 57,200 in 2007. Again the program was designed to complement the existing program in the 25 sites mentioned above

PEPFAR project operates in government centers as well and in urban areas. Even the private facilities offering unclear level of services are located largely in the urban areas. To be able to achieve decentralization, complementarities and strengthening of PHC structure, the services have to be expanded from the capital cites to the periphery. The import of this is that the existing ART activities in the country are centralized and largely urbanized. It requires that the beneficiaries will have to travel to these centers before they can access treatment. However the health structure has provision for general hospitals and primary health care facilities in the periphery (states and local governments).

This proposal intends to scale up existing programmes on ART. The scale up will be in line with decentralization from tertiary, Federal government facilities to state and local government entities (ownership). The current proposal hopes to expand the current units of service delivery to secondary and primary facilities. It intends to train new cadres of staff in the periphery and capacitate them to assume modified responsibilities. The proposal will provide greater access to more beneficiaries than all the currently accommodated in existing programmes. However the lessons learnt in those other programmes will be put into use in the current proposal.

While the proposal intends to expand the existing programmes, it will enjoy the gains and lessons of the previous ones. The existing tertiary centers will receive referrals from the new centers and some of them can serve as training sites as well as provide data for research and quality control.

Innovations introduced in this proposal include the approach towards linking various services into what will function as comprehensive HIV/AIDS treatment, care and support clusters. Plans to incorporate stigma reduction efforts and promoting uptake of HIV/AIDS related services within the context of the National Youth Service Corps, represent another innovation.

4.4.2 Describe how the activities initiated and/or expanded by this proposal will be sustained at the end of the Global Fund grant period.

At the end of the Global fund grant, the government will have gradually integrated HIV/AIDS interventions into the development programmes such as the NEEDS and SEEDS. This will ensure that national poverty reduction measures are also directed to HIV/AIDS management.

Sustainability is a crucial aspect of this kind of peculiar health service, which requires beneficiaries continuing to benefit for life. The health system that will be involved in the service delivery, as being proposed, is inherently equipped to sustain the services through the following linkages:

- The service components are being integrated into the routine mandates of the involved institutions
- There is existing a Federal Government budget line for this service and it is expected that government will continue to increase the value of this funding
- State Governments also have budgetary provision, as well as external support for responding to HIV/AIDS. They are at liberty to apply these funds in line with their priority, of which ART provision is tops. This proposal will release this state potential into the ART initiative
- There is growing global interest of development partners in contributing to the care and support of PLWHA. Consequently, increasing support is being made available to poor and developing countries, including Nigeria
- Between 2006 and 2009, with the utilization of the first Global Fund grant and that in support of this proposal, the sustainability needs of the care service will become almost limited to provision of the necessary drugs and kits/reagents. Already, the system in place provides for some financial input from the consumers and drug cost is expected to continue to fall in the years ahead. This measure will leave significant fund available by 2009 to take the initiative forward.
- The Federal Government of Nigeria is seriously pursuing a commitment to local manufacture of ARV drugs and HIV testing kits. It should be up and running by 2009.

4.4.3 Describe gender inequities regarding program management and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities *(2 paragraphs)*.

The ART services will be delivered in a manner that ensures gender balance in their access. To ensure that this happens, all the staff that will be trained to deliver ART services will be trained to be gender sensitive in delivering their services. Women will specifically be targeted through providing PMTCT services. Spouses of women who test positive will be encouraged to also get tested. All that are found eligible for ART up on assessment will be initiated on ART. The treatment statistics that will be collected from the ART service delivering facilities will be gender disaggregated. They will be used to detect any early tendency for gender bias, thereby triggering measures to redress the tendency.

Additionally, utilizing the comparative advantages of civil society, in particular, the JIREH Foundation, which has experience on gender considerations, will utilize their experience in designing appropriate strategies to address gender inequalities.

4.4.4 Describe how this proposal will contribute to reducing stigma and discrimination against people living with HIV/AIDS, tuberculosis and/or malaria, and other types of stigma and discrimination that facilitate the spread of these diseases *(1–2 paragraphs)*.

This proposal will contribute in a number of ways towards stigma reduction. The service delivery area of stigma reduction and respect for confidentiality included in this proposal seeks to empower people living with HIV/AIDS, young people and other civil society to actively advocate for and promote stigma reduction. In addition, stigma reduction will be made an integral part of training provided to health workers, other caregivers and workplace.

4.4.5 Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs) *(1–2 paragraphs)*.

By scaling up ART provision to all states in the country, issues of equity are also been

addressed as that enables many more people in different geographical locations to access the vital service. Experience with the current ART programme in the public sector indicates that people of various socioeconomic levels and both genders are able to access these services. Measures have not yet been put in place to address the issue of access for indigent populations. The government is considering removing all kinds out payment for treatment of children. A position would be taken on this matter by the end of 2005.

4.5 Program and financial management

[In this section, CCMs should describe their proposed implementation arrangements, including nominating Principal Recipient(s). See the Guidelines for Proposals; section V.B.3, for more information. Where the applicant is a Regional Organization or a Non-CCM, the term 'Principal Recipient' should be read as implementing organization.]

4.5.1	Indicate whether implementation will be managed through a single Principal Recipient or multiple Principal Recipients.	☐ Single
		☒ Multiple

[Every component of your proposal can have one or several Principal Recipients. In Table 4.5.1 below, you must nominate the Principal Recipient(s).]

4 Components Section

Table 4.5.1 – Implementation Responsibility

Responsibility for implementation			
Nominated Principal Recipient(s)	**Area of responsibility**	**Contact person**	**Address, telephone and fax numbers, e-mail address**
National Action Committee on AIDS (NACA)	Programme Management; Procurement; Financial Management; Monitoring and Evaluation	Prof Babatunde Osotimehin	Plot 823 Ralph Sodeinde Street, Central Business District, Abuja 234-803-315-4600 234-9-290-4415 bosotimehin@naca.gov.ng osotimehin2000@yahoo.co.uk
Society for Family Health (SFH)	Programme Management; Procurement; Financial Management; Monitoring and Evaluation	Bright Ekweremadu	Plot 2380, Nanka close, Off Sultan Abubakar Way, Wuse Zone 3, PMB 5116, Wuse, Abuja bekweremadu@sfhnigeria.org brightgee@yahoo.com 234-803-505-3338 234-804-316-3880 234-9-524-0831 234-9-524-0830 (fax)

4.5.2 Describe the process by which the CCM, Sub-CCM or Regional CM nominated the Principal Recipient(s).

[Minutes of the CCM meeting at which the Principal Recipient(s) was/were nominated should be included as an annex to the proposal. If there are multiple Principal Recipients, questions 4.5.3 – 4.5.6 should be repeated for each one.] [Question not applicable to Non-CCM and regional Organization applications].

????

4.5.3 Describe the relevant technical, managerial and financial capabilities for each nominated Principal Recipient.

[Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, please refer to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).]

????

4.5.4 Has the nominated Principal Recipient previously administered a Global Fund grant?	☒ Yes (NACA) ☒ No (SFH)

4.5.5 If yes, provide the total cost of the project and describe the performance of the nominated Principal Recipient in administering previous Global Fund grants *(1–2 paragraphs).*

Total cost of the project being managed by NACA is about $70m in five years. The PR had a slow start due to multiple factors which included inadequate understanding of the results-based disbursement mechanism as well as unclear guidelines for oversight and implementation functions at various level of engagement with the two projects. Performance improved tremendously after the six-month lull and has accelerated immensely beginning from the fourth quarter of the project time cycle. Implementation and reporting have remained good thereafter. Project draw down of funds has also improved with service delivery to most beneficiary levels recording increasing coverage and

impressive outcomes.

4.5.6 Describe other relevant previous experience(s) that the nominated Principal Recipient has had:

[Please describe in broad terms the relevant programs, as well as their objectives, key implementation challenges and results (2–3 paragraphs).]

Both PRs (NACA and SFH) have had tremendous experiences in managing donor funds at levels that command international reputation for effective programme implementation.

NACA has been managing the funds for the three-year HIV/ AIDS Development Project under the World Bank-funded MAP to the tune of $93m among other funds coordinated from the stand point of the "Three Ones". The key implementation challenges have been the establishment of robust response programmes at state and district levels to contribute to the reduction of the prevalence by as much as 25% within 5 years of its operations.

SFH, on its part, has also been delivering outstanding services to partners like USAID, DFID and its mentor, PSI, during the past ten years. Currently, it is responsible for the effective fund management of the grant for the Strengthening of the National Response jointly supported by DFID and USAID. These allude to a commendable track record of effectiveness, while responding to the challenges of institutional strengthening to cope with increasing responsibilities.

4.5.7 Describe the proposed management approach and explain the rationale behind the proposed arrangements.

[Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM (2–3 paragraphs).]

The standard Global Fund arrangements will be adopted in the tripartite relationship that will be put in place for operation of the grant. The CCM will have oversight functions for the PR and SR while maintaining the link for in-country Global Fund processes. The nominated PR, while being answerable to the CCM, will work with the respective SRs to ensure timely and effective implementation of the work plan. Their role will include facilitating capacity building for the SR to ensure their capacity for maximum programmatic delivery.

4.5.8 Are sub-recipients expected to play a role in the program?	☒ Yes ➔ go to 4.5.9
	☐ No ➔ go to 4.6

4.5.9 How many sub-recipients will be, or are expected to be, involved in the implementation?	☒ 1-5
	☐ 6-20
	☐ 21 – 50
	☐ more then 50

4.5.10 Have the sub-recipients already been identified?	☒ Yes → go to 4.5.11 - 4.5.13
	☐ No → go to 4.5.14 & 4.5.15

4.5.11 Describe the process by which sub-recipients were selected and the criteria that were applied in the selection process (e.g., open bid, restricted tender, etc.); *(2–3 paragraphs).*
The sub-recipients were selected on account of their core mandate for service delivery. It is possible that some programmatic skills may be assumed, however, capacity strengthening will be part of the implementation process for effective performance.

4.5.12 Where sub-recipients applied to the CCM, but were not selected, provide the name and type of all organizations not selected, the proposed budget amount and reasons for non-selection in an annex to the proposal *(1–2 paragraphs).*
Not applicable

4.5.13 Describe the relevant technical, managerial and financial capabilities of the sub-recipients.
[Describe anticipated shortcomings or challenges faced by sub-recipients and how they will be addressed (e.g., capacity-building, staffing and training requirements, etc.).]
Limited capacity for Programme management is anticipated but a Participatory Planning and Learning process will be designed to improve performance and ensure sustainability over time. The reality of frequent staff postings within the health facilities also makes retraining a routine necessity.

4.5.14 Describe why sub-recipients were not selected prior to submission of the proposal.
Not applicable

4.5.15 Describe the process that will be used to select sub-recipients if the proposal is approved, including the criteria that will be applied in the selection process *(1–2 paragraphs).*
Not applicable

4.6 Monitoring and Evaluation (M&E)

[The Global Fund encourages the development of nationally owned monitoring and evaluation plans and M&E systems, and the use of these systems to report on grant program results. By answering the questions below, applicants should clarify how and in what way monitoring the implementation of the grant relates to existing data-collection efforts].

4.6.1 Describe how this proposal and its Monitoring and Evaluation plan complements or contributes towards existing efforts (including existing Global Fund programs) to strengthen the national Monitoring & Evaluation plan and/or relevant health information systems.
In 2003 the National Action Committee on AIDS (NACA) developed a national framework for monitoring and evaluation of HIV/AIDS known as the *Nigerian National Response*

Information Management System[15] (NNRIMS).

The NNRIMS framework contains a list of 26 core indicators for health sector - related interventions, including VCT, PMTCT, ART and STI, which were informed by. These have formed the This was a fall-out of the global system for tracking the epidemic introduced through the UNAIDS Country Response Information System (CRIS). The CRIS which requires countries to use, but not be limited to, an agreed set of indicators so that. In this way, the responses can be compared among countries and regions. Drawing on CRIS, NNRIMS was developed as the guideline to drive monitoring and evaluation of the national response across all the sectors and by all stakeholders in Nigeria.

NNRIMS is currently being piloted in six states in Nigeria. An evaluation of the framework will be carried out before the end of the third quarter of 2005. Expansion and full implementation of the national framework to the remaining 30 states and the FCT will commence immediately after the evaluation exercise.

The indicators listed in this proposal are all captured in the national framework for M & E. The Federal Ministry of Health is working in collaboration with NACA to ensure that indicators needed but not presently captured in measuring the effectiveness of HIV/AIDS prevention, treatment, care and support programmes are incorporated in a reviewed version of the document.

During the review of the national M & E framework, the three indicators in this proposal which was not initially included in the NNRIMS will be included. The review will also enable us to disaggregate the data into age group, sex and rural and urban distribution to enable us make necessary follow-up.

Monitoring and evaluation will also allow to extract data for GFATM funded sites, but in its totality go beyond the federal government supported sites to include those supported State governments, Partners and even the private sectors. This is important as it will provide comprehensive information on HIV activities in Nigeria.

4.7 Procurement and Supply Management

[In this section, applicants should describe the management structure and systems currently in place for the procurement and supply management (PSM) of drugs and health products in the country]. [When completing this section, applicants should refer to the Guidelines for Proposals, section V.B.5.]

4.7.1 Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities such as National Drug Regulatory Authority (or quality assurance department), Ministry of Finance, Ministry of Health, distributors, etc.

The Organisational structure of the Procurement Unit of NACA

Currently, NACA is responsible for procurement of health products for the Global Fund Round 1 grant. NACA maintains a Procurement Division, headed by a Procurement Specialist. There are also procurement officers who report to the Head of the Division. There is a procurement officer assigned to the Global Fund unit who manages all Global Fund procurement activities.
The following are the essential activities of the Procurement and Supply Management (PSM) systems

1. Product Selection
National Aids and STD Control Program (NASCP) is responsible for identifying the required health products to be procured. NASCP will finalize a list of essential drugs and other health products that are to be procured as per the WHO guidelines and conforming to the National Standard Treatment Guidelines/Essential Drug List of Nigeria. Only those products, that have the required registrations with the National Drug Regulatory Authority, namely National Agency for Food and Drug Administration & Control, Nigeria, will be selected.

The products chosen for treatment of HIV/AIDS will include the drugs required for the first line and second line of treatment as listed in the Standard Treatment Guidelines. The drugs required for the second line of treatment will be decided after closely assessing the clinical requirements of the patients.

2. International Agreements and National Laws
Nigeria is a member of the WTO. It has signed the TRIPS (Trade Related aspects of Intellectual Property Rights) and has adopted legislation within the framework of this Agreement. The Federal Ministry of Justice shall be responsible for overseeing compliance with IPR and WTO agreements.

Nigeria has a patent law as per Patent and Design Act, 1970 No.60. The law provides certain safeguards for the use / production of generic drugs in Nigeria. Presently, the generic versions of ARV drugs are imported, but none is under patent in Nigeria. The purchase of ARV drugs is based on the fact that HIV/AIDS scourge is an emergency in Nigeria, and the Government has to purchase them from affordable sources.

The procurement will be done under "Government use" clause. To effect procurement under this clause, a declaration by the Minister of Health that the product is needed in the interest of public health to save lives will be issued. Another condition for procurement under Government use is that the product to be procured must be registered with NAFDAC. These conditions will be adhered to.

3. Procurement Systems
The health products identified for procurement are Anti Retroviral (ARV), PMTC Drugs, other essential drugs, Consumables and Laboratory equipment, Reagents and Chemicals and HIV Rapid Kits. The Non-health Products include Computers & Office equipment, Motor Vehicles, Furniture and Refrigerators. The pharmaceuticals to be procured will be only those, which are in the Essential Drug List developed in Nigeria. Only those drugs, which have the NAFDAC registration, will be procured.

NACA has identified M/s. Crown Agents as the procurement agent for ARVs. Other products will be procured directly by NACA's Procurement Group constituted from within

the system. NACA will effect the procurement in collaboration with its sister agencies that have technical expertise and experience in procurement. The procurement process will strictly adhere to international norms as per the World Bank procurement policies and guidelines.
A NACA/NPT procurement manual approved by the Fund is already available, which spells out the processes required for procurement under the following methods.

a) ICB International competitive Bidding
b) LIB Limited international Bidding
c) NCB National competitive Bidding
d) NS National Shopping
e) DC Direct Contracting

The type of procurement to be adopted will be based on the World Bank guidelines and all the procurements will be made as per an approved list.

The procurement process will:
1. Facilitate purchase of the right drugs in the right quantities;
2. Ensure that all drugs procured meet recognized standards of quality;
3. Ensure that all drugs are stored safety under appropriate storage conditions.
4. Arrange timely delivery to avoid shortages and stock-outs;
5. Ensure supplier reliability with respect to service and quality; and
6. Set the purchasing schedule, formulas for order quantities and safety stock levels to achieve the lowest total cost at each level of the system.

3.1. Procurement Responsibility
For finalizing the drug list and the standards, NACA will constitute two committees, one for Quality Assurance another for Monitoring and Evaluation.
The Monitoring and Evaluation Group will have sub-Groups at the end user level to facilitate study of Patient Compliance, Resistance to Therapy, Adverse Drug Reaction and Feedbacks received from the field.
The members of these committees will be drawn from:
i) NACA
ii) NPT
iii) FMOH (Federal Ministry of Health)
iv) Federal Government Medical Centers
v) Central Medical Stores
vi) NAFDAC

The Procurement Group of NACA is responsible for developing and carrying out tenders for the global fund purchases. However, the identification of the types, specifications and amount of drugs needed, will be developed in conjunction with the SR and its relevant units. NACA in conjunction with the managements of the Central Medical Stores (CMS), co-ordinate the supply chain to ensure:
a) Up-dating inventory
b) Proper storage and
c) Efficient distribution.

The procurement Group will co-ordinate with the QA Group of NACA and the NAFDAC authorities on the quality control issues.
The WHO/PAHO (Pan American Health Organization) will provide information and updates about the policies that govern procurement at the international level.
The tender documents will be designed in such a manner that the documents submitted by a prospective supplier will include information and supportive documentation, which will facilitate a critical evaluation of the products, offered in addition to a critical assessment of the company's experience, financial standing and production capabilities.
The company's reputation will be assessed from its list of customers, market standing and non-conviction under laws of the land.
The procurement Group will perform the evaluation exercise as part of the "Technical Bid Evaluation", and it will call for any information on that helps it to assess the bidder's

capability to meet the contractual obligations set out by NACA.

4.0 Quality Assurance
The National Agency for Food and Drugs Administration and Control (NAFDAC) is responsible for Quality Assurance & Quality Control. It will ensure the quality of supplies through several means. Products registered with NAFDAC alone will be procured under the grant. At the preliminary stage, stringent pre-qualification norms will be imposed; these will include annual turnover criteria, market standing and non-conviction under laws related to Drugs and approved quality certification.

NAFDAC will further ensure adherence to quality assurance elements (of the suppliers) like current good manufacturing practices (GMP). It will arrange for pre-shipment inspections by SGS by drawing samples from every batch at ports of entry and also at the Central Medical Stores.

The samples, so drawn will be analyzed at the NAFDAC laboratories. The number of such samples to be drawn randomly will be as per a plan outlined by NACA. Above all samples will also be drawn and tested as and when the PR desires or on receipt of complaints on lapses in quality.

4.7.2 Procurement Capacity

a) Will procurement and supply management of drugs and health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of these products?

- ☒ Principal Recipient only
- ☐ Sub-recipients only
- ☐ Both

b) For each organization involved in procurement, please provide the latest available annual data (in Euro/US$) of procurement of drugs and related medical supplies by that agency

NACA is involved with the procurement of over $12m for drugs and related medical supplies, while SFH manages supplies worth well over $25m for drugs and commodities.

4.7.3 Coordination

a) For the organizations involved in section 4.7.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc.

For NACA, the project percentage of national will be 65% while for SFH this will about 40%

b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal *(1 paragraph)*.

Drugs for TB are being procured through the GDF and additionally, this proposal will benefit from the ongoing Nevirapine drug donation programme of Axios as well as any others that develop during the entire project cycle office years.

4.7.4 Supply Management (Storage and Distribution)	
a) Has an organization already been nominated to provide the supply management function for this grant?	☐ Yes → continue ☒ No → go to 4.7.5

b) Indicate which types of organizations will be involved in the supply management of drugs and health products. *[If more than one of these is ticked, describe the relationships between these entities (1 paragraph)]*

- ☒ National medical stores or equivalent
- ☐ Sub-contracted national organization(s) (specify which one[s])
- ☐ Sub-contracted international organization(s) (specify which one[s])
- ☐ Other (specify)

c) Describe the organizations' current storage capacity for drugs and health products and indicate how the increased requirements will be managed.

The National Medical Store is the mainframe for the drug logistics management and this has an installed capacity to fully absorb the increased requirements that this proposal will introduce. It is necessary that human resources strengthening will be needed to close technology gap that will arise from a computerized facility which is part of the ongoing refurbishment effort for the medical stores.

d) Describe the organizations' current distribution capacity for drugs and health products and indicate how the increased coverage will be managed. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal.

There is a nation-wide distribution chain linking several zonal-level stores to the Central Medical Store. The logistic requirements of movement between these points will require further strengthening as these have been broken over the years due to inadequate sustainability arrangements. This area of work is however being addressed in another component (Strengthening Health Systems) of this proposal as a strong linkage and cross cutting issue. The entire country is targeted.

[For tuberculosis and HIV/AIDS components only:]

4.7.5 Does the proposal request funding for the treatment of multi-drug-resistant TB?	☐ Yes ☒ No

[If yes, applicants should be aware that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the Committee has already been made. If not, a Green Light Committee application form must be completed and included with this proposal (see AnnexB).]

4.8 Technical Assistance and Capacity-Building

[Technical assistance and capacity-building can be requested for all stages of the program cycle, from the time of approval onwards, including Technical Review Panel Clarifications, development of M&E or Procurement Plans, etc.]

4.8.1	Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further develop national capacity, capacity of principal recipients and sub-recipients, as well as any target group. Please ensure that these activities are included in the detailed budget.
	The capacity constraints are largely those of human resources in the various areas of service delivery for the objectives stated. The strategy will be that of developing and strengthening the skills of implementers in a ???

5 Budget Section

[Please note that this section is to be completed for each component. Throughout, 'year' refers to the year of proposal implementation. For example, if Table 4.1.1 indicates that the proposal starts in June, year 1 would cover the period from June to the following May.

Financial information can be provided either in Euro or US$, but must be consistent throughout the proposal. Please clearly state denomination of currency.]

All budget breakdowns requested in the following sections are to be provided as an attachment to the hard and soft (electronic) copies of the proposal form.

5.1 Component Budget

[The budget should be broken down by year and budget category. The budget categories and allowable expenses within each category are defined in detail in the Guidelines for Proposal, section V.B.7. Costs that do not fall within the above-mentioned categories can be allocated under 'other' but must be specified. The total requested for each year, and for the program as a whole, must be consistent with the totals provided in sections 5.1.]

Table 5.1 – Funds Requested from the Global Fund

	Funds requested from the Global Fund (in US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	298,080	260,680	260,680	260,680	260,680	1,340,800
Infrastructure and equipment	3,765,549	2,810,752	2,731,208	2,768,208	2,768,208	14,843,925
Training	6,450,764	6,063,149	5,969,380	5,906,636	5,942,383	30,332,312
Commodities and products	1,593,166	3,635,976	5,407,288	6,890,043	10,142,799	27,669,272
Drugs	6,515,030	13,332,229	20,292,639	27,819,484	34,715,253	102,674,635
Planning and administration	924,566	361,882	432,690	477,990	553,290	2,750,418
Technical support to CCM, PR and SR	206,230	206,230	206,230	206,230	206,230	1,031,150
Total funds requested from the Global Fund	19,753,385	26,670,898	35,300,115	44,329,271	54,588,843	180,642,512

The component budget must be accompanied by a detailed year 1 and indicative year 2 workplan and budget. This should reflect the main headings used in section 4.4. (component strategy) and should meet the following criteria, (please attach this information as an annex):

a) It should be structured along the same lines as the component strategy—i.e., reflect the same goals, objectives, service delivery areas and activities.

b) It should be detailed for year 1 and indicative for year 2, stating all key assumptions, including those relating to units and unit costs, and should be consistent with the assumptions and explanations included in section 5.2.

c) It should provide more summarized information and assumptions for the balance of the proposal period (year 3 through to conclusion of proposal term).

d) It should be integrated with a detailed workplan for year 1 and an indicative workplan for year 2.

e) It should be fully consistent with the summary budgets provided elsewhere in the proposal, including those in this section 5.

5 Budget Section

5.1.1 Breakdown by Functional Areas

[Provide the budgets for each of the following three functional areas—monitoring and evaluation; procurement and supply management; and technical assistance. In each case, these costs should already be included in Table 5.1. Therefore, the tables below should be subsets of the budget in Table 5.1., rather than being additional to it. For example, the costs for monitoring and evaluation may be included within some of the line items in Table 5.1 above (e.g., human resources, infrastructure and equipment, training, etc.).]

Monitoring and evaluation:

[This includes: data collection, analysis, travel, field supervision visits, systems and software, consultant and human resources costs and any other costs associated with monitoring and evaluation.]

Table 5.1.1a – Costs for Monitoring and Evaluation

	Funds requested from the Global Fund for monitoring and evaluation (in US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Monitoring and evaluation	209,255	135,200	266,244	264,200	395,844	1,270,743

Procurement and supply management:

[This includes: consultant and human resources costs (including any technical assistance required for the development of the Procurement and Supply Management Plan), warehouse and office facilities, transportation and other logistics requirements, legal expertise, costs for quality assurance (including laboratory testing of samples), and any other costs associated with acquiring sufficient health products of assured quality, procured at the lowest price and in accordance with national laws and international agreements to the end user in a reliable and timely fashion; do not include drug costs.]

Table 5.1.1b – Costs for Procurement and Supply Management

	Funds requested from the Global Fund for procurement and supply management (in US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Procurement and supply management	8,108,196	16,968,205	25,299,927	34,709,527	44,858,052	130,343,907

Technical assistance:
[This includes: costs of consultant and other human resources that provide technical assistance on any part of the proposal—from the development of initial plans, through the course of implementation. This should include technical assistance costs related to planning, technical aspects of implementation, management, monitoring and evaluation and procurement and supply management.]

Table 5.1.1.c – Costs for Technical Assistance

	Funds requested from the Global Fund for technical assistance (in US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Technical assistance	179,267	148,136	133,986	136,686	85,631	689,906

5.1.2 Breakdown by Service Delivery Area

[Please estimate the percentage allocation of the annual budget over service delivery areas. The objectives and service delivery areas listed should resemble, as closely as possible, those in Table 4.4b.]

Table 5.1.2: Estimated Budget Allocation by Service Delivery Area and Objective.

		Year 1	Year 2	Year 3	Year 4	Year 5	Total
Value per year							
Objectives	Service delivery area	Estimated percentage of budget					
Objective 1...	Service delivery area 1.1	45.18%	60.06%	65.54%	69.98%	71.48%	62.46%
	Service delivery area 1.2	0	0	0	0	0	0
	Service delivery area 1.3	5.77%	4.28%	3.22%	2.57%	2.08%	3.58%
Objective 2	Service delivery area 2.1	14.26%	13.74%	14.15%	13.45%	14.54%	14.03%
Objective 3	Service delivery area 3.1	9.59%	7.10%	5.35%	4.26%	3.79%	6.02%
	Service delivery area 3.2	2.01%	1.63%	1.89%	1.79%	1.88%	1.84%
	Service delivery area 3.3	6.31%	4.67%	3.52%	2.80%	2.28%	3.92%
	Service delivery area 3.4	4.48%	3.19%	2.28%	1.82%	1.48%	2.65%
Objective 4	Service delivery area 4.1	3.69%	2.21%	1.93%	1.54%	1.27%	2.13%
Objective 5	Service delivery area 5.1	6.30%	2.41%	1.21%	1.07%	0.38%	2.27%
Objective 6	Service delivery area 6.1	2.41%	0.71%	0.90%	0.72%	0.82%	1.11%
Total:		100%	100%	100%	100%	100%	

5.1.3 Breakdown by Partner Allocations

[Indicate in Table 5.1.3 below how the requested resources in Table 5.1 will, in percentage terms, be allocated among the following categories of implementing entities.]

Table 5.1.3 – Partner Allocations

	Fund allocation to implementing partners (in percentages)				
	Year 1	Year 2	Year 3	Year 4	Year 5
Academic/educational sector	0	0	0	0	0
Government	75.79%	84.18%	88.03%	90.07%	91.67%
Nongovernmental/ community-based org.	3.35%	2.48%	1.87%	1.49%	1.21%
Organizations representing people living with HIV/AIDS, tuberculosis and/or malaria	6.59%	5.02%	4.45%	3.83%	3.54%
Private sector	6.30%	2.41%	1.21%	1.07%	0.38%
Religious/faith-based organizations	7.97%	5.90%	4.45%	3.54%	3.20%
Multi-/bilateral development partners	0	0	0	0	0
Others (please specify)	0	0	0	0	0
Total	100%	100%	100%	100%	100%

5.2 Key Budget Assumptions for requests from The Global Fund

Without limiting the information required under section 5.1, please indicate budget assumptions for year 1and year 2 in relation to the following:

5.2.1 Drugs, commodities and products

[Unit costs and volumes must be fully consistent with the detailed budget. If prices from sources other than those specified below are used, a rationale must be included.]

a) Provide a list of anti-retroviral (ARVs), anti-tuberculosis and anti-malarial drugs to be used in the proposed program, together with average cost per person per year or average cost per treatment course. *(Please attach annex).*

b) Provide the total cost of drugs by therapeutic category for all other drugs to be used in the program. It is not necessary to itemize each product in the category. (Please attach annex).

c) Provide a list of commodities and products by main categories e.g., bed nets, condoms, diagnostics, hospital and medical supplies, medical equipment. Include total costs, where appropriate unit costs. *(Please attach annex).*

(For example: Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS. Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2003, (http://www.who.int/medicines/organization/par/ipc/sources-prices.pdf); Market News Service, *Pharmaceutical Starting Materials and Essential Drugs*, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mns/pharma.html); *International Drug Price Indicator Guide on Finished Products of Essential Drugs*, Management Sciences for Health in Collaboration with WHO (published annually) (http://www.msh.org); *First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility* (http://www.stoptb.org/GDF/drugsupply/drugs_available.html).)

Attached as Annex.

5.2.2 Human resources costs

In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent human resources spending will strengthen health systems' capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over *(1–2 paragraphs). (Please attach annex).*

5.2.3 Other key expenditure items

Explain how other expenditure categories (e.g., infrastructure, equipment), which form an important share of the budget, have been budgeted for the first two years *(1–2 paragraphs).(Please attach annex).*

Attached as Annex.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APIN	AIDS Prevention Initiative in Nigeria
ART	Anti retroviral Treatment/Therapy
ARV	Anti retroviral
BMS	Breast Milk Substitutes
CACA	Community Action Committee on AIDS
CDC	Centre for Disease Control
CCM	Country Coordinating Mechanism
CEDPA	Centre for Development and Population Activities
CHAN	Christian Health Association of Nigeria
CLMS	Contraceptive Logistics Management System
CiSNHAN	Civil Society Network on HIV & AIDS in Nigeria
CIDA	Canadian International Development Agency
CRIS	Country Response Information System
CSW	Commercial Sex Workers
CRIS	Country Response Information System
CRS	Catholic Relief Services
CSO	Civil Society Organisation
DFID	Department for International Development (UK)
DOD	Department of Defence (US)
DOTS	Directly Observed Treatment Short Course
DPH	Department of Public Health
FCMS	Federal Central Medical Stores
FCT	Federal Capital Territory
FGD	Focus Group Discussion
FGN	Federal Government of Nigeria
FHI	Family Health International
FMC	Federal Medical Centre
FMoH	Federal Ministry of Health
FMoWA	Federal Ministry of Women's Affairs
FP	Family Planning
GAP	Global AIDS Programme
GHAIN	Global HIV & AIDS Initiative in Nigeria
GIPA	Greater Involvement of People Living with HIV & AIDS
GFTAM	Global Fund to fight AIDS Tuberculosis and Malaria
HAF	HIV & AIDS Fund (World Bank)
HBC	Home Base Care
HAART	Highly active antiretroviral therapy
HEAP	HIV & AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
IDI	In Depth Interview
IDU	Injecting Drug User
IEC	Information Education and Communication
ILO	International Labour Organization
IMR	Infant Mortality Rate
INH	Isoniazid
IT	Information Technology
LACA	Local Government Action Committee on AIDS
LGA	Local Government Area
LDD	Long Distance Driver
LMIS	Logistics Management Information System
MAP	Multi Action Programme
MCH	Maternal & Child Health
MDG	Millennium Development Goal
MoF	Ministry of Finance
MMIS	Making Medical Injections Safer
MMR	Maternal Mortality Rate
MSF	Medecins Sans Frontieres
MSM	Men having Sex with Men
MTP	Medium Term Plan
NACA	National Action Committee on AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NARHS	National HIV & AIDS and Reproductive Health Survey

NASCP	National AIDS and STI Control Programme
NBTS	National Blood Transfusion Scheme
NEACA	National Expert Advisory Committee on AIDS
NEEDS	National Economic Empowerment and Development Strategy
NEPAD	New Partnership for Africa's Development
NELA	Network on Ethics Law and AIDS
NEPWHAN	Network of People Living with HIV and AIDS in Nigeria
NGO	Non-Government Organization
NHMIS	Nigeria Health Management Information System
NIBUCAA	Nigerian Business Coalition for AIDS
NIMR	Nigerian Institute of Medical Research
NIPRD	Nigerian Institute of Pharmaceutical Research and Development
NNRIMS	Nigeria National Response Information System
NPHCDA	National Primary Health Care Development Agency
NPT	National Project Team.
NSF	National Strategic Framework
NYSC	National Youth Service Corps
OD	Organizational Development
OR	Operations Research
OI	Opportunistic Infection
PHC	Primary Health Care
PEP	Post Exposure Prophylaxis
PEPFAR	Presidential Emergency Plan for AIDS Relief
PHRPlus	Partners for Health Reform Plus
PLWHA	People Living with HIV & AIDS
PMTCT	Prevention of Mother to Child transmission
PR	Principal Recipient (Global Fund)
RH	Reproductive Health
SACA	State Action Committee on HIV & AIDS
SASCP	State AIDS/STD Control Programme
SDP	Service Delivery Point
SEEDS	State Economic Empowerment Development Strategy
SFH	Society for Family Health
SIPAA	Support to International Partnerships Against AIDS in Africa
SMoH	State Ministry of Health
SME	Small and Medium Size Enterprises
SMEDAN	Small and Medium Scale Enterprises Development Agency of Nigeria
SOP	Standards of Practice
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNAIDS	Joint United Nations Programme on HIV & AIDS
UNODC	United Nations Office on Drugs and Crime
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Department for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
VDRL	Viral Disease Research Laboratory
WB	World Bank
WHO	World Health Organization

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Correct Tables

Table 5.1.1b – Costs for Procurement and Supply Management

	Funds requested from the Global Fund for procurement and supply management (in US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Procurement and supply management	8,108,196	16,968,205	25,299,927	34,709,527	44,858,052	129,943,907

Table 5.1.1.c – Costs for Technical Assistance

	Funds requested from the Global Fund for technical assistance (in US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Technical assistance	179,267	148,136	133,986	136,886	85,631	683,906